

# Input from People and Families Engaged in or Previously Engaged in Receiving Mental Health Services

This Appendix includes input from people and families who are engaged in or were previously engaged in mental health services from each OMH region. It also offers the perspective of individuals who are hospitalized in OMH forensic facilities across the State. Finally, OMH attended the public hearing held by the New York City (NYC) Department of Health and Mental Hygiene (DOHMH) and took notes regarding issues, concerns and recommendations. The summary notes, which have been reviewed by DOHMH, also appear in this appendix.



## Central New York Recipient and Family Meeting Recommendations

April 20, 2011

Advocate Specialist Tony Trahan from the Office of Mental Health (OMH) Central Office facilitated a videoconference with individuals and family members from the Central New York Region and OMH Planning staff. The meeting focused on planning for this year's Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from family members and individuals engaged or previously engaged in mental health services about impending changes to the system of care: behavioral health networks and behavioral health homes.

Participants were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of "ideal" elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down recommendations by the strategic framework content domains.

## **PEOPLE FIRST**

**Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.**

- Provide education to people and families engaged in substance abuse programs about the role psychiatric medication can play in working toward recovery

## **PERSON-CENTERED DECISION MAKING**

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- Encourage the use of tools and approaches that are proven to support recovery, such as wellness recovery action planning (WRAP), where individuals can include natural supports in helping them (e.g., to manage their own triggers and their choices for dealing with them).
- Ensure that WRAP is part of the support services available in behavioral health homes.

## **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.**

- While difficult to attain, continue where possible to provide affordable, safe housing.
- Promote work opportunities for people who wish to work and supplement their social security income benefit.
- Rather than build more prisons, provide more safe, affordable housing that promotes a person's abilities to engage in work and feel a sense of dignity and worth.
- Strive to make sure that individuals with serious mental health challenges who have criminal histories (e.g., felony) are not placed at greater risk for victimization and greater symptom development secondary to stress because they are locked out of safe, affordable housing and left to live in very bad buildings and neighborhoods.
- Improve access to "safe" buildings for people with mental illness who will benefit from living in environments with "honest working people."
- To ensure stable community living for ex-felons who are now excluded from federally funded housing, seek a waiver from the federal government that would allow ex-felons to access and utilize such housing after demonstrating for a certain length of time (e.g., two years) that they have no new legal entanglements.

## **LIVING A HEALTHY LIFE**

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

- Understand that when people with serious mental health challenges experience frustration in accessing services, they may lessen their efforts and risk becoming disconnected from care.

- Increase engagement in services for individuals and families by providing education on mental health early to help with symptom recognition, and increase understanding of effective treatments, including medication management.
- Include effective alternative medicine approaches as part of the continuum of care (e.g., reiki, chiropractor, yoga, pain management).
- Know that when people have access to medications and care, they are able to “stay on track” and do better.

## **MENTAL HEALTH TREATMENT AND SUPPORT**

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

- Strengthen provider-to-provider communications within the same organization or between organizations to reduce the probability of harm and to improve care coordination and outcomes.
- Build a sense of collegiality and team among providers in an organization and across organizations so the best outcomes can be achieved.
- Assess the degree to which independent substance abuse and mental health providers are taking seriously the importance of treating both substance abuse and mental health disorders and encouraging dual recovery and integrated care.
- In responding to crises, providers should try, whenever possible, to avoid police involvement and the community and personal trauma associated with police intervention, which carries over after recovery and may show up as fear of the police.
- Realize that the police and first responders (e.g., ambulance personnel) have assumed the role of filling a mental health support and safety void in communities and use peers in helping them improve their understanding of mental health issues and empathic responses that will help to maintain calm or de-escalate situations.
- Rather than referring people to emergency departments for crisis care, encourage providers to have a crisis response that begins with having a person answer the call for help rather than an answering machine.
- Avert the need for emergency department care by having a range of crisis services available to people, such as a respite setting where people can go to talk with people who are supportive and understanding, using much less costly hospital diversion programs such as respite homes where the change in environment removes a person from a crisis situation.

## **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

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

- Understand that when providers are connected by computers and they are used effectively, care is improved and helps to set a foundation for good self-advocacy.

- Encourage peer advocates to be involved in strengthening communication skills and teaching individuals how to make the most of their visits to hospitals, clinics, and other care providers.
- Encourage positive mentoring experiences, similar to that seen in programs where people with a cancer diagnosis serve as mentors for people newly diagnosed with cancer.
- Separate out peer mentoring services so they are provided “authentically” by peers who are not employed by the organization in which services are received.
- Utilize standardized peer support training so that peers are able to effectively help people in crisis and at risk for going over the edge.
- Use peer services earlier in the course of a person’s trajectory toward crisis and avert the need for emergency department services.
- Make peer support services and diversion initiatives the first line of intervention before emergency department care is sought.
- At the point a person does seek emergency department services for a psychiatric crisis, ask if he or she would like to talk with a peer while awaiting professional psychiatric assessment, provide a supportive and caring environment away from the hubbub of the department, and make certain that people in crisis are not isolated and alone with their thoughts and feelings.
- Realize the power of peer support services to people seeking emergency department care for crisis because peers are trusted and effective in using their own knowledge and experience (e.g., having walked in their shoes) to provide comfort and help allay fears.
- Place emphasis on the integration of authentic peer support services into all levels of the system of care.
- Call upon peer specialists to help with care coordination when there is a waiting time for emergency department services.
- Use peer bridger services to avert crises.
- Include peer support in standard emergency department care, whether accompanying people in crisis to emergency departments and providing ongoing support or being on hand when a person in crisis arrives at the emergency room.
- Employ the use of crisis lines staffed by peers who can be responsive and compassionate.
- Encourage the use of peer support for people who feel as though they are heading toward crisis, and include preventive options such as peer hospital diversion, peer empowerment centers, peer drop-in centers, crisis lines, and warm lines.
- Look to peer-run services to strengthen employability such as the Intern Work Program (IWP), which offers 1-to-2 year internships and opportunities for strengthening confidence, respect, and credibility.

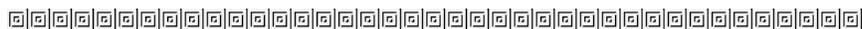
- Ensure that peer services are billable under Medicaid as well as the resources necessary to support this work (e.g., family education, medication management classes).
- Use research findings to strengthen the case for the value of peer services and compensate peers for their expertise and knowledge and as valued members of the health care team.
- Push out more peer support resources into rural areas so that these areas receive the same resources as more urban areas.

#### **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.**

- Ensure that people engaged in services and their families are involved in policy and decision making and are included in planning to shape the design of services and supports.
- Provide education and training that will enable mental health and primary care providers to work more effectively together.
- Help people to understand their current options under fee-for-service or managed care and what services are covered and not covered (e.g., bus passes not covered by Fidelis, but are under Medicaid, supportive housing from Medicaid).
- Address the problems caused by individuals who are covered by Medicaid, yet on psychiatrist waiting lists because too few are available to meet need.
- Know that emergency department visits are the least effective use of mental health dollars for people in crisis, in addition to contributing to negative experiences for people with mental health issues.
- Understand that while substance abuse and mental health agencies are charged with providing care for dual diagnosis, people are not getting integrated care (e.g., Double Trouble does work and should be available whether a person seeks mental health *or* substance abuse care).
- To achieve more cost-effective care, set a goal for diverting emergency department visits (e.g., reduce by 10%), while ensuring that appropriate services and supports (e.g., peer support, bridger services) are in place.
- Provide a place where people engaged in services can ask questions about Medicaid managed care, which continues to be introduced in counties by the Department of Health, and ensure that people have access to the information about whether to en-roll in a managed care plan or continue to receive Medicaid on a fee-for-service basis.
- Under Medicaid, make the expectation that doctors cannot turn people away who have complex medical and behavioral health conditions.

- Address the problem that burdensome paperwork required by Medicaid serves as a barrier to providers participating in the Medicaid program and reduces access to care.
- Because prescription drug copayments come out of pocket under managed and serve as a barrier to obtaining medication, people are not able to obtain their medications as ordered.
- Help people to understand the limits to participating in managed care (e.g., no taxi or bus fare for appointments) and help people who have signed up for managed care and not having their needs met to switch back to straight Medicaid coverage.
- Understand the problems associated with the limit on the number of prescriptions permitted by Medicaid in one year (e.g., once threshold is met people cannot get prescribed medications and end up hospitalized from complications of seizures, diabetes), particularly for people with mental health problems who have other serious chronic health conditions such as seizure disorders, diabetes, newly diagnosed cancer.
- Put in place a warning system for people requiring many medications under Medicare to let them and their physicians know when the threshold for medications is near so that waivers may be requested in a timely way that does not cause untoward effects associated with a lapse in medications.



### **Hudson River Recipient and Family Meeting Recommendations**

April 29, 2011

Advocate Specialist Tony Trahan from the OMH Central Office facilitated a videoconference with individuals and family members from the Hudson River Region and OMH Planning staff. The meeting focused on planning for this year’s Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from family members and individuals engaged or previously engaged in mental health services about impending changes to the system of care: behavioral health networks and behavioral health homes.

Participants were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of “ideal” elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down recommendations by the strategic framework content domains.

## **PEOPLE FIRST**

**Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.**

- Keep an open door policy in health homes, so that wherever people go they will be helped.
- Ensure that every behavioral health homes has an “open-door” policy.
- Ensure truly integrated general medical and behavioral health services (mental health and substance abuse) that treat the whole person, and make certain that care is not provided in silos.
- Focus behavioral health care on enabling people to be better citizens than patients.
- When working with people who have had very long stays in psychiatric hospitals, remember that their lives are like the Flintstones, while life in the community is in the Jetsons age.
- Understand that people need to be in recovery to recover.
- Wherever possible, avoid institutional models of care; rather help people to express and fulfill their hopes, dreams, and goals.

## **PERSON-CENTERED DECISION MAKING**

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- If PROS programs will be part of health homes, examine how to move them to a more recovery-oriented orientation, even replacing staff not supportive of recovery concepts.
- Use tools to help prevent re-hospitalization and to identify preferences for care, such as relapse prevention plans and advance directives.
- Begin preparing people to return home from hospitals at the point they are admitted, emphasizing self-directed approaches to treatment, education, and supports for regaining life roles.
- Understand that remarkable things can occur when people care and promote partnerships with providers that are committed to recovery and resiliency.
- Provide the opportunity for people to select their own health coaches, and offer their natural supports who agree to do so, training to be effective health coaches.
- Do not allow “cases to close” in health homes; recognize that as with physical illness, exacerbation and remission can occur with mental health problems; and ensure that access to health care is facilitated through an ongoing relationship with a primary physician who takes responsibility for coordinating and working with each person to manage all aspects of health care.
- Work with people who have behavioral and physical health problems to identify their fears about their conditions and to help them hook up to resources in the community that

they desire and will be critical to maintaining health (e.g., practicing yoga and exercising in the gym to help manage hypertension).

### **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.**

- Ensure financial education counseling services (e.g., to address IDA, PASS funds, EITC) to offer sound advice, enable people with serious mental health conditions to access resources within reach, and aid people in financial planning and management
- Help people to identify barriers to care and supports in the community (e.g., money, a lack of internet access for independently identifying resources for community living).
- Make certain that strategies are in place to enable community living for people who have been hospitalized for long periods and have become too dependent on the system.
- Offer access, when appropriate, to the Medicaid Buy-In program, which permits people with disabilities the opportunity to earn more income without the risk of losing vital health care coverage.
- Create community resource liaisons within health homes to aid providers and people being served so they may identify community resources that will aid overall health, including accessible transportation options.
- Help people to achieve independent community living by helping them to get and keep employment.

### **RELATIONSHIPS**

**Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- Support the creation of recovery-oriented peer-led groups that are based on member interests.
- Have strong linkages in health homes to natural support opportunities in the community.
- Pay attention to “social wellness,” particularly with peer bridger support, so that people can pursue lives they see for themselves (e.g., friendships, healthy romantic relationships), experience full community integration (e.g., with ties to natural social opportunities such as book nights at the book store), and break a reliance on the mental health system to have social needs fulfilled.
- Aid people to live successfully in the community by helping them to explore and become engaged in interests and hobbies.
- Ensure that health home providers have strong ties to and knowledge of community resources to support wellness.

## **LIVING A HEALTHY LIFE**

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

- Use marketing approaches to convey the shift in health care from illness to wellness and the positive benefits wellness approaches bring to us.
- Rely upon marketing approaches to engage people in learning how to use health homes and get away from old approaches to seeking health care (e.g., rather than using an ER, using peer services as a first step for getting support).
- Encourage a full array of wellness approaches in health homes, from yoga, meditation and other alternative therapies that people can use to support wellness.
- Have health homes engage recovery planners or health coaches to work with people on developing and implementing wellness plans.
- Knowing that people return to hospitals because they lack connections and support in the community, provide an array of services that help people to live successfully following discharge (e.g., peer warm lines, education re: recognizing and managing symptoms).
- Utilize mobile crisis services that emphasize listening, problem solving, and stabilization.
- Think of the emergency department as a place to promote the health home option by having a person who seeks emergency care immediately engaged with the health home, and strengthening engagement in this care with empathetic, respectful care givers (e.g., the health home should be seen as a five-star hotel that people desire to go to rather than an emergency department).
- Borrow practices from traditional medical practice management such as, based on a person's choice, reminder calls for health home behavioral care appointments, helping to foster engagement in care and optimal health.
- Seek providers to join health home networks who have the passion for helping people recover by fostering resiliency, and providing tools and helping people to learn how to use them in living productive lives in their communities.
- Help people to transition from hospital care to outpatient services, where they are supported in their abilities to regain important life roles (e.g., student, father, secretary).
- Encourage the use of natural community supports rather than reinventing the wheel (e.g., the 211 support system is rich with information about community resources that can aid in linking people to the resources that best meet their need).

## **MENTAL HEALTH TREATMENT AND SUPPORT**

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

- Strive to maintain the quality of care while making changes during challenging economic times.

- Don't divide services that will be offered in health homes by the degree of illness.
- Ensure that people who are "less sick" receive the services and supports that help them to maintain health independent living.
- Call upon health homes to do outreach to hard-to-reach populations (e.g., people who are homeless).
- Understand that for health homes, the goal is not necessarily to create new services, but rather to help people access what is already available in the community.
- Encourage options for care that foster self-direction, health choices, and no forced treatment (e.g., peer-run services)
- Ensure that forced treatment, paternalistic care-giving attitudes, and coercive approaches are not be part of any health home; rather design approaches to encourage the use of tools to enable people to determine approaches for wellness, self-care etc.
- Ensure that recovery centers providers are attractive to the people being discharged from hospitals so "they are hip to them" and use them upon discharge.
- Break the cycle of repeated hospitalizations, working with people to avoid having them be lost to the system of care or have their conditions worsen and to focus on community connections.
- Match the level of care to a person's needs and rely upon crisis diversion programs to help people avoid hospitalization and even as places where people can go as part of a plan to transition back to their homes in the community.
- Utilize physician assistants and nurse practitioners as much as possible in providing behavioral health care because they take more time to listen.
- Look to successful models like the one being employed in Rockland County where physician assistants assume the role of "wellness assistants," and help people to access the care they desire.
- Encourage comprehensive health care approaches for persons who are living with serious mental health conditions (e.g., meet with nutritionist to assess and implement dietary modifications to manage diabetes).
- Encourage behavioral health homes to attract physicians and providers who love working with people who are dealing with serious mental health conditions.
- Attract providers to the health home network who truly believe in and have a demonstrated commitment to recovery and wellness.
- Ensure that health home networks have expert services for people who have experienced trauma and provide them with clinical care (e.g., wellness action recovery planning) that helps them move toward wellness.
- Avoid the use of the term "health homes," which unfortunately does not convey the concept of coordinated care through an integrated network of physical and behavioral care providers.

## **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

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

- To engage people in the range of services to be offered by health homes, make the health home concept an attractive one by stressing care coordination, choice, and education in how to use the health home effectively.
- At the heart of the health home, give priority to having providers teach people how to live self-determined lives.
- In health homes, focus on wellness and wellness approaches that do not necessarily take place in the mental health system (e.g., cooking class in the community center that features good nutrition).
- Provide peer support as a standard part of care in emergency departments and continue to educate and encourage professional providers to tap into the expertise of peers.
- Offer supportive alternative care environments such as the Rose House that provide respite, offer peer support and avert hospital care.
- Use peer-run “safe houses” as places for people to receive support and come and go.

## **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.**

- As is happening in primary care, change the culture that hospitals are not the place to go unless acute care (e.g., a person is dangerous to self or others) is required.
- Make certain that health homes are cohesive networks of providers and they do not have walls.
- Within the package of services offered, make sure a set amount of flexible funding (e.g., \$1,000 of unrestricted funding) is available for the purchase by the health home of self-directed wellness services in the community that would otherwise not be possible for each person to have (e.g., bicycle, running shoes, gym membership).
- Attract and retain a sufficient number of good therapists in each health home network, to ensure, particularly for children and parents, consistency in care and to minimize gaps in services when providers leave the network.
- Require participation by independent peer-run providers in the network mix of health homes.
- Do not have health homes directly employ peers, to avoid having peers be co-opted into roles not designed for them (e.g., assistant case managers), thereby valuing the independent status of the peer specialist and ensuring effective peer services.
- Educate providers, including hospitals, and promote system change about alternatives to hospitalization and diversion of care to the community.

- Encourage provider education aimed at effective treatment for co-occurring mental health and substance abuse disorders (e.g., participation in the Focus on Integrated Care (FIT) learning curriculum).
- Educate and give providers tools to enable them to offer comprehensive, integrated care.
- Incentivize and attract physicians and other health professionals in short supply (e.g., nurses) to become home health by instituting educational loan forgiveness programs for those who agree to practice for a set number of years in health home serving areas that lack adequate medical care such as remote and/or economically depressed regions.
- Realizing that one of the most important factors in engaging people in integrated care will be the engagement skills of physicians, ensure that preparation for health homes includes a focus on engagement in services and its importance to positive outcomes.



### **Long Island Recipient and Family Meeting Recommendations**

April 19, 2011

Advocate Specialist Tony Trahan from the OMH Central Office facilitated a videoconference with individuals and family members from the Long Island Region and OMH Planning staff. The meeting focused on planning for this year’s Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from family members and individuals engaged or previously engaged in mental health services about impending changes to the system of care: behavioral health networks and behavioral health homes.

Participants were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of “ideal” elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down recommendations by the strategic framework content domains.

#### **PEOPLE FIRST**

**Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.**

- Ensure that individuals in the lesbian, gay, bisexual, and transgender (LGBT) community are provided with culturally competent care.

- Ensure cultural and linguistic competence education and training of providers, direct-care staff, and volunteers, especially so that care is premised upon respect for the individual and his or her culture and values.
- Reaffirm with providers how critical hope is to recovery and encourage use of this knowledge so they do not give up on people, rather they continually offer them options for growth and know when the time is right these individuals will move along in their recovery journeys.

### **PERSON-CENTERED DECISION MAKING**

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- Provide family education on mental health issues and develop mechanisms for individuals and families to work together toward recovery.
- Educate providers that mental health treatment and supports are most effective when offered with empathy and caring, are designed to allay fears and help people cope effectively, take the whole person into account, and not provided in a way that people engaged in care sense that providers “are just going through the motions.”

### **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.**

- Provide the option for a home through single residency housing (SRO), which offers onsite medical and mental health services that promote health and well-being and have the potential for coordinated and integrated care.
- Provide more integrated, affordable community housing.
- Make certain transportation services are available so that people may access care.
- Assess and strengthen, where indicated, daily living skills that enable individuals to sustain productive community living (e.g., cooking, writing checks and balancing check books, paying bills, doing laundry, managing chronic physical conditions such as diabetes, maintaining orderly and clean residences, navigating the public transportation system).

### **RELATIONSHIPS**

**Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- Help providers to understand that maintaining a person’s privacy—even when a people have not provided staff with a release under the Health Insurance Portability and Accountability Act (HIPAA) to discuss their cases with their families—does not mean that staff should ignore families nor listen to their concerns. Rather, they should tap into families’ knowledge of their loved ones to help foster recovery.

- Educate communities about the importance of housing for people dealing with mental health challenges and the options that are available, to help enhance public knowledge about what helps people to be stable, productive members of the community.
- Particularly for individuals engaged in mental health care who are incarcerated, ensure supportive family involvement as much as possible.
- Address the stigma and discrimination associated with mental illness through general education that emphasizes the abilities of people with mental health challenges, including the ability to recover.
- Help to bridge the gap between when people first experience symptoms to when they seek care by incorporating a curriculum, such as an adapted “Breaking the Silence,” program for the early elementary grades that engages children, fosters compassion and caring, eliminates fear through education regarding early signs and symptoms, encourages children to ask for help when needed, and eliminates the stigma associated with mental health challenges and illness.

## **LIVING A HEALTHY LIFE**

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

- Ensure that young adults dealing with serious mental illness are engaged in the normal developmental work of the young adults—discovering who they are as individuals and separating from their families of origin—by supporting young adults to gain access to housing, rather than forcing their families to evict them, possibly to be homeless, before they can be considered for housing support services.
- Recognize the needs of families that are providing housing to their loved ones with serious mental health challenges and aid them in supporting their loved ones (e.g., respite care, respect for the role families play in helping their loved ones recover).
- Help communities to identify people at risk for mental health problems (e.g., homeless individuals) and develop strategies to intervene (e.g., crisis intervention teams during nights and weekends, strong connections to community care) so they do not end up in the criminal justice system where they do not get the treatment they need.
- Educate providers, from physicians to case managers, about recovery-oriented resources that are naturally available in their communities and promote the integration of such resources into strengthening a person’s ability to use natural supports in coping with mental health challenges.

## **MENTAL HEALTH TREATMENT AND SUPPORT**

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

- When care is provided through a “network,” it must truly help people to manage their own care and navigate the system successfully.

- Ensure that people who need case management services have access to them.
- Ensure case management services for individuals who find it difficult for, or may be incapable of, navigating behavioral and physical health services.
- Help increase sensitivity and knowledge about cultural groups in a provider's community, to ensure that beliefs and values are seen within the context of culture rather than misinterpreted as signs and symptoms of mental health challenges.
- Ensure that mechanisms are in place in behavioral health homes that foster communication between physicians.
- Redirect funds from inpatient care to services that support vocational and educational programs for persons engaged in services.

### **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

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

- Make sure that OMH gives attention to education on advance directives and other aspects of self-directed care during licensing visits, and invite people engaged in services and their families to participate in licensing visit debriefings.
- Focus client and family education on different approaches to personal safety and wellness such as the use of advocates, wellness recovery action planning, advanced directives, and power of attorney.
- Provide information to individuals engaged in care and family members on how to designate legal proxies, so that individuals have a way to protect their self-interests.
- Encourage people engaged in services and their families to be involved in advocacy at all levels of the system of care.
- Ensure that natural community services are incorporated into a behavioral health home's network of services and increase the level of awareness about how these services support recovery.

### **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.**

- Make certain that physicians, nurses and other professionals are knowledgeable and current about wellness recovery action planning and other tools that aid people engaged in care to be mindful about what helps and hinders recovery, while providing structure and support.
- Educate providers on the importance of programs such as Family-to-Family, National Alliance on Mental Illness (NAMI), In our Own Voices, and Federation of Organizations to recovery and resiliency.

- Work with providers to change the culture of care from one that is focused on what is wrong with an individual to one that seeks from individuals their personal stories that tell what happened to them.
- Mandate training of first responders and law enforcement officers so they may intervene more effectively with individuals who have psychiatric histories or are demonstrating behaviors that may indicate mental health problems.
- In the forensics mental health system, ensure that clear, accessible grievance processes are in place.



### **New York City Recipient and Family Meeting Recommendations**

April 26, 2011

Advocate Specialist Tony Trahan from the OMH Central Office facilitated a videoconference with individuals and family members from the New York City Region and OMH Planning staff. The meeting focused on planning for this year’s Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from family members and individuals engaged or previously engaged in mental health services about impending changes to the system of care: behavioral health networks and behavioral health homes.

Participants were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of “ideal” elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down recommendations by the strategic framework content domains.

## PEOPLE FIRST

Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.

- Incorporate recommendations from [Infusing Recovery-Based Principles into Mental Health Services](#) ☞ the 2004 white paper into every aspect of health home development.

Ten Rules for Quality Mental Health Services in New York State  
(from *Infusing Recovery-Based Principles into Mental Health Services, 2004*)

Care must:

1. Be based on informed choice
2. Be recovery focused
3. Be person centered
4. Cause no harm
5. Ensure free access to records
6. Be based on trust
7. Have a focus on cultural values
8. Be knowledge based
9. Be based on a consumer-provider partnership
10. Accessible, regardless of ability to pay

- Incorporate recommendations from the *Infusing Recovery-Based Principles* white paper into training of professional staff members.

- Develop public education strategies to address cultural barriers to treatment based on a culture's long-held values and beliefs (e.g., medications are not good to take) and provide education on how to be sensitive to cultural values while getting people the help that will help them to be healthy and well.

- To engage people in services and supports when they would be helpful, make

sure that outreach and engagement strategies are culturally competent and produce dialogue between people who may benefit from services and the people who are trying to help (e.g., to better understand how stigma may be expressed, what helps to deal with symptoms, how is "recovery" understood and integrated or not culturally, how cultural beliefs impact treatment and response to treatment).

- Guide development of health homes using the 10 components that comprise the [National Consensus Statement on Recovery](#) ☞ as well as recommendations contained in the Institute of Medicine 2001 [Crossing the Quality Chasm](#) ☞ report.



- Address the issues related to the disproportionate number of persons of color with mental health problems involved in the criminal justice system and community impact (e.g., more people going to jail than college).
- Understand that a system of care truly based on the values of recovery and resiliency is essential to aiding hard-to-engage people to stick with treatment and support.
- Always keep in mind that the individual and family being served are at the core of good health care, which is enhanced by close connections between members of interdisciplinary teams.

- Given that with any illness other than mental illness second opinions are valued, work to engender respect and turn around the attitude that people engaged in care “don’t” know what’s best for them.”
- Remember that what works in one community will not necessarily work in another, so tailor approaches to the community and its culture.

### **PERSON-CENTERED DECISION MAKING**

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- Work with clinicians to help them understand the importance of not discouraging hope for recovery.
- Have processes in place to support consumer choice (e.g., how to change your physician without a hassle) and effective care.
- Provide good education and support for medication management so that people engaged in services are able to work with physicians collaboratively to fine-tune medications so they are most effective.

### **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.**

- Increase the availability of training opportunities for peers so more of them can be actively involved in health homes and available to help each other live, work and socialize fully in their communities.

### **RELATIONSHIPS**

**Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- To engage people in services earlier in the course of having psychiatric symptoms, create community partnerships that help to foster engagement in services in ways that are culturally sensitive and appropriate.
- Address the substantial barrier to care due to the stigma and discrimination associated with mental health care by improving community and family education and by engaging people and their families in care without stigma.
- Provide a great deal of well-advertised public education that helps link people to support and treatment services, helping to reduce the stigma through normalizing messages (e.g., Feeling stressed? Call xxxx to speak with a supportive person).
- Don’t wait for people to come to behavioral health homes for help; rather, reach out in communities to where people who need help are.
- Realize that one of the best ways to break down the stigma and discrimination associated with mental health problems is wide community involvement in health homes.

- Be instrumental in conveying facts and information about mental health, mental health conditions and what works, about the essential nature of recovery, and about how important it is to give people a chance to try and, when they fail, to learn from their experiences.
- Help to correct public misunderstandings and perceptions about mental health conditions by taking us “out of the closet,” and telling it like it is (e.g., we can recover, we can take care of ourselves and, given the opportunity, take care of others).
- Provide ongoing and regular family education to people who are just entering the health home and newly diagnosed or identified as in need of mental health treatment and supports.

## **LIVING A HEALTHY LIFE**

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

- Educate people enrolled in health homes to seek help when symptoms worsen, thereby helping to reduce the window of time between the onset of disabling symptoms and treatment.
- Provide an array of tools that help prevent mental health conditions from developing or for early intervention when symptoms become problematic:
  - Peer-staffed warm lines for support (not emergency care) 24 hours a day, seven days a week that take into account coverage to meet cultural and linguistic needs
  - A central way for community agencies to be better connected across the system of care in a community
  - Advertising resources aimed toward eradicating stigma and discrimination and promoting mental health wellness
  - Educational resources for individuals and their families to help them understand mental health conditions, treatments, supports, recovery, etc.
  - Certification as peer counselors
  - Incorporation of peers as valued members of health teams in health homes
  - More peer guidance counselors and youth peer advocates in schools, particularly to work with adolescents
  - Support for youth peer networks
- Provide public education on the common signs and symptoms of psychiatric conditions (e.g., with schizophrenia, person goes to college, has a breakdown, receives diagnosis) so that people can recognize when a loved one or friend may be in need of help.
- Among groups offered in health homes, make sure there are groups devoted to education and support for integrated physical and behavioral health care (e.g., a group where people discuss interactions between physical and mental health).

## **MENTAL HEALTH TREATMENT AND SUPPORT**

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

- Make sure that primary health care and behavioral providers are aided in communicating effectively with each other so that people engaged in care do not get mixed messages or conflicting information.
- Make certain that behavioral health homes provide a range of recovery services within the context of comprehensive behavioral and primary medical care.
- To the degree possible, make medical health homes “one-stop shopping” places.
- Build into health homes mechanisms to foster good communications between primary care providers and behavioral providers so that individuals receive care from providers who are “on the same page.”
- Provide an array of specialty care in behavioral health homes, from peer to clinical expertise.
- Make MyPSYCKES available online within health homes so that people engaged in care and providers can discuss medication decision making.
- To engage people with serious mental health conditions who have become disconnected from care, rely upon peer support, which will be critical in avoiding treatment failures that may have been experienced by individuals in the past.
- Make sure that behavioral health homes are welcoming environments in which people feel comfortable in obtaining care.
- Set the expectation that mutual respect for the varied strengths and contributions of peers and professionals will be central to cohesive health home teams.
- Make sure that at the heart of every health home are integrated teams of health care providers offering treatment and support services.
- Work with professional and ancillary staff to help them understand the role peers play in promoting health and well-being and help them to incorporate peers and their expertise into integrated health teams (e.g., treating peers as members of the team who bring peer expertise and knowledge, not as “patients.”)
- Make certain that health homes have peers as essential clinical health team members, in a way similar to the integration of peers into assertive community treatment teams.

## **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

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

- Employ peers to provide employment, socialization, benefits counseling, transportation, and advocacy services in each health home.
- Employ peer bridgers to avoid costly institutional care.

- In health homes, rely upon professional staff to provide cognitive treatment and medication therapy and use peer to do everything else.
- Seek to employ peers in promoting good communications among behavioral health home providers.
- Use trained peers to provide support services such as groups for co-occurring disorders.
- In preparing to develop health homes, have ongoing communications and meet frequently with peers to seek guidance and their expertise.
- To ensure that people get the best care possible at the onset of psychiatric symptoms, be sure peers are part of the care team, which not only helps individuals feel hopeful but also helps to allay the stigma and discrimination associated with seeking mental health services.
- Know the power in having peers be part of health home teams, where by their presence they convey that recovery is possible and give hope to people who would otherwise not have it.
- Made sure that one-to-one peer counseling by well-trained peers is available on demand.
- Provide warm line telephone support services around the clock.
- Involve peers at pivotal points in a person's journey through a health home (e.g., intake, treatment planning).

#### **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.**

- Monitor and evaluate what happens as health homes are introduced, engage people who receive or have received services and their families in identifying indicators of progress (e.g., recovery outcome measures), use valid and reliable measures of primary and behavioral health care, and use the data obtained to ensure quality health care.
- Ensure that regular training of health home providers, including HIPAA training and data sharing rules) is driven by a core curriculum designed for professional and peer staff.
- Include peers in training for professional staff members as well as professional staff in training for peers, thereby facilitating mutual understanding and respect for what each contributes to a multidisciplinary health team.
- Provide sufficient funding for peer training.
- Provide good education and training of health home staff so they are able to provide quality care based on best practices.
- Consider having health homes offer clinical treatment and medication therapy and contract with peer-run services to meet support needs, ensuring sufficient financial support to meet goals and objectives.

- Ensure that the voice of people who have been or are engaged in services and family members is represented in the assessment, development, operations and evaluation of health homes.
- Realize that electronic records can be vital in helping with physical and behavioral care coordination, improving communications between providers and the people they serve, and ensuring safe care (e.g., documentation of medication side effects helps providers in decision making).



## **Western New York Recipient and Family Meeting Recommendations**

April 21, 2011

Advocate Specialist Tony Trahan from the OMH Central Office facilitated a videoconference with individuals and family members from the Western New York Region and OMH Planning staff. The meeting focused on planning for this year’s Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from family members and individuals engaged or previously engaged in mental health services about impending changes to the system of care: behavioral health networks and behavioral health homes.

Participants were asked to consider what they wished to see happen under behavioral managed health care and physical/behavioral health care homes. They were provided with a list of “ideal” elements of integrated behavioral care aimed at enhancing engagement, safety, and improvement outcomes. And, they were asked if the elements rang true, how they might be modified for a person-centered, recovery-oriented system of care, and whether any elements were missing from the list. Participants were also invited to look over the current strategic framework to consider its relevance for behavioral health homes.

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down recommendations by the strategic framework content domains.

### **PEOPLE FIRST**

**Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.**

- Make certain that care is individualized and guided by each person’s personal choices.
- Ensure that behavioral health homes are organizations that are integrated into the fabric of communities and reflect that people who use their services are respected, and valued citizens.

## **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.**

- Look closely at the [Veterans Administration recovery services model of psychosocial support](#) to promote full community living for people dealing with serious mental health conditions.

## **RELATIONSHIPS**

**Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- Educate primary care physicians about mental health conditions, the value of mental health services and supports, and the types of interventions proven effective in promoting mental health and well-being; at the same time, work on the stigma associated with mental health conditions that exist among medical practitioners, which will help people to be open with their physicians about their mental health challenges and facilitate more effective and integrated care.
- Use strategies for engaging people in mental health care much like the strategies used for other health conditions (e.g., as cancer centers tout their experts, mental health centers could do the same; people with mental health problems do have enjoyable lives; remind people that they are not alone and empower them to seek help).
- Understand that marketing provides a road map for people who wish to have better integrated physical and behavioral (mental health and substance abuse) care, particularly services that are holistic in nature.
- Understand that one of the best ways to engage people in getting mental health care is to market these services well.
- Look for places to get the word out about mental health symptoms (reaching people affected, families, loved ones, friends, and co-workers) and what to do about them (e.g., signs at bus stops that ask, “Are you depressed? Don’t be alone. Go to xxxx for help.”)
- With peer outreach and engagement, make sure that peers visit homeless shelters and help people to make appointments that help them with recovery (e.g., doctor’s visit, AA meeting) and build relationships that help people to see opportunities for recovery.
- Provide peer outreach and engagement services in soup kitchens and houses of worship and advertise them (e.g., church bulletins, coffee shop listings, bus stops, public service announcements, social clubs).
- Make certain that care is truly integrated under managed care and reflected by robust community connections and activities that help to address trauma, depression, and other challenges for communities.
- Keep the messages about how mental health is treatable out there constantly, because people are in various stages of readiness about when to seek help; continual messaging may catch them when they are ready to seek help.

- Keep literacy in mind when creating mental health messages for marketing purposes (e.g., public service announcements).
- Provide resources that enable peer networking groups to showcase people's strengths and engage people with mental health conditions in using their talents to foster community living and participate in valued community events.
- Realize that when people with mental health problems become active members of their community, the connections they make may be helpful in times of crisis, especially when a community member contact peer network members to intervene rather than calling police.
- Realize the importance of social activities, in concert with treatment, in preventing isolation and promoting a good life in the community.
- Encourage behavioral health organizations to tap into natural support systems, such as houses of worship that often link to resources that are used by people who are disconnected from care (e.g., church sponsors AA meetings) and work with spiritual leaders to increase knowledge of trauma and trauma treatment.
- Work with schools and houses of worship to reduce violence and offer resources to youth who wish to deal with mental health and substance abuse problems.
- See the opportunities in community activities to help people with mental health challenges become more fully integrated into the life of the community.
- Realize that stigma is reduced and public education about mental health enhanced when people with mental health challenges are engaged productively and fully in their communities.

## **LIVING A HEALTHY LIFE**

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

- Design innovative marketing campaigns that sends the message that people with mental health conditions desire to be alright (e.g., "It's all about us being alright), much like the "Got Milk?" campaigns (e.g., "Got Depression?").
- Promote the abilities of each person to be seen as person with strengths, to gain citizenship, and to lead a full life in the community.
- Teach children how to deal with anger issues by providing more positive alternatives.
- Teach children in the early grades about mental health challenges, focusing on the basics of mental health and wellness, how to be supportive of people with mental health conditions, and how to seek help when experiencing symptoms because early intervention and prevention are so important.
- Provide scholarships to people who are homeless so they can be involved in community events that link them to peer support (e.g., HA-HA conferences), expand their

knowledge about the wide array of services available traditionally and nontraditionally), and help to foster positive views of mental health).

## **MENTAL HEALTH TREATMENT AND SUPPORT**

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

- Enable providers to educate people and families desiring care on available programs, particularly peer-run and peer-operated programs.
- Encourage providers to help people engaged in care to explore the different programs available to them.
- Help general medical practitioners to understand that help seeking for mental health symptoms sometimes gets expressed through physical conditions (e.g., accidents) and encourage physicians, when indicated, help patients to attain mental health treatment when indicated.
- Expect that hospitals will move from a culture of fostering dependency to promoting discharge planning that embrace peer services, fostering each person's confidence and strengths, and building skills for community living.
- Help people with mental health challenges to embrace life more fully by making life outside an institution more attractive (e.g., peer services immediately upon admission to a hospital, peer bridgers who work with individuals well ahead of hospital discharge).
- Have health homes provide counseling services in schools and deploy grief counseling services in times of community need (e.g., school shooting).
- Promote programs such as [Fathers who Care](#)  in high schools, where young men have the opportunity to learn healthy approaches to managing feelings as well as good parenting skills.
- Ensure that health homes provide prevention and early intervention services, so that people can avoid the development of mental health challenges and avoid life-long disability and functioning.
- Make sure that peer outreach services are part of the behavioral health organization efforts and behavioral health homes.
- Ensure that holistic health services are options offered in behavioral health homes.

## **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

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

- Use knowledge about the value and proven effectiveness of peer support services to make certain that the role of peer is respected as A member of the health care team.
- Be sure to promote peer networking groups because they help people to find their strengths and build upon them.

- Rely upon peers to serve as mentors to people who wish to learn how to manage symptoms and gain stability in community living.
- Realize that peer services give people struggling with mental health problems hope for the future, most notably by the very presence on the health care team of people who have dealt with mental health issues and are in recovery.

**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.**

- Strongly advocate for Medicaid-billable peer outreach and engagement services that provide essential education and support.
- Fund integrated services that focus on autism and provide teacher and ancillary health professional (e.g., occupational therapists) education on autism and strategies for dealing with autism spectrum disorders.



**Forensic Peer Network Group (PNG) Meeting Recommendations**

March 30, 2011

Advocate Specialist Tony Trahan from the OMH Central Office facilitated a videoconference focused on planning for this year’s Statewide Comprehensive Plan for Mental Health Services between OMH Planning staff and recipients from Kirby Forensic Psychiatric Center, Mid-Hudson Forensic Psychiatric Center, Central New York Psychiatric Center, Rochester Psychiatric Center Regional Forensic Unit, and Buffalo Psychiatric Center. The goal of the meeting was to obtain feedback from individuals receiving forensic mental health services in OMH facilities for use in planning mental health services that help people on their recovery journeys and promote mental health and well-being. As with the many stakeholder meetings held in preparation for the development of the yearly statewide plan, the recommendations are not meant to be prescriptive, but rather to serve as guidance to OMH as it develops strategic priorities for the entire public mental health system.

Mr. Trahan began the session by pointing out that every state in our nation is required to help people who are elderly and/or have disabilities to live in the most integrated community setting possible. The community for individuals served by OMH forensic settings is the secure forensic hospital or civil psychiatric center. Mr. Trahan posed the question, “Until you are able to physically leave the facility, what can OMH do to help you be integrated into the community.” During the meeting, he explained an integrated setting for people in secure forensic hospitals who are managing mental illness would include being more involved in the hospital community or, even to the degree possible, the community outside the hospital.

To help people consider this larger question, Mr. Trahan also asked a series of related questions:

1. What does most integrated care look like for people in secure forensic hospitals (Kirby/Mid-Hudson/Rochester)?
2. What does most integrated care look like for people in civil facilities (Buffalo)?
3. What does most integrated care look like for people at Central New York who don't seem to fit into the other two categories?
4. What happens in your facility during non-treatment times?
5. Are there trainings that may be helpful for you as you plan for the future?
6. What can we do to increase positive family involvement?
7. For people sentenced to lengthy sentences, up to and including life, or who have not been sentenced but will be here for a while and have recovered from their mental illness, what role could you see yourself in helping people?
8. The traditional path to the community from a secure hospital is to a civil facility, then community residence. All of these are big changes. What can we do to help with the transition at each stage?

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. The following summary breaks down their recommendations under each of the first seven questions. The summary groups responses from questions 1, 2 and 3 together and from questions 4 and 5. While time ran out for discussion of Question 8, Mr. Trahan noted that he and Mr. Allen will be discussing this question during upcoming Peer Network Group meetings this year.

### **QUESTIONS 1, 2, AND 3**

#### **Recommendations for supporting integrated care across secure forensic settings and hospitals**

- Support forensic wellness and recovery action planning to integrate recovery into forensic mental health treatment and strengthen a person's abilities to manage mental illness as he or she moves through the forensic process from secure to civil to community placement.
- Support family days and encourage Recipient Affairs Committee members to be active in sharing information and educating families on a range of issues, from becoming involved in legislative days to learning how to support behavioral health recovery.
- Offer family visiting hours that take into account and accommodate a person's work hours, which would help improve community integration.
- Hold family days, consider more social events during the year other than holidays (e.g., movie nights) and offer education programs that would bring people receiving care in the secure forensic facilities together with their families and treatment team members in a more general way than happens with treatment team meetings (more programs like these would be a win-win for everyone).

- Help to strengthen the quarterly education meetings for family members by having ones that are more issues oriented, for example, with medication and mental health education being offered as in the past.
- When concerns about ensuring a safe environment are of chief importance and visiting hours are not permitted within the first month of admission, consider permitting phone contact with family members to help people receiving services to maintain their connections to their families.
- Consider having social workers reach out and connect with families more, providing information and support that encourages family involvement in care.
- Make the computer room available so that people receiving care in the facility can responsibly access recovery information via the internet and visit other authorized web sites having to do with mental health treatment and recovery.
- Provide access to a public law library that will enable people who are receiving forensic psychiatric care to participate in their own defense.
- Consider the use of technology (e.g., skype) to permit people receiving services to connect with family members, which would help in overcoming a barrier to telephone communications resulting from the costly charges associated with using the phone.
- Continue work skills' program to help people develop skills that are marketable in today's society (e.g., providing clerical services, stripping and waxing floors, planting vegetables and flowers for the upcoming season), recognizing that these programs are very therapeutic, provide a sense of pride in work accomplished, permit people to make a contribution to the facility, gain experience in working and dealing with mental illness, help them to do things they thought they would never be able to do, and earn valuable volunteer and paid work experience.
- When possible, maintain the stable nature of the living environment, and help to increase each person's abilities to cope with stress and chaos when this is not feasible (e.g., people boarded on units as new admissions who don't shower, don't behave).
- Sponsor peer-run programs to come into the facility, such as Howie the Harp, to discuss ways to bring sheltered workshop activities (e.g., a frame shop) to the facility and increase learning and vocational development opportunities.
- Promote informal information sharing and community integration by inviting into the facility groups that could offer concerts, shows, vocational presentations, 12-step meetings.
- Encourage donations to the library that would increase vocational knowledge and options (e.g., books on auto mechanics).
- For individuals who enter secure forensic psychiatric centers for "tune ups" and return to prison, continue to work closely with DOCS to promote more recovery-oriented approaches for engaging with people in prison who have psychiatric disorders.

- As persons prepare for discharge from a facility, begin well ahead of time to put in place supports (e.g., SSI, medication access) that will help individuals to make a successful transition into the community.
- As persons prepare for transition from inpatient civil psychiatric centers back into the community, help to prepare them using approaches such as tiered privileges that allow the individuals to progress step-by-step through various stages of reintegration (e.g., passes to adult education classes, weekend visits to home, group home on the grounds of the psychiatric center, single-room occupancy).
- Strive to create environments that provide hope, help to bring out each person's strengths and help staff to understand the value of person-centered care and therapeutic support for recovery, realizing such approaches help shackles to go away.

#### **QUESTIONS 4 AND 5**

#### **Recommendations for non-treatment times, desired training and effective use of treatment**

- Recognizing that hospitalization is focused on treatment, strive to have balance between treatment/group time and non-treatment time so that people can get the most benefit from and are not “worn down” by nonstop structured treatment.
- Look at the mix of treatment groups and see where redundancies can be omitted or limited.
- Engage people receiving care in helping to shape group treatment, thereby increasing its potential to engage participants in relevant content.
- Consider the structure of the day for diagnoses (e.g., a day of nonstop treatment may not be indicated for a person with bipolar disorder who is striving to strike a balance in life's activities).
- Use groups as opportunities to help people strengthen social skills that are needed inside and outside of forensic settings.
- Allow some time on weekends for “reflection” on thoughts and activities from the previous week.
- Provide opportunities for physical activity and strength training, which are essential to good physical and mental health and help to improve recovery.
- Encourage groups that people can join optionally (e.g., stress management, current events) and use to help structure their own time.
- Increase positive non-treatment individual, group and social opportunities such as karaoke, Latin music, movies, concerts, board games, video games, drumming, and spiritual counseling.
- Take a look at how the groups by nursing students can be freshened (they tend to “border on boredom”) and more engaging.

- Authorize guest speakers to come in and speak to persons receiving services on recovery and resiliency.
- Offer training to persons engaged in services who desire to learn how to run groups, enabling these individuals to use these skills and knowledge as they move into the community (e.g., yoga, knitting circle to knit blankets for children in hospitals).
- Help people to integrate into their community more effectively through attention to personal hygiene (e.g., bring in nursing students to provide basic hygiene classes, hand washing technique).

## **QUESTION 6**

### **Recommendations for increasing positive family involvement**

- Recognize and incorporate, where possible, families in therapy so that they better understand their role in promoting health and well-being, providing education so families do not encourage unhealthy behaviors (e.g., encourage a loved one to stop medication because of a lack of knowledge about its therapeutic effect and benefits), and gaining skills to support the recovery of a loved one who is returning to the community.
- Engage the person receiving services in determining the degree of family involvement he or she wishes (e.g., email, participate in family day, visiting privileges) and support each person's choices.
- Work with the individual and family to identify values that may be at odds with treatment approaches and develop strategies for dealing with them.
- Educate people receiving forensic services so they can, in turn, educate their families.
- Provide families with education on medications, discharge planning, what to expect when a family member enters the forensic system (length of stay issues), and how to be supportive through long incarcerations.
- Use the treatment plan as a tool to engage families in supporting recovery and following a person's progress toward it.
- Particularly for facilities in remote areas or those with limited visiting hours, recognize that a lack of family contact and involvement in treatment can be discouraging, limit a family's engagement in the treatment process, and serve as a barrier to recovery.
- Support family participation in treatment as a way to boost morale and strengthen individual spirituality.
- Use the internet (email, skype, VTC, access to mental health sites) as tool to help keep families involved and help persons engaged in care to connect with each other for peer support and education.
- Hold family education days that focus on specific topics (e.g., stigma, treatment planning) and help to engage families in participating.
- Encourage the development of a family support network so that families can share information and support each other in supporting their loved ones.

- For people without immediate family, allow other supportive people visitation privileges.

**QUESTION 7**

**Recommendations for helping others, by people sentenced to lengthy terms of incarceration, or who have not been sentenced but will be here for a while, and have recovered from their mental illness**

- As people enter the system, support them in serving their terms and never returning to prison.
- Use personal knowledge and talents to help others, for example by tutoring others.
- Genuinely being involved in groups, opening up and sharing individual insights, and reinforcing one's rehabilitation and recovery in positive ways.
- Contribute to improving one's community and environment through work actions.
- Talk with people who are readying to leave prison, help them to see that there is a future, inspire hope and encouragement, and affirm the reality that it will be challenging to succeed on the outside because of having mental illness and having a criminal record.
- Encourage people about to leave prison to think about making amends for past actions and remembering what it feels like to lose family and freedom.
- Encourage people sentenced to long terms of incarceration and who have learned to handle their illness in day- to-day life to use their knowledge to help prisoners in the special housing unit better cope.
- Help people receiving services to come to terms with their illness and manage it as best they can.
- Use some symptoms of illness in a positive way, e.g., OCD can help people organize, stay on task, and keep things orderly on the wards.
- Encourage participation in activities such as the RAC and the PNG to reach the forensic mental health community as a whole.
- Encourage the work of peer advocates and peer specialists in helping to keep people receiving services and their families linked in supportive ways (e.g., family education, stigma reduction).



**Information Gathered by OMH during the Public Hearing  
sponsored by the  
New York City Department of Health and Mental Hygiene  
May 11, 2011**

The New York City Department of Health and Mental Hygiene (DOHMH) invited in May 2011 peers, families, service providers and other stakeholders from the Bronx, Manhattan, Queens, Brooklyn and Staten Island to a mental health planning forum. As noted by DOHMH, the goal of the City forum, which was held in a public testimony format, was to aid DOHMH in determining systematic goals and priorities to improve the City's mental health service system. While the forum focused on the adult system of care, DOHMH provided participants with the opportunity to comment on any aspect of mental health planning.

As part of its effort to collect broad stakeholder input into the development of the annual statewide comprehensive plan, OMH attended the public forum held by DOHMH and noted concerns and ideas expressed by forum participants. The OMH summary below is intended to capture participants' ideas relevant to planning and to convey them in actionable language. The summary also shows participant suggestions and recommendations within the context of the OMH strategic framework content domains.

**PEOPLE FIRST**

**Respect individuality by demonstrating hope, positive expectations, a belief in recovery, and a regard for diversity.**

- Place people engaged in care and their families at the center of service delivery.
- Recognize that one of the biggest challenges to mental health care today is to not destroy hope, increase learned helplessness, hinder the abilities of people to get on with their lives, and create an "us" and "them" system of care.
- Rather than concentrating on building new programs and new ways to offer services, work with people individually, nurture their hopes and dreams, and help them to move forward in achieving their own recovery.
- Support the partnership forged between with the Citywide Lesbian, Gay, Bisexual and Transgender Committee of the New York City Federation for Mental Health, Mental Retardation and Alcoholism Services, particularly for its ability to find collaborative solutions to issues.
- Respect individual rights of each person and not label every person who chooses to engage in services as a "consumer."
- Strive to understand what it is like to be in another person's shoes and support the capabilities of people dealing with mental health challenges.

## PERSON-CENTERED DECISION MAKING

**Provide supports and treatment based on self-defined needs, while enhancing personal strengths.**

- Read Vega's piece, [Self-Determination and Responsibility in Transformation](#) <sup>4</sup>, to gain a fuller understanding of the importance of having power over one's own life to proceed toward recovery and the role professionals can play as transformation agents.
- Truly understand HIPAA and its intent; avoid having it become a barrier to including the family in an individual's plan of care.
- When people engaged in care desire to have their families participate in care planning, try to accommodate the needs of working families by scheduling family meetings for evening and weekend hours.
- Recognize that listening to families of children with mental health needs and being respectful of their understanding of their children's needs will go a long way toward producing positive outcomes for the child's growth and development.
- Find creative ways to help people express their hopes and dreams and create environments that allow them to pursue them.
- Listen carefully to what people engaged in services say helps and hinders recovery and understand how crucial it is for people engaged in services to be heard and have this demonstrated through the words and actions of providers.

## 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.**

- Preserve the community safety net for vulnerable New Yorkers, redirecting savings from state-operated service reductions to maintain and protect the safety net.
- Recognize that the persistence of mental illness is linked to poverty.
- Understand that recovery is not a cure and, when it persists as a chronic condition, it is important to protect the benefits that enable people to live productive lives.
- Recognize that safe, stable housing is essential to recovery.
- Recognize that decent, affordable housing and the stigma and discrimination associated with mental health problems are formidable obstacles to recovery.
- Promote each person's ability to advocate for himself and herself in meeting and sustaining basic needs (e.g., housing).
- Understand the importance of supported housing to recovery.
- Increase the supply of supported housing for people with serious mental illness.
- Understand that the intensity of services expected from housing providers makes it difficult for them to attract skilled staff within funding provided.

- Understand that, as housing is being priced out, housing providers are being forced to find opportunities in marginal neighborhoods.
- Know that under NY/NY III, people being served have much higher levels of co-morbidity and serious mental illness than seen under previous NY/NY initiatives.
- Ensure that people engaged in services living independently in the community who experience deterioration in mental health functioning and require a higher level of care have access to supported housing, thereby avoiding homelessness and attendant costs associated with it when supported housing would have been the appropriate level of care.
- Look for subsidized housing opportunities as new projects such as luxury apartments are introduced.
- Ensure access to low-income, public housing for people with mental health conditions.
- Provide supported housing with on-site support, particularly support that enables older adults to live independently.
- Reserve 40 percent of housing units for people with mental illness.
- Provide diverse housing opportunities to meet individual need.
- Give SPOA priority for meeting the supported housing needs of people residing in adult homes and who seek community living.
- Work more collaboratively with the Department of Housing and Urban Development so it can better respond to the housing needs of people with serious mental health challenges.
- Help people with mental health challenges in overcoming barriers to employment.
- Counter effects experienced by people living with psychiatric challenges in for-profit homes (e.g., indignities, lack of privacy, loss of choices, low morale, lack of initiative, learned helplessness).
- Support people in working toward their educational and vocational goals.
- Support people with mental health conditions to pursue their vocational and educational goals.
- Encourage consumer-run business ventures through partnerships with not-for-profit agencies that can serve as training grounds.
- Promote vocational and employment support opportunities (e.g., training support, on-the-job-training) for people with mental health challenges.

## RELATIONSHIPS

### **Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.**

- Rather than losing sight of the people with mental health challenges who need help but do not stay engaged in services, reach out to them in nurturing ways.
- Provide better outreach to people underserved by or not served by the mental health system who display clear mental health needs (e.g., people who are homeless and showing symptoms of mental health conditions).
- Work with communities to fund and engage people with mental health challenges who would otherwise be isolated from participating in community activities.
- Educate families about mental health disorders and challenges and aid them to facilitate the recovery of their loved ones.
- Respect the work of the Federation and its committees to be voice for people with mental health challenges who deal with stigma and discrimination, experience abuse, and are driven out of care because of their harmful experiences.
- Realize that Federation plays a crucial role in fostering communications among stakeholders of the mental health, developmental disabilities, and substance abuse systems.
- Encourage greater participation of peers in Borough Councils, where people dealing with mental health issues have the opportunity for collegial interactions rather than being seen as in need of services.
- Do not undermine the structure that is critical to good communications, public input and consultation between the NYC DOHMH and boroughs by withdrawing DOHMH staff from Borough Council meetings, but rather foster the robust relationship between the Borough Councils that advise DOHMH.
- Realize that after DOHMH decided to no longer send representatives to Borough Council meetings, it was perceived as a lack of interest in hearing feedback from people engaged in services, family members, advocates and other interested community members.
- Foster collaboration between the DOHMH and Borough Councils to address serious challenges in the boroughs (e.g., closure of mobile crisis teams, reduced ACT capacity, increased reporting of child abuse).
- Provide public school teachers and support staff with training and education about mental well-being and mental health challenges.
- Recognize that the stigma and discrimination associated with mental illness dramatically affects recovery.
- Educate primary and specialty care providers to effectively work with people and not stigmatize people because of their mental health challenges.

- Work to eliminate the stigma and discrimination experience by people with mental health issues who seek housing and community living.
- Combat stigma and discrimination regarding people with mental illnesses and promote public education opportunities that increase awareness and understanding of where and how to access services and supports.
- Develop strategies to deal with the stigma and discrimination experienced by people with mental health challenges upon discharge from incarceration so they do not encounter barriers to care and are aided in community living.

## **LIVING A HEALTHY LIFE**

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

- Enhance the ability of each person to work toward his or her self-determined goals, recovery, well-being and good mental health.
- Ensure strong support services that promote independent community living (e.g., peer services, crisis intervention, police training).
- Promote hope, encourage people with mental health challenges to persist, and help them to advocate for themselves effectively.
- Support the abilities of people living in adult homes to live full, productive lives in their communities via affirmative processes that bring together all stakeholders to find solutions to providing community living options.
- Widely implement preventive, early intervention techniques and strategies supported by research to build emotional resilience.
- Provide community crisis interventions and ensure mental health training for police at the academy level and regularly thereafter.
- Support the plan of Rights for Imprisoned People with Psychiatric Disabilities (RIPPD) for the New York Police Department to implement Community Crisis Intervention Teams (CCITs) in New York City in 2011.
- Support community crisis intervention teams and diversion programs that help people obtain needed mental health services and stay out of the criminal justice system.
- With cuts to Medicaid affecting providers and people engaged in services, help providers and people seeking services to keep abreast of service system changes and referral resources in their communities.

## **MENTAL HEALTH TREATMENT AND SUPPORT**

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

- Ensure effective integrated mental health services through strong coordination and collaboration among behavioral, primary, specialized, and long-term mental health providers, both public and private.
- Promote providers' integration of primary and specialty health and mental health services.
- Ensure a robust discharge planning process that takes into account how each person's needs will be met upon discharge (e.g., Has SSI paperwork started, has a psychiatrist's visit been scheduled for follow-up after discharge? Where will the person be living? Has the family been involved in discharge planning per the wishes of the individual receiving services?)
- Recognize that inadequate discharge planning is a primary contributor to the "revolving door" seen in mental health care.
- Strive at the City and State levels to improve communications among the child- and family-serving systems so professionals can better understand each other and work collaboratively to serve children and families.
- Provide developmentally appropriate treatment and support options for children who no longer have day treatment available to them.
- Help realize the intent of the Children's Plan with better coordination of care across the multiple child- and family-serving systems.
- Continue to strengthen collaboration and service integration between the mental health system and other systems serving children and their families.
- Increase public health efforts to prevent suicide and identify effective interventions for reducing suicide among adolescents and young adults, among adults with serious mental illnesses, and among older adults.
- Provide more resources for comprehensive community-based system of care for children and adolescents with serious emotional disturbances and their families.
- Continue to provide essential community support services for children and their families, including case management, mobile services, crisis management and outpatient treatment.
- Provide in-home and in-community case management and crisis services for older adults and for people whose mobility is limited by a lack of transportation.
- Attend to the broad needs of older adults with mental health challenges (e.g., ensure that homes are constructed or modified to meet their physical needs) and provide ongoing community monitoring for older adults in need of mental health services.
- Attend to the behavioral health needs of New York's aging population.

- Help people who have lost access to drop-in centers to adapt and not become disengaged from care because of the feelings of loss they are experiencing.
- Foster comprehensive care for people with mental health challenges who are involved in the criminal justice system.
- Recognizing that three times as many people with mental health problems are in jails and prisons compared to people with mental health problems in hospitals, make it a priority to build on success to date (e.g., diversion programs, mental health courts) to better meet the needs of persons with mental health conditions involved in the criminal justice system.
- Use tools and resources available from the national GAINS Center to promote diversion from the criminal justice system and movement as early as possible of individuals already in contact with the criminal justice system out of it and into treatment.
- Ensure a smooth transition to community services and continuity of care for people with mental health conditions in prisons and jails by planning for discharge as early as possible.
- When clinically indicated, place people with mental health conditions into supported housing upon discharge from the criminal justice system and ensure ready access to treatment services.
- Ensure that police receive good training and know that responding to a person having a mental health crisis does not equate to dealing with an “emotionally disturbed person.”
- Provide first responders with training that enhances their abilities to be empathic and handle crisis situations in ways that help to de-escalate situations and possible arrests or hospitalization for people with psychiatric disabilities.
- Create community crisis intervention teams.
- Know that the systemic problem of cycling in and out of emergency departments can be remedied with empathic, less costly crisis care approaches.
- Strive to reduce the harmful effects associated with polypharmacy.
- Recognize that services provided under Kendra’s Law lead to positive outcomes for the people engaged in care.
- Recognize that forced treatment, such as that under Kendra’s Law, is a failure of the system.
- Do not support or strengthen Kendra’s Law.
- Replace assisted outpatient treatment (AOT) in Queens with a mental health diversion program.

## **SELF-HELP, PEER SUPPORT, EMPOWERMENT**

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

- See the value of peer services, especially because peers have “been there” and strongly believe in recovery.
- Promote peer opportunities that strengthen individual resilience and well-being and enable people to draw on their experience and strengths to help others.
- Protect “authentic” peer-driven, peer-run services.
- Support peer services.
- Ensure that recovery-oriented care and peer support are given priority regional behavioral health organizations.
- Ensure the delivery of peer respite services in the five City boroughs.
- Engage peer providers in delivering services and supports when and where they are needed.
- Implement a citywide 24/7 peer support line.
- Provide empathetic, cost-effective, and humane support services through a 24/7 peer warm line in New York City.
- Recognize the limits of LIFENET and make sure a 24/7 peer hotline is instituted.
- Expand peer support provided in emergency rooms beyond Kings County so that emergency rooms around the City have peers available to individuals in crisis.
- Improve the quality of emergency department services through peer services.
- Provide peer-run hospital diversion services.
- Fund alternative approaches to hospital care for people in crisis such as the Rose House peer respite program sponsored by People Inc., which costs about \$160 per day compared to hospital care of \$1,700 per day.

## **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.**

- Examine the structure of the City Department of Mental Hygiene to determine points at which it can reduce complexity and foster better access to and engagement in services.
- Prioritize serious mental illness and use this as a criterion for making budgeting decisions.
- Provide adequate reimbursement for the delivery of evidence-based treatment and supports to ensure quality care.
- Ensure careful monitoring of the implementation of clinic restructuring and how small agencies are able to manage the change.

- Recognize that the 30-visit limitation before reduced reimbursement under clinic restructuring is likely to be a barrier to care for people with the most serious mental illnesses.
- Monitor the impact of the 30/50 visit reduction for children with serious emotional disturbance especially when evidence-based interventions may require up to three visits per week.
- Know that under clinic restructuring, it will be hard to provide quality care and cover the costs of licensed professionals.
- Recognize that highly flexible rehabilitation services by supported housing providers requires additional funding.
- Monitor closely the impact of budget cuts on the quality of care and ensure that adequate resources are available for providing quality care.
- Recognize that budget cuts that reduce staffing can lead to increased costs elsewhere (e.g., hospitalization, incarceration, residential care).
- Recognize that permitting multiple visits in one day, while important for engaging people in and providing quality care, does not change the need for quality care, which is much more difficult to provide when multiple services in a day are discounted.
- Capitalize on the opportunities for integrated care in health homes as the system of care moves from a fee-for-service to a managed care environment.
- Monitor changes associated with the shift to managed care to identify unintended consequences that could result from shorter hospital lengths of stay and insufficient and inadequate discharge planning.
- Remove standards and unfunded mandates that needlessly make it difficult for housing providers to implement services and are not consistent with best practices.
- In supported housing programs, avoid regulating wellness approaches such as smoking cessation and good nutrition.
- Have behavioral health organizations create financial incentives for the use of peer services.
- Maximize the use of peer services by contractually including these services in the benefits package offered by the behavioral health organization.
- Enhance training of staff responsible for working with children ages 0 to 5/older teens.
- Ensure that people who seek public services and have mental health challenges are served by individuals who have good knowledge of how to work collaboratively with people who are coping with serious mental health problems.