

## Appendix 5

# Input into the Statewide Comprehensive Plan for Mental Health Services

*The following statements, comments or opinions expressed are solely those of the individuals submitting the statements. These individuals are solely responsible for their statements, comments and opinions, and they do not necessarily represent the views of the New York State Office of Mental Health.*

## Advisory Group Input

### Families on the Move of NYC

- What is the linkage between the 5.07 Plan and the Children’s Plan?
- In focusing on the needs of children and families in the early years from ages 0 to 5 and adolescents ages 16 to 25, how can we guard against overlooking the unique needs of children from 6 to 15 years of age? During these years children are in elementary and middle schools, where many developmental changes and challenges present (e.g., dealing with emotions, bullying, puberty, gang influences, drug experimentation, foster care, suicidal thoughts and suicide completion). It is important that the Plan be inclusive of all age groups and not overlook the needs of any one.
- Be mindful of systemic changes that can have a profound effect on the provision of mental health services. In NYC (NYC), for example, the consolidation of the child welfare and juvenile justice systems. What are the implications of such change on help-seeking by families, on children cycling in and out of foster care? How will the mental health needs of children touched by these systems of care be affected? Specifically, how will the consolidated juvenile justice and child welfare system meet the prevention, early identification and intervention, and treatment needs of children?
- How can we be certain that our policies are consistent with and support a strategic direction toward recovery, resiliency and transformation?
- How can we be sure that children’s clinic restructuring provides incentives for the right kind of care?
- Look to the role of single-point-of-access (SPOA) in helping to break down barriers to care and address them so that children and families are advantaged and able to receive integrated care across systems.
- Use legislation to promote policies that enhance and strengthen cross-systems collaborations.

- Provide fiscal support for family peer-run and peer-support organizations, ensuring that they are independent of the clinical entities in which they serve children and families. This is important in providing accountability for care.
- Promote education and credentialing of family peer advocates through “Just the Basics” training, Parent Empowerment Training, and the Family Development Credential (FDC) Program:
  - The Just the Basics training program is sponsored by Families on the Move and provides participants with basic information and skills needed when advocating for themselves, children and families. The training addresses each of the child-serving systems—i.e., Mental Health, Juvenile Justice, Child Welfare, and Education—and prepares advocates for cross-systems advocacy.
  - Funded by OMH and the Department of Education, the Parent Empowerment Program is an education and support program developed by the Mental Health Association of NYC, in collaboration with researchers from OMH and Columbia University, to improve knowledge about children’s mental health, strengthen advocacy skills among parent advisors, and assist them in their work with parents of children with mental health needs.
  - Developed by Cornell University in collaboration with the State Council on Children and Families and Department of State, and the NYC Department of Youth and Community Development, the FDC Program provides frontline workers with the skills and competencies they need to empower families. FDC-trained workers help families capitalize on their strengths and set and attain their goals for healthy self-reliance.
- Use the Plan to remind people that training provides a wonderful opportunity to work toward transformation.

## **Mental Health Association in NYS**

### ***Model Programs***

- The Invisible Children’s Program in Orange County aimed at supporting parents diagnosed with psychiatric conditions and their families
- The Mental Health Association of NYC Adolescent Skills Centers, which aid adolescents and young adults with serious emotional and mental health issues who are no longer in school to improve their academic standing with remedial instruction and general education development (GED) preparation; also help students acquire job skills with vocational training and internships so they may lead productive, healthy lives in their communities and healthier re-entry into the community
- Camp New Horizons, a therapeutic residential summer camp program of the Mental Health Association of Cattaraugus County that serves children and adolescents, ages 8-15 who have social, emotional and/or behavioral needs

- The Mental Health Association of NYC and National Alliance on Mental Illness (NAMI) of NYC Veterans Mental Health Coalition, which is modeled after the Long Island Coalition and designed to promote the mental health and well-being of NYC service members, veterans, and their families through education, information, collaboration, and promotion of a comprehensive array of services
- Innovative programs of the Mental Health Association of Columbia-Greene Counties
- Geriatric Mental Health Alliance of the Mental Health Association of NYC
- Take a look at the Mental Health Workers' Assistance Program, operated by the State Mental Health Association and through 10 resource centers statewide, which helps healthcare workers to learn about and evaluate benefit options available in the state (e.g., Family Health Plus, Child Health Plus) based on their individual circumstances.
- Spotlight the Care Monitoring Project and its success with engaging providers in careful monitoring of people identified at risk who have fallen out of care; as with assisted outpatient treatment (AOT), when people receive good care coordination, outcomes will be improved.

### ***Issues to be Reflected in the 5.07 Plan***

In addition to continuing the focus on trauma-informed care, person-centered planning and care coordination, attention to the following specific issues in the plan should help to continue momentum with transformation:

#### Parents with Psychiatric Disabilities

- Give attention to the issues parents with psychiatric disabilities are facing.
- Work to remove the discrimination experienced by parents and termination of parental rights due to their psychiatric conditions needs through legislative, practice and policy efforts.
- Strive to change the perceptions of the issue through public education; any time a family unit is disrupted and children are removed is one time too many.
- Realize that families suffer because they avoid seeking psychiatric care due to a fear of having children taken away by the system, sometimes even moving to other states with less punitive laws to seek needed care.
- Look to other states for models that help families to remain united and received the services and supports that strengthen each family member.

#### Youth Transitioning into Adulthood

- Move from discussion to action on supporting vulnerable youth who are moving into young adulthood through culturally competent programs such as the Life Skills program in NYC, the PASS program operating in Monroe County.
- Look at models of success in helping youth to continue their education with support in community college settings (e.g., Cleveland, Hudson Valley).

- Take action on the fact that more than 6 out of 10 youth with serious emotional and behavioral challenges drop out of school and become the “forgotten youth,” at risk for contact with the criminal justice system, homelessness, and other untoward effects.
- Find models of success in systemically creating links between youth who drop out of school and early intervention to keep youth engaged in supportive programs (not necessarily mental health) that help them to identify vocational and academic goals and be successful in achieving them.
- Realize the importance of creating culturally competent programs for youth in services who are transitioning out of the children’s system of care. Youth in their early ’20s reject traditional programs that they perceive will destine them to lives as patients. Emphasize engaging youth early on in educational and supportive services that are designed to meet their unique social and emotional needs.

#### Workforce Development

- Realize that the problem with turnover among direct care staff persists even in the worst of economic times; workers leave direct care positions to because of the low pay.
- Create meaningful alternatives to help retain trained direct care staff (e.g., tuition reimbursement, career ladders, training programs).
- Look to other systems of care that have developed effective approaches to retaining staff and replicate them (e.g., Office for People with Developmental Disabilities [OPWDD] targets funds to help underwrite the cost of health care for direct care staff via health care accounts).
- In thinking about the challenges for families and the formidable challenges they face in gaining access to care and ensuring that their children’s social and emotional developmental needs are met, use the following graphic representation to consider a simple, helpful guide for navigating a system of care.
- Look to other novel approaches to retain staff, such as the federally funded program available through OPWDD that matches every \$25 saved by a worker with \$100 toward savings to use toward making a down payment on a new home.

#### Housing

- Help to quantify the number of people being served who live with aging parents so that strategies can be created to ensure ongoing supportive living arrangements when parents die.
- Look to promising approaches such as NAMI Promise in Syracuse where active and concerned families and friends of people who suffer from serious and persistent psychiatric illness support families of aging parents and their children with serious mental illness..

## Employment

- Highlight successes with the evidence-based supported employment model, efforts under the Medicaid Infrastructure Grant, benefits counselors, and tax credits for employers who hire people with disabilities.
- Look to the work of the Mental Health Association through its Business Advisory Councils in eight affiliates, each of which brings together employers, providers, and people diagnosed with psychiatric conditions to find employment opportunities that lead to success for the employers and the people employed.

## Juvenile Justice

- Look to approaches that help identify youth at high risk for contact with the juvenile justice system (e.g., youth who is dropping out of school) and provide early intervention screening, and, if indicated, assessment that leads to supportive interventions at the clinical (e.g., motivation interviewing, family functional therapy) and recovery (e.g., advance directives, person-centered planning) levels.

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## Mental Health Empowerment Project

### ***Strategic Framework***

- Continue the use of person-centered language and strive to provide training that deepens an understanding of why the use of person-centered language is crucial to recovery.
- Ensure that providers receive training that allows them to make the shift to a recovery-oriented model of services and supports and ensure that people who have are labeled as having psychiatric disabilities are included in such training.

### ***Policy and Principles to Guide Plan Development***

- See that forced treatment is a systems failure and seeks ways to lessen the use of AOT, in line with what is happening at the national level.
- Make housing the number one priority and show what is working and not working for people.
- Have the Plan emphasize housing, employment, education, and access to services.
- Make sure there is a focus on trauma-informed services so that we don't just talk about it but do something to make it come to life.
- Seek to reduce the stigma and discrimination associated with disabilities through support for the United Nations' Universal Declaration of Human Rights and the Convention on the Rights of Persons with Disabilities, both of which take the perspective of the human dimension to living with disabilities and honor the following principles:

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
- Non-discrimination
- Full and effective participation and inclusion in society
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
- Equality of opportunity
- Accessibility
- Equality between men and women
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities
- Let the Olmstead laws and policies guide mental health services and supports, particularly in seeing each person as an individual and supporting him or her in gaining strength and coping effectively with the challenges of everyday life.
- In providing services and supports, be guided by the reality that support for a person with a psychiatric diagnosis is no different than the support of a person without such a diagnosis.
- Approach care with the understanding that people with psychiatric disabilities have the same needs as any other person to enable them to live their lives fully and productively.
- Advocate not to have peers be employed directly by the clinics they are working in, but rather by independent peer agencies.

### ***Invaluable Programs, Practices and Tools for Recovery***

- Look to knowledge shared by the International Network toward Alternatives and Recovery (INTAR) to build “safe spaces and positive relationships, wherein the ordeal presented by extreme states of mind can be met with proven tools and seasoned presence.” (The fall 2009 conference offered a number of alternatives to hospitalization.)
- Consider models such as Soteria House (opened 1971 and closed 1983), which provide residential alternatives to hospitalization, where nonprofessional staff are available in small, homelike, quiet, supportive and protective social environments that aid healing and anticipate that people will get better.
- Rely upon peer support models to promote grassroots change, a sense of community, and an awareness of alternatives to forced treatment.
- Utilize the resources and knowledge being gained through Nathan Kline Institute (NKI) Center to Study Recovery in Social Contexts, a National Institute of Mental Health (NIMH)-funded program of research set up in 2007 to investigate “quality of life” issues for people who have been diagnosed with severe mental illnesses, especially those who use public mental health services in NYS. In particular, the Center focuses on capabilities and their impact on the recovery trajectory.

- Take more of a trauma-informed focus to services and supports, approaching individuals more holistically from the vantage of “What happened to you,” rather than, “What’s wrong with you?”
- Provide training and technical assistance to providers on current trauma-informed practices.
- Consider highlighting the Westchester Community Services Treatment Center for Trauma and Abuse, which was established in response to the growing concern for services that address violence and abuse in our families and communities and offers programs geared toward preventing violent and aggressive acts by children and adults and helping to heal the trauma of victims.
- Talk with staff from the NYS Coalition against Sexual Abuse to learn about model programs that are meeting the needs of persons affected by trauma and abuse.
- Give attention to programs that are effective in meeting the needs of parents who are diagnosed with psychiatric disabilities, particularly when these parents face higher levels of stress because of fear that the system will intervene in ways that are not supportive of families’ capacity to nurture and parent new children.
- Find an example of a LifeSPAN program that doesn’t blame individuals for not taking steps toward a healthy lifestyle, but rather takes into account the realities of life with a serious psychiatric disability and the barriers that must be removed in working toward a healthy lifestyle (e.g., dealing with a low income that limits healthy food choices, the safety of a neighborhood for walking and exercising, ways to deal with debilitating effects of medication).
- Look to programs that do a good job in clinician training and offering an environment in which people who have psychiatric labels are not treated differently because of the labels.
- Stress programs that offer alternative treatments and not likely to rely on medication as the first line of treatment; look at the program offered by Green Chimneys in which children with trauma histories are involved in working with abused animals and nurturing them back to health.
- Focus on self-directed recovery tools such as meditation, wraparound planning, yoga, journaling, positive affirmations, and strategies people use to turn off the “negative tape recorder” in their heads.
- Look to programs such as Deegan’s “personal medicine” (the “things that raise our self esteem and make life worth living” . . . [and] “vital to recovery”) that helps people to connect to those things that give their lives meaning, are foundational to hope, and move away from having illness define a person’s being.
- Find community opportunities where people can connect in positive ways with others not involved in the mental health system, thereby reinforcing messages that recovery and full, productive lives are possible.

## Families Together in NYS

### ***Recommended Programs for Recognition in the Plan***

We have selected these programs because they are consistent with Families Together's and system of care values, and promote the youth and family voice in all that they

- YOUTH POWER!
- Finger Lakes Parent Network
- Camp Get-A-Way
- Prevention, Access, Self-Empowerment and Support (PASS)
- Jewish Board of Family and Children's Services Center for Trauma Program Innovation
- Family Ties of Westchester
- Chemung County Children's Integrated Services Youth Advisory Council
- Positive Alternatives to Restraint & Seclusion (PARS) 2010 award winners

OMH has done a commendable job of moving children's mental health services to the forefront. We recommend that this new focus on children and families be acknowledged throughout the Statewide Comprehensive Plan including in the Transformation, Recovery and Resilience section, and in the Strategic Framework. The language of recovery and resilience is frequently used in the adult section and should be included in the children's section, making it clear that we don't expect our youth to graduate into the adult system. We expect them to graduate into the community as students, employees, small business owners or whatever their pursuits may be.

It's important to remember that youth, families and peers are the most important stakeholders in the children's mental health system. Thank you for maintaining a youth and family centric approach in the Strategic Plan. We urge you to maintain this focus and strengthen it where possible by making it clear that all services should be "family and youth centered and driven."

In addition, we strongly support the use of The Children's Plan as the cornerstone of the Children's and Family Services section. In the 2009–2013 Statewide Comprehensive Plan, The Children's Plan was highlighted and the cross-system collaborations were noted under a number of action items. We urge you to build on this cross-system approach by promoting a truly cross-system entry mechanism and delivery system that unifies systems rather than perpetuates silos which prevent families from accessing appropriate services. System of care and CASSP values and principles should be infused throughout the Children's and Family section with a paragraph that describes the system of care philosophy and why this approach should be adopted by every county.

Finally, essential pieces of a system of care must be highlighted. They are independent, peer run family support, respite and family and youth peer advocacy. These pieces need specific action steps to insure their implementation.

## NAMI–NYS

### ***Strategic Framework***

- Under Basic Needs, emphasize the importance of access to affordable and safe housing. This is the Number 1 priority for NAMI–NYS.
- Continue the use of person-centered language and strive to provide training that deepens an understanding of why the use of person-centered language is crucial to recovery.

### ***Policy and Principles to Guide Plan Development***

- Help to move mental health into the mainstream and reduce stigma and discrimination associated with mental illness and mental health challenges.
- Involve families at all levels. To quote NAMI national, “Family members are a central resource in the treatment of children and adults living with serious mental illnesses and should be an integral part of the treatment team and empowered to facilitate mutually agreed upon treatment team goals. Research overwhelmingly shows that when families take an active part in treatment decisions, consumer outcomes are better. Families bring a knowledge of and relationship with the consumer that is unique and can be a significant help in determining the best course of treatment and recovery.”
- Attend to the issues related to an aging population and the needs of adult children with serious mental illness whose parents are dying or unable to help their children in navigating day-to-day life. Look at models of support that provide safe, affordable housing and supports to these adult children facing the loss of parents and stability in living.
- Put more emphasis on education that enables people with serious mental illnesses to manage medication effects, while at the same time working to improve communications between psychiatric and primary care providers to reduce and avoid untoward medication effects (e.g., systematic, routine monitoring of individuals receiving antipsychotic and other medications for high cholesterol, high blood sugar, weight gain) and treat medication-related side effects as they develop.
- Tie regular medication monitoring practices to licensing of clinics operated by the State.
- Promote policies and practices that create synergy between health and mental health care so that family care and mainstream medical providers are more effective in treating the whole person.
- Promote language on the children’s mental health side (e.g., Children’s Plan) recognizing that serious mental illness is a brain disorder. An emphasis on social and emotional well-being should not negate the seriousness of illness that is biologically based. The Recovery after an Initial Schizophrenia Episode (RAISE) grant, for example, is examining how to change the course of schizophrenia early on when signs first appear in teens and young adults.

- Be attentive to using language in the Plan that does not contribute to feelings of inadequacy in people who live with chronic, debilitating mental illnesses and that does not contribute to feelings of false hope. Realistically, recovery for one person is not the same for another; it does not always mean getting better like one would get better from the measles. Recovery for one person could mean obtaining competitive employment, yet for another it could mean getting up, bathing and dressing each day. Unfair expectations can lead to poor self-esteem and setbacks.
- Do not avoid using the term “mental illness.” It perpetuates stigma, rather than eliminating it and is reminiscent of the days when people dared not use the word cancer and called it “the big C” instead. Recognize the term for what it is, particularly because early recognition and intervention are key to improving outcomes.

### ***Invaluable Programs, Practices and Tools for Recovery***

- Continue to focus on the crucial priority of access to safe, affordable housing, particularly programs that are leading the way in fostering the availability of such housing.
- Highlight programs that are invaluable in eliminating stigma and discrimination and in positively portraying mental illness (e.g., NAMI Walks, which are part of the national campaign that is taking place in NYC/Long Island).
- Bring attention to the education projects that are making exciting inroads in schools. *Breaking the Silence* is a NAMI-developed educational package that enables health educators, teachers and students to better recognize mental disorders, understand that they can be diagnosed and treated just like any other illness, challenge biases associated with mental illness, foster acceptance, and end discrimination and stigma. The curriculum is available for the upper elementary, middle and high schools.
- Be sure to stress the value of reaching out to school communities and promoting school education as an effective strategy to overcome stigma and discrimination. While getting to know a person who has a mental illness is a powerful way to reduce stigma, a recent NIMH-funded study of the Middle School *Breaking the Silence* curriculum by co-investigators Dr. Otto Wahl, University of Hartford and NAMI Queens/Nassau shows that school education is effective in improving knowledge, attitudes and behaviors related to mental illness.
- The NAMI Walks for the Mind of America campaign plays an important role in raising awareness about mental illness and fighting stigma both nationwide and in NYS. The NAMI-NYC Metro walk over the Brooklyn Bridge and the NAMI Long Island/Queens walk at Jones Beach attract several thousand walkers each May and this year together raised more than a half a million dollars. They provide the opportunity to portray people who are coping with mental illness and mental health challenges as heroes, much in the same way that breast cancer awareness efforts celebrate the recovery of people who have been fighting cancer. Also give public recognition to individuals and groups that are successful in raising funds that are used to improve mental health and well-being.

- Take a close look at arts projects that deal with the issues of mental illness in sensitive and caring ways, such as the Tony award winning Broadway musical, *Next to Normal*, which was also the recipient of the 2010 Pulitzer Prize for drama.
- Check with Judy Watt in Rochester about programs that may be doing a good job in regularly screening for and preventing the occurrence of psychiatric medication side effects and in intervening early when such effects are detected.
- In the Plan, describe the value and importance of NAMI signature programs that are making a difference in the lives of persons with serious mental illness and mental health challenges and their families (e.g., Family-to-Family education program, In our Own Voice, NAMI Connection). Clubhouse of Suffolk is using the Family-to-Family for its PROS program ([http://www.nami.org/template.cfm?section=Education\\_Training\\_and\\_Peer\\_Support\\_Center](http://www.nami.org/template.cfm?section=Education_Training_and_Peer_Support_Center)).
- Highlight NAMI Queens/Nassau's Friendship Network is a unique service that introduces single men and women recovering from mental illness of the same or opposite sex to one another. Created to help its members make new friends and alleviate the isolation of their illness, the Network matches people with similar interests and backgrounds and mentors them in developing and maintaining relationships. Members also regularly participate in group activities such as bowling, tennis, and theatre trips. The FN serves members throughout the metropolitan New York area, giving them the confidence to socialize in a variety of public settings (<http://www.friendshipnetwork.org/>).
- Point to programs that are doing a good job in treating mental health and substance abuse disorders.
- Call attention to disorders beyond schizophrenia and bipolar having a significant impact on people's lives (e.g., obsessive-compulsive disorders) and contributing to substantial disability.

## **New York Association of Psychiatric Rehabilitation Services**

### ***Strategic Framework***

- Continue the use of the newly revised person-centered, recovery-oriented framework.
- Ensure that providers receive training that allows them to make the shift to a recovery-oriented model of services and supports and ensure that people who have are labeled as having psychiatric disabilities are included in such training.

### ***The Plan as a Tool for Achieving Goals and Monitoring Progress toward Transformation***

- How do we know the Plan is taking root? How can we make the Plan more relevant and report on measurable progress?
- As clinic restructuring is being rolled out, how will we measure progress toward goals?

- How can we reflect cutting edge concepts that are having a positive effect on the recovery trajectory for individuals, such as greater financial literacy (e.g., increased knowledge and its application to accumulating savings and using) and health literacy (e.g., improved social functioning as evidenced by an ability to sustain healthy relationships)?
- How can we provide the breadth and depth of data needed to monitor transformation and improve accountability for results?
- How do we determine that the support provided by mental health treatment and services helps people to move toward more integrated lives (e.g., people no longer requiring ongoing treatment, people gaining employment or meaningful work in the community, people have full social lives)?
- Look for alignment between the goals of the agency and those of the Most Integrated Setting Services Council (MISCC).
- Redirect some resources from research to measure change and monitor the degree of success (e.g., How many families are preserved? How many people have attained a higher level of self-care and health literacy? How do we help to reduce risks associated with mental health treatment, such as obesity, cardiovascular disease, etc?)
- Build on last year's Plan by focusing on best practices and using data to highlight exemplary practices.
- Have OMH formally join the 10 x 10 campaign to promote the importance of addressing each part of a person's life with the goal of increasing life expectancy for all persons with mental health problems by 10 years over the next 10 years.
- Look toward the next generation of person-centered care, called self-directed care, and examine ways to incorporate it into services and supports so that individuals have the flexibility to overcome real barriers to a fully integrated life in the community. (The elements of self-directed care, as defined by CMS, include having service recipients control funds for the purchase of services and supports that align with the goals of a person-centered recovery. Treatment dollars are budgeted to meet these goals, with support to help the person broker services and manage the plan and with a fiscal intermediary to handle billing, taxes and other administrative functions.)
- Examine models of self-directed care being piloted elsewhere in the nation (e.g., Judith Cook's managed care pilot in Dallas, Texas, Joseph Rogers in Delaware County, Pennsylvania) for their utility in breaking out of the illness model toward a strength-based approach of securing flexible, community-based services and supports.
- Enhance the Personalized Recovery-Oriented Services (PROS) model through the introduction of self-directed care.
- Pay attention to the emerging trend toward better integrated care, especially through efforts such as the chronic illness demonstration projects under way through the State Department of Health (DOH).

- Utilize a “feet on the street” approach to integrated care by utilizing trained peer wellness coaches (e.g., as is taking place under Optum in Queens), with emphasis on forming relationships, engaging people in care, and helping them to maintain health and wellness through such support.
- Look to peer outreach and crisis diversion as important components of integrated care (e.g., mental health, substance abuse, health).
- Examine the concept of a “recovery home,” or the place a person receives integrated health, mental health, substance abuse care, using tools such as self-directed care, person-centered planning, wellness recovery action planning, advance directives to promote seamless care and overall well-being.
- Promote the use of voluntary wellness alternatives (e.g., yoga, Chinese medicine, reiki, good nutrition) for those individuals who desire nonconventional, complementary medical approaches to care.
- In promoting good mental health, keep in mind the power from individual stories of recovery.
- Consider TV and radio PSAs and placement of stories of “real people” in these media to promote the portrayal of having a mental health challenge as one where recovery is possible and that dealing with a mental health challenge is a normal part of life.
- Consider annual awards during mental health week to New York media that portray accurate, non-stigmatizing, and positive images, reports, and stories of people dealing with mental health challenges, etc.
- Continue to address issues affecting communities of color (e.g., overrepresentation in the criminal justice system, disparities in outcomes).
- Address the cultural diversity of the workforce so the workforce is representative of the people served and competent in the delivery of care to meet people’s unique needs.
- Work with professional training, accreditation and professional development programs (e.g., social workers, psychiatrists, psychologists, nurses, peer counselors) to ensure that students have the requisite skills and knowledge to deliver recovery-oriented care (see recovery to practice literature of Larry Davidson, Yale University).
- Focus on culture and the need to change practitioner attitudes and practices through the incorporation of peers into services delivery and attend to the nature of organization culture—alignment between recovery principles and values and organizational climate—in licensing and certification processes.
- Continue to identify and implement models of care that increase provider responsiveness and accountability (e.g., Mental Health Monitoring Teams in NYC, Westchester care coordination) for positive outcomes.

## PEOPLE, Inc.

### ***The Plan as a Tool for Aligning Recovery Values with Provider Cultures and Monitoring Progress toward Transformation***

- Do we back up our talk with action? While we talk about recovery, do we show good outcomes? Examine how good organizations, both traditional and nontraditional, not only speak the language of recovery, but also show positive outcomes as a result of action.
- Look at how organizations have assessed their own organizational climate, examining core values and striving to strengthen their place in shaping or reshaping the organizational culture.
- Try to understand how providers back up their core values with corresponding actions (e.g., respectful relationships are manifest at every level, from the way phones are answered, assessments conducted, and people engaged in planning and choosing options). Look for examples of how providers excel at aligning core values and everyday behaviors.
- Look at innovative approaches to examining organizational culture and aligning values and actions (e.g., use of a sports coach to help build a championship team, use of agreements that clarify roles and expectations, attention to respectful communication, recognitions of achievements in adhering to mission).
- Look at how values are related to the outcomes desired by the provider and strategies used to attain them (e.g., the kind of Executive Team needed to be successful).
- Look at the outcomes being achieved in organizations by monitoring quality of life data (e.g., improved social networks, improved job skills and employment retention at regular intervals).
- Focus attention on self-directed care and its outcomes (e.g., look at models in Florida, Texas).
- Underscore the importance of natural supports in the community, where people who are engaged in services come together in natural settings for friendship and social opportunities (e.g., Barnes and Noble book reading, the local coffee shop to play games, social club that devotes itself to raising funds for charitable causes, smoking cessation program at a health club).
- Consider complementing the Plan with a DVD that shows what excellent services and supports look like and highlights the implementation of recovery-directed services and supports (e.g., PROS, jail diversion, entitlement education).

### ***Needs PEOPLE, Inc., Hears about at Community Forums***

- Better education and stigma reduction
- Alternative treatments
- Lack of information and support, especially for families with children in school

- More education in school settings (e.g., PTA meetings, teacher education) that enable families to more readily access resources and supports (e.g., out of county hospitalization, school clinic services)
- More natural supports and information that enable families to participate fully in services (e.g., wellness recovery action plans {WRAPs}, advance directives, public library resources)
- Use of PSAs to help people know about resources available to help them
- Local training and education by agencies to meet the strong demand for mental health information and resources (e.g., rights, how to access out-of-county care, particularly hospital care so that families are empowered, involved, and so care is seamless)
- Culturally competent attention and person-centered approaches to the needs of children turning 18 and making the transition into adulthood (e.g., based on the recognition that youth reject traditional mental health services)
- Tools to help with navigating the system of care, including a schematic aid
- Better collaboration and communication among and between care givers, with a focus on fidelity to a person-centered plan where each care giver contributes expertise toward goals identified by the individual engaged in services

## **We the People**

### ***Strategic Framework***

- On the front cover of the Framework, add “diversity” right after the word “embraces.”
- Under Person-Centered Decision Making, change the language of “Collaboration with Providers to consider and decide on treatment plans that capture personal preferences and goals” to emphasize self-directed care and its importance for each individual’s recovery (e.g., “With clinician guidance, develop self-directed plans of care that capture personal interest, preferences, and goals.”)
- Under Mental Health Treatment and Supports, move up “Access to treatment that is not forced . . .” to the top of the list.
- Under Person-Centered Decision Making, change “Access to clinicians adequately trained in the principles of recovery and person-centered training” to “Access to clinicians adequately trained to deliver trauma-informed treatment and care based on the principles of recovery and person-centered planning.”
- Under Relationships, change the ending of “Availability of public education . . .” from “to reduce stigma and discrimination,” to “to eliminate stigma, discrimination, and racism.”

### ***Policy and Principles to Guide Plan Development***

- Meet the challenge of putting words into action.

- Move toward the ideal of self-directed care, identify what is needed to stay the course, and capitalize on opportunities for improvement.
- Recognize and act upon the knowledge that many people served by the mental health system have endured trauma and incorporate this knowledge into training.
- Focus research on a shared agenda for crafting research questions and examining approaches to ending forced treatment.
- Understand the limitations of CQC investigations, especially the workload and strategy used to investigate only “credible” complaints; very serious abuses such as rape, while reported, “are not heard.”
- Promote the use of self-directed care programs that enable people to develop their own recovery plans and identify and purchase the services necessary to meet their goals (e.g., safe, affordable housing).
- Understand the limitations of patient satisfaction surveys and particularly understand that people who are engaged in services fear retribution for negative evaluations.
- Make clear in the plan the importance of the peer movement in helping to move the field of mental health services and supports to its current focus on recovery, resilience, and self-directed care.
- Give credit to peers for the substantive work being done inside the system to make positive change and the result of their collective “blood, sweat, and tears.”
- Respect peers for their contributions to transforming the system of care.
- Ensure that peers are substantively involved in all facets of the implementation of clinic restructuring and its ongoing evaluations.
- Operate from the knowledge that a change in language does not translate into a change in behavior; be certain that providers receive the training and support in deepening their understanding of person-centered, recovery-oriented services and support values and beliefs and reflecting it in enacting concepts and words.
- Develop strong linkages to academic training programs to ensure current knowledge regarding mental health recovery, peer movement, etc., is reflected in curricula (e.g., no use of introductory textbooks that inaccurately portray and ultimately denigrate the role of self-help and peer support to wellness and recovery).
- Examine disparities in care and bring these to light in the Plan (e.g., whites are 4 times more likely to get PROS than people from minority populations).
- Realize that in its implementation, PROS is having unintended consequences that impact largely on people engaged in services (e.g., people are told they must show up to programs or they risk losing the services altogether, peers being threatened with the closure of services if they do not show up to programs, providers cherry picking, peers feeling obligated to participate in an unethical way).
- Ensure that training opportunities for PROS are clearly open to peers and all persons participating in services delivery understand that peers should be at training events.

- Place more of an emphasis on creating peer-to-peer training programs for PROS.
- Recognize that unfortunately in a clinic setting, peers employed by the clinic end up being “escort” workers; independent, external peer advocacy in clinic settings is necessary for quality peer services and supports.
- Realize that cultural competence training does not work without getting to the heart of the matter: racism, oppression, and an appreciation of social context; incorporate such discussion into ongoing cultural competence training.
- Infuse into regulations and licensing requirements a focus on indicators of recovery and standards for culturally competent care.
- Move away from stigmatizing language of “serious mental illness” and state the truth: Recovery is often recovering from happened to us in the system.
- Know that having a person complete a wellness plan, while it may look good on paper, is not an indicator of success. Success is met when the individual is able to access resources to put the plan into action and progress is monitored so that the individual is able to work toward the goals without impediments standing in the way.
- Embrace the human rights agenda to end torture and abuse (e.g., Ms. Green at Kings County Hospital) and ensure accountability for care through human and civil rights training.
- Seek adequate Medicaid and insurance reimbursement for independent, external advocacy services (e.g., credentialing of such services for quality and reimbursement purposes).
- Examine the feasibility of synthetic cannabis as an alternative medical therapy, given studies showing positive outcomes for persons with diagnosed psychiatric conditions. Give credence to alternative treatments that open doors to recovery.
- Respect and respond to our call to not support Kendra’s Law because it is not consistent with the values espoused by the public mental health system. How can providers be accountable for care, without mandating forced care, so people get what they need in the community to live safely, fully and productively? Positive outcomes from Kendra’s Law would be the same outcomes that would occur if people received the same level of services and supports without coercion.

### ***Invaluable Programs, Practices and Tools for Recovery***

- Look to healing alternatives as a necessary component to trauma-informed supports and services.
- Involve more peers in licensing site visits so they can actively engage peers in discussions focused on their experiences with care, quality of care, and other related issues.
- Structure wellness programs so they do not inadvertently blame the victims—those individuals who faces serious barriers in seeking a healthy lifestyle; rather, address structural issues that serve as formidable barriers to participation (e.g., lack of income to

buy gym membership, lack of income to afford more expensive healthy food choices, unsafe neighborhoods).

- Look to examples of organizations that have recruited and retained peers for higher level administrative positions, particularly in the field of independent external advocacy.
- Avoid agency-employed peers for outreach and engagement under clinic restructuring. Rather, have providers contract with independent peer agencies to conduct this work. (Simply adding a peer to a provider organization ≠ recovery.)
- Look away from the illness model as the foundation for services and supports and look to culturally competent models of care that appeal to emotional well-being (e.g., the African American community highly values emotional wellness).
- Incorporate the People’s Institute for Survival and Beyond Undoing Racism™ training into cultural competence educational programming, so as its web sites notes, we “move beyond a focus on the symptoms of racism to an understanding of what it is, where it comes from, how it functions, why it persists and how it can be undone.” This training emphasizes learning from history, developing leadership, maintaining accountability to communities, creating networks, undoing internalized racial oppression and understanding the role of organizational gate keeping as a mechanism for perpetuating racism.
- Feature programs that are effective in meeting the needs of parents who are diagnosed with psychiatric disabilities and keeping families intact, and, not contributing to another generation “for the adult service system.”
- Consider Soteria House as a model to meet current need and one for which there is an opportunity to try a totally different approach to caring, safe and supportive care that aides healing and expects people to get better.
- Rely upon peer support models to promote grassroots change, a sense of community, and an awareness of alternatives to forced treatment.
- Expand the best practices PARS Seclusion program from children and adolescents to adults.
- Feature We the People in the Plan as one program outside mainstream services that advocates for change premised on the principles underlying human rights and civil rights.

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## **YOUTH POWER!**

### ***Policy and Principles to Guide Plan Development***

- Help YOUTH POWER to consider creative ways to fund self-directed community youth activities (e.g., using the County Planning System that captures county planning priorities each year to pose a few questions that help to gather pertinent planning information to aid this effort).

### ***Invaluable Programs, Practices and Tools for Recovery***

- Point to the successes taking place in youth leadership and the incorporation of this leadership across the systems of care serving children and their families.
- Look to the good work taking place at the Pederson-Krag Center Work, Achievement, Values, Education (WAVE) Youth Leadership Program.
- Feature the strengths of the Finger Lakes Parents Network.
- Spotlight the substantive role of youth in supporting youth aided by the Chemung Single-Point-of-Access program.
- Give attention to the programs that were showcased during Children’s Mental Health Day as programs doing good work on behalf of New York’s children, youth and families.

## **OMH Advisory Body and Staff Input**

### **OMH Field Office Directors**

#### ***Invaluable Programs, Practices and Tools for Recovery***

The OMH Field Office Directors have indicated the following programs have shown to be leaders in promoting self-directed, recovery-oriented mental health services.

- Baltic Street Clinic
- Hands Across Long Island
- Housing Options Made Easy in Western and Central regions
- Integrated Housing initiative
- Low-Income Housing Tax Credit Investment program of Bank of America
- Recovery Center initiative being led by OMH
- Services for the Underserved
- Southern Tier Environments for Living, Inc.
- State University of New York at Purchase college support

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### **OMH Division of Children and Family Services**

#### ***Invaluable Programs, Practices and Tools for Recovery***

Programs recognized May 3, 2010, by OMH during Children’s Mental Health Day, and celebrated as a “program uniquely impacting the lives of young people and families.”

- Camp Get-A-Way  
Interborough Developmental and Consultation Center Clinic-Plus Program

- The Jewish Board of Family and Children’s Services Center for Trauma Program Innovation
- Jewish Board of Family and Children’s Services
- Parsons Center Child and Adolescent Mobile Team
- Prevention, Access, Self-Empowerment, and Support (PASS).

Programs recognized May 3, 2010, by OMH during Children’s Mental Health Day for their contributions to helping New York’s children and families. These organizations participated in poster presentations and include:

- Astor Bronx Outpatient Clinic
- Catholic Charities Teaching Family Home Program
- Family Service League/Children and Parents Together Program
- Hillside Children’s Center Cross Systems Solutions
- Madonna Heights Family Service Clinic
- Parsons Child and Family Center Youth Council
- Ready, Set Parent!
- The Richard D. Tenenini) Foundation
- Children’s Single-Point-of-Access (CSPOA) Program of the Child and Family Institute at St. Luke’s and Roosevelt Hospitals
- Better Days Ahead System of Care Family Roundtable

Information on these programs is available in Appendix 4.

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### **Mental Health Planning Advisory Committee**

- Focus on youth in transition, particularly youth who are at risk for entering the adult mental health system, by providing the supports and services that enable them to make a successful transition into adulthood. The goal would be to have a policy direction that helps youth flourish and not have to enter the adult mental health system. When youth do enter the system, however, services and supports should be provided in a manner that is relevant to the individual needs of young adults and the youth culture. Look to programs in Westchester County (case management), programs that link to Clinic Plus and Family Health Plus, and innovative local programs such as the PASS program in the Binghamton area to highlight successes.
- Give attention to veterans and service members leaving the National Guard after combat duty, particularly because National Guard member are not eligible for veterans benefits. Look to programs at the state level that are preparing civilian providers to ask about military service upon intake and conduct screening, assessment and referral so

individuals in need of services and supports (e.g., for post-traumatic stress disorder [PTSD] and traumatic stress) are helped.

- Highlight the South Bronx Mental Health Council's early intervention program with schools, a demonstrated prevention program that is meeting with success (bilingual and monolingual services) in helping families whose children have been identified by school staff with possible mental health challenges.
- Given attention to the need for standard grievance and complaint processes and the elimination of fear from repercussions by individuals who wish to follow through on issues of concern to them. Acknowledge the intimidation and fear felt by individuals who reside in adult homes and engaged in services in other settings when they file a complaint.
- Continue to promote an inclusive and integrated planning process at all levels of the system of care.
- Help people to understand the rationale for systemic changes in policy and planning (e.g., NYC Bureau of Policy Analysis is phasing out).
- Examine the variability in the quality of the Community Services Board processes across the State.
- Highlight changes in the balanced scorecard in relation to new directions for the agency and the system of care and include this information in the Plan (e.g., measures of recovery valued by people who are engaged in services and the people/providers who are aiding recovery).

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## **Multicultural Advisory Committee**

### ***Model Programs for Consideration***

- South Beach Psychiatric Center peer run program
- Community clinics that integrate mental health into health care delivery
- Harlem integrated planning
- Programs outside of mental health

## Recipient Advisory Committee: Long Island and Hudson River

### ***Strategic Framework***

- Under Person-Centered Decision Making, include the concept of shared decision making.
- Under Living a Healthy Life, add the concept of a WRAP plan, to focus on prevention and complement advance directives. Rather than refer to a proprietary program like the WRAP, use the term “recovery plan.”

### ***Principles and Values to Guide Development of This Year’s Plan***

- Show the importance of the State working with, responding to, and supporting grassroots and local initiatives.
- Place more of an emphasis on fighting stigma and highlight the “Think beyond the Label” campaign active in 43 states and a part of our Medicaid Infrastructure Grant.
- Make the Plan available in more than English; translate it into Spanish as a start.
- Work to bring the reading level down to a level where the Plan can be more relevant and useful to readers.
- Bring to light the value and importance of alternative approaches to wellness such as spirituality and holistic and complementary medicine.
- Don’t let the language of recover become an actual impediment to recovery. Rather than talking about recovery in the Plan, just get to the point of helping people succeed in meeting their goals.
- Use the Plan as a tool to help people better understand what we do, and try not to rely upon catchy phrases.
- Be mindful that what is recovery to one person may not be for another and that our perspectives on recovery differ. How we define recovery may also not be the same (e.g., rather than “recovery,” “discovery” might be an apt term for some persons).
- Be aware that people generally do not think in terms of “recovery.” They are more likely to think about their lives. Many people experience a range of emotions, not specifically recovery, and for them their experiences are just a part of life.
- Realize that for people who are striving to live full, productive lives, they are looking to be better, to be well. For them, negotiating life does not equal recovery. Negotiating life is living a life.
- Use the Plan to foster a better understanding that small baby steps for some really signify giant leaps and should be celebrated as such.

### ***Invaluable Programs, Practices and Tools for Recovery***

- Help ready peers and others for change that will be occurring in the system of care. Ensure that peers have the opportunity to participate in an interactive process where

they have access to information that will enable them to understand and either advocate for or avail themselves of more recovery-oriented services and supports (e.g., PROS).

- Look for ways to celebrate the accomplishments of people in recovery and look to other successful models to create mechanisms to honor individual achievements (e.g., Cable News Network [CNN] Heroes, our Keys to Success). Programs that annually nominate and recognize role models/heroes not only provide them with well-deserved recognition, but also give hope to people and reinforce that recovery is real and possible.
- Use the Plan to say where we have been and where we are now. In other words, “Close the loop” by showing how partnerships and growth in parts of the system yield concrete accomplishments. Just as people are striving to recover, so too does the system.
- Point out the usefulness of tools offered by peer-run services.
- Support and show success in local efforts to counteract blatant discrimination. Mental Health Empowerment Project is one agency that does a good job at this, particularly in reaching rural areas.
- Give attention to the challenges faced by parents with psychiatric disabilities. Highlight work being done by MHANYS and model programs such as Partners in Parenting, which is sponsored by the Mental Health Association of Westchester or Invisible Children’s programs.
- Give attention to the issue of loss in working with children of parents with psychiatric disabilities as well as the parents and other populations (e.g., peers who are incarcerated or become hospitalized, people who experience divorce), pointing out the need to address such loss, grieving, and even suicide. Promote the development of tools and resources that foster a sense of support for people who encounter loss.
- Need toolkit to address loss suicide
- Promote peer-run and empowerment activities where peers look to an array of community resources beyond traditional services and supports to help in working toward recovery.
- Look into featuring the Veterans Alliance of Long Island.
- Provide a glimpse of how the Hands across Long Island forensic program is succeeding (e.g., on site peer services to individuals incarcerated in Sing/Sing and following them into the community to help with transition and integration.
- Feature Project Return Foundation in NYC, which is dedicated to educational, vocational, and supportive housing services that enable people experiencing mental illnesses to live productive and fulfilling lives in the community. In particular, this organization is effective in working with people who deal with chemical dependency and criminal justice issues.
- Highlight successes in meeting the needs of individuals with mental health challenges in the lesbian, gay, bisexual and transgender (LGBT) community. Look at what the Ulster County Mental Health Association MHA is doing (e.g., resource guide).

- Point out the real challenges in serving individuals who live with chemical dependency and mental health challenges and the need for greater integration of care. Point out how agencies can meet with greater success in serving this population (e.g., no wrong door for services, individualized, integrated care that takes into account both disorders, insurance barriers, staff training needs).
  - Point people toward successful models of support (e.g., Hands across Long Island) for people with co-occurring disorders.
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## **Recipient Advisory Committee: NYC**

### ***Strategic Framework***

- Place more emphasis under “Basic Needs” on the different types of housing.
- Emphasize integrated housing and its importance to living a good life in the community.
- Reverse the order of the objectives under the “Basic Needs” so the most important—housing—appears first and so on.
- Under the values, try to add in the importance of quality assurance and program evaluation to having care that emphasizes recovery. OMH should provide leadership in including families and recipients, for example, in review of licensed programs.

### ***Principles to Guide Development of This Year’s Plan***

- Make housing the number one priority and show what is working and not working for people.
- Have the Plan emphasize housing, employment, education, and access to services.
- Make sure there is a focus on trauma-informed services so that we don’t just talk about it but do something to make it come to life.
- Take a look at reimbursement under the new clinic restructuring to see if peer-run trauma-focused groups could be supported financially.
- Focus on wellness.
- Take a look at waiver programs that have been successful in other care systems (OMRDD, TBI, and other programs that provide housing subsidies, with attention to a person’s individual needs) and expand the model to the mental health system.

### ***Invaluable Programs, Practices and Tools for Recovery***

- Address the culture in organizations where respect for individuals and their needs are lacking and do this in part through a strong complaints and grievance process.
- Hold programs licensed by OMH to standards of good care (especially an environment in which people are respected) so that the quality of care in state-licensed programs meets that of the state-operated programs.

- Look to programs that do a good job at meeting the individual needs of people, whether art therapy, counseling, or helping with transportation by providing a Metro Card.
- Help people to move out of mental health shelters, where providers have a tendency to “keep people.” Importantly, while aiding people to move to more independent housing, make sure it is safe, thereby avoiding retraumatization.
- Look to programs that help people find and keep housing, get a job, provide opportunities for peer support. When people have jobs they can have decent housing and when these basic needs are met, then people can think about other things that help with recovery, rather than just trying to survive day in and day out.
- Look to programs that accept you as you are, don’t judge you, welcome you, find out what you want, and then help you get there.
- Look to programs that help people develop basic job skills, such as filling out a job application.
- Look to programs where individuals are empowered to manage their own time and activities, such as at South Beach where individuals have a place to meet and engage in meaningful activities on the weekend (the peer-run “Living Room”).
- Promote programs that help families (Family Support Programs) and encourage them to get information and services right in their communities.
- Promote employment programs that meet people where they are in their recovery, especially helping people to find opportunities initially that serve as stepping stones to mainstream employment. Peer counseling jobs, for example, are helpful for people just beginning recovery because they provide the important components of peer support and camaraderie that are essential to growth and well-being.
- Look to programs that help people obtain education and gain credentials that enable them to meet personal and work goals. Getting through the process of higher education is challenging and support is critical to help people meet with success.
- Promote programs like Howie the Harp and Baltic Street where peer support makes all the difference. It is crucial to helping people get housing, get jobs, and obtain education.
- Give priority to programs that help people get housing that brings stability to their lives.
- Acknowledge that recovery services replacing clubhouses can be threatening and scary for persons who have been relying upon the clubhouses.
- Put more emphasis in the framework on individuals who have been caught up in the criminal justice system and the need for programs that divert people with mental illness from incarceration into treatment (Mental Health Courts).
- Promote programs that improve access to mental health treatment for people in the criminal justice system and promote accommodation to the barrier of gaining employment because of a history of co-occurring disorders.
- Look for programs that do a good job in integrating people with forensic histories into their communities in a way that meets the needs of the community and the needs of the

individuals joining it. Identify providers that specialize in these services and are good at helping people to have the skills necessary for successful community living.

- Look for programs that do a good job in forensics training for the array of services that may be utilized in community living (e.g., housing, social services, mental health) and enable people to grow, flourish, and full and meaningful lives.
- Promote programs that do a good job in addressing the stigma and discrimination associated with having a mental health diagnosis.
- Look to programs that are successful in helping peers to take on the responsibility of doing the hard work necessary to be mentally healthy, especially those that help to overcome stigma through the promotion of personal responsibility and accountability.

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## **Recipient Advisory Committee: Buffalo and Syracuse**

- Look to peer-run programs like the Mental Health Peer Connection that meet people where they are at in their lives and help to empower, educate and enhance their abilities to live to their full potential.
- Look to programs that help people to get real jobs in the community, not just jobs that involve cleaning floors, bathrooms, and table tops in fast-food restaurants; find programs that do a good job in addressing stigma and discrimination that serve as barriers to gaining meaningful work (e.g., educating prospective employers about the potential of each person to be successful in the workplace and the importance of matching a person's talents to job needs).
- Promote programs that help people to deal with the effects of hospitalization, maintain skills necessary for successful community living, and avoid the development of dependence and learned helplessness; in other words, look to programs that, even in the worst of times for individuals, believe in their abilities and capabilities, recognize strengths, and strive to maintain or enhance them.
- Point out the importance of language and how it affects recovery. Pay attention to the intention of words and their vibrations and make sure there is correspondence between the expected outcomes and the words we use to describe getting to them (e.g., personalized recovery-oriented services describes a concept that its acronym PROS appears to be at odds with, especially because it brings up the image of professionals and experts that are outside of the person who is striving toward recovery and possibly conveying incorrectly a sense that it takes experts outside of the individual to achieve recovery). At best, look to programs that raise awareness to the nuances of language and strive to adopt language truly supportive of recovery at all levels.
- Look to programs that clearly convey respect for each individual in word and deed and are not accepting of negative stereotypes associated with mental health challenges.

- Promote programs that encourage and embrace the needs of individuals to voice their concerns about the quality of care and their experiences while engaged in services and supports. Especially support those programs that do a good job in helping people to understand their rights and responsibilities while engaged in services and supports.
- Find programs that show an understanding of how the system of care can cause trauma and demonstrate knowledge of how to recognize and deal with traumatic experiences of persons engaged in care. Find programs, for example, that are sensitive to the needs of parents with psychiatric disabilities who have lost their children, by supporting grieving, acknowledging loss, etc.
- Promote programs from the state down to the local level that increase knowledge among professional and direct care staff about the basics of trauma-informed care so that individuals receive care that is culturally competent and relevant to their specific needs.
- Make sure the gains made in serving individuals caught up in the criminal justice system are highlighted (e.g., mental health courts, diversion from the criminal justice system to mental health care, prison re-entry programs).
- Promote programs that support the basic need of housing and do so with a very strong peer component and the goal of helping individuals to make a smooth transition into housing and community living after a long-stay hospitalization.
- Support peer programs whose success to a large degree rest on individuals who use their own experiences, authenticity and mutual relationships to assist others who are not as far along in their recovery journeys and for whom a sense of deep satisfaction comes from helping others to help themselves..
- Promote Recipient Associate Managers at the Buffalo Psychiatric Center, who serve as the voice of persons engaged in services through participation in hospital task group committees (e.g., Trauma, Environment of Care, Treatment Mall), offer peer support groups, and provide skills training and more.
- Look to initiatives such as the Action for Mental Health Leadership Training Program, which provides students accepted into the program twice each year with educational offerings (e.g., team building, skills development, Social Security entitlements, and work activity, delegation of responsibility) designed to advance their personal advocacy and leadership skills, enabling many graduates to return to volunteer, work, and school activities.
- Focus attention on programs that promote wellness and holistic healing, such as HA-HA. Alternative practices provide individuals with healthy ways to express feelings (e.g., drumming, humor, yoga, salsa dancing) and opportunities for people to come together socially.
- Highlight programs such as Native American Independent Living Services, which reaches out to an array of individuals (e.g., veterans, correctional facilities) to provide services and supports that are culturally competent (e.g., Talking Circles, drumming circles).

- Look to programs such as the Invisible Children’s Project, sponsored by the Mental Health Association in Jefferson County, to emphasize effective practices for supporting parents with psychiatric disabilities and keeping families intact in a safe, nurturing way.
- Take a look at programs that are helping to address transportation needs of individuals—not just to get to appointments—but to have the opportunity to take part in community events and activities. How can we help people to advocate at the local level for transportation funds through the coordination and smart use of scarce transportation resources?
- Examine programs that are moving toward transformation through staff education and certification, such as Lakeview Mental Health in Ontario and Seneca counties. Focus on how credentialing of staff can help to create a climate for change toward a system of care where people engaged in services feel empowered and help to enrich their environment (e.g., the gentleman who suggested the book “*Reinventing Your Life*” be the topic of a support group).
- Highlight ways that access to computer technology can be enhanced and enable people to take advantage of opportunities that are presenting themselves via this medium (e.g., job searches, connection to community resources) and particularly highlight opportunities that exist in hospitals for people to stay connected to family and friend through email. Related to this would be programs that help people to increase their computer literacy skills.
- Look to programs that are effective in helping us to manage our lives, our finances, and promote our sense of being free. Highlight those that help us to see that answers are within reach (e.g., benefits advisement that could help a person plan how to save for a personal computer) and help in gaining the resources that lead to meeting personal goals (e.g., PASS Plans). Also highlight how shifting our thinking can help us to embrace our freedom, and, when entering the system of care, not lose our sense of empowerment. Find those programs that value freedom as well as rights.

## Input Received via the Transformation Mailbox

***Melissa Farrell, Peer Advocate, Staten Island Peer Advocacy Center***

There need to be alternatives to getting well and recovery from the biomedical model.

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We need some sort of community education to overcome prejudices held by community members against us. (For example: My neighbor hates me because she thinks she is paying so that I can stay home and not work, for example. She needs to be shown clearly just how much she herself is paying for me, which I'll bet is a fraction of a cent if anything.)

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***Rita Cronise, MS, Instructional Design Consultant. Copeland Center Trained Recovery Educator, Victor***

People in peer-led self-help support groups often talk about how much their dogs mean to them. I recall instances where people have shared how their dogs have saved their lives. In their darkest moments - when they were ready to "check out" - the only thing that stopped them was the fear that the dog would end up at a shelter.

Last night, PBS had a heartwarming special about companion service dogs...\_  
(<http://www.washingtonpost.com/wp-dyn/content/article/2010/04/20/AR2010042004802.html>)

It occurred to me while watching the show that even when people with psychiatric challenges live in a place where they can't have a dog of their own—perhaps there could be a place they could go to have a dog to care for (both the responsibility of feeding and walking—and the companionship that could grow out of that caring).

With so many humane shelters filled to capacity and dogs euthanized... there is no shortage of dogs, many of whom could be wonderful companions if only given a chance. Likewise, there is no shortage of lonely people, many of whom are simply misunderstood and feared by human society - who could make wonderful companions to dogs currently held captive (and often awaiting death) in the humane society.

I wonder what it would take to create a place... for those with psychiatric histories to come together with, care for, care about, and learn from shelter dogs who might eventually have the capacity to become trusted service/companion dogs.

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**Peter K. Navratil, LCSW-R, ACSW, CASAC, Vice President of Behavioral Health, Catholic Family Center, Rochester**

Model Programs

- Integrated care - more specific
- screening for domestic violence
- screening for substance use disorders
- integration of primary health care needs
- smoking cessation

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**Shirley A. Fritz, LMSW, Director of Mental Health Services, Pathways, Inc.**

The following is the input of program directors from the Pathways, Inc. Mental Health Department. Pathways, Inc. operates an OMH-licensed Home and Community-Based Services, a family-based treatment program, two community residences for children and adolescents and a day treatment program for children and youth.

- In a transformed system, consumers' mental health services needs and wishes will be better met by a system that supports a more speedy, seamless and flexible transition/ access among the various levels and models of care and services.
- In a transformed system, all models of care and services serving children and youth will incorporate a family support/parent partner component for which fiscal support is provided.
- In a transformed system, the mental health care providers serving children and youth will be better prepared to provide care, services and treatment to the dually diagnosed (MH/DD) population within existing programs that are designed to serve children with only serious emotional disturbances.

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We need to include Forensic Patients and their families in all of the strategic planning & transformation process.

Forensic patients should not be kept so.... long in Forensic settings& should get a chance to move on. They get frustrated & lose hope. They need positive hope & programs to prepare them for release. The Forensic hospitals have a stigma attached of a black hole . . . once you get in you never get out. Release planning should start from day one! Treatment teams should be more Family Friendly as it is our loved ones in there. Patients that want their Families involved in their treatment should be entitled to that without a problem. The prison mentality has to be removed from our Forensic Hospitals as of right now they are based on prison not a hospital.

Treatment teams need to be doing treatment. Stop killing the souls of Forensic Patients and give them the opportunity to be able to live a productive life(real life).Talk about cutting the budget, it costs less for these patients to be in a locked unit @ the civil hospital. And for everyone 1 release to civil 1 more is sent from jail to a Forensic setting.

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The Strategic Framework, I believe, is very thoughtful and well written. It is also very "adult-centric" in its use of language and orientation. OMH embarked on a new public policy path a few years ago for children and their families, namely a public health framework. In order to fully elucidate this policy and to guide the public and the provider community to align with it, I would suggest a comparable Strategic Framework for Children and Families.

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I believe that there should be some type of safeguard for those with mental disorders who are capable to work. When one is able to work for a period and medical comes with the job, the Medicaid is lost. I have seen my daughter struggle with the in between moments. She wants to work but has been unable to hold on to a job for a long period of time. By the time her medical kicks in her Medicaid is lost and she cannot keep up the premiums of the COBRA coverage.

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The Forensic system, does not work. It keeps people way too long. It is not Family or Patient friendly. It has no transparency. It kills the souls of the patients & families. It is not cost effective. It is very punitive & has a prison mentality. It is very controlling, not recovery oriented. When released from Forensics they go to a civil, which makes no sense as they have already served their time in forensics. It is time for an overhaul.

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***Laila Yasmin, MD***

Smoking cigarettes excessively causes psychotropic medications to be washed out from a patient's system quickly leading to decompensation within 2 to 3 weeks after discharge from an Inpatient facility to the community. Smoking accounts for a lot of readmissions and 30-day returns for people with severe mental illness. OMH should take more actions to provide stronger smoking cessation efforts and more choice of medications to help quit smoking in the community for this population.

# Public Hearing Testimony Summary and Written Comments

Statewide Comprehensive Plan for Mental Health Services (5.07 Plan)  
(Hearing Held August 24, 2010)

The public hearing on the NYS OMH Statewide Comprehensive Plan for Mental Health Services was held from 1 to 3 PM on Tuesday, August 24, via videoconference between Albany, Syracuse and NYC. Commissioner Hogan opened the hearing with brief remarks, noting that this hearing would focus on an update to the current Plan. It provides us with the opportunity to make mid-course adjustments and respond to current needs.

While we face challenging economic times, we still may see a worsening before things improve. Typically state budgets lag behind the national budget. In New York we have avoided substantial cuts to mental health care over the last three years, but going forward more challenges are anticipated.

Despite the challenges, we are in a time of dramatic change, with clinic restructuring, which involves paying for what good clinics already do. Comprehensive health care reform is also under way and expanding coverage with guarantees of a mental health insurance benefit. While this is good news, this does not necessarily mean good access to care and we will need to monitor its implementation along with the rest of the nation.

This year's update will focus on change happening more from the inside out, representing change that we must make ourselves as individuals and groups. Such change is synonymous with recovery, resiliency and transformation. We each make our own adjustments and improvements.

The focus of last year's Plan was on people and this year it is on programs engaged in collaborations for change. We hope the profiles will be inspiring, offer confidence, and show that practical solutions are possible. While the Plan has attempted to identify great examples, it is important to recognize that others are out there.

We look forward to accepting revisions and contributions to the Plan. The update is a process. The document notes our status and aspirations. While we are in tumultuous times, there are many wonderful examples of resiliency.

*Testimony follows. It includes that offered during the Hearing and otherwise submitted to OMH. Please go to the end of this testimony for closing comments offered by Commissioner Hogan.*

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## NYC Testimony/Written Comments

- Isaac Brown, Director, Baltic Street AEH (Advocacy, Employment, Housing)
- Leah Gitter, Criminal Justice Support Group Facilitator, NAMI-NYC Metro
- Beth Wendy Gundfest, Rockland County
- Gary Klemuk, Director, South Beach Psychiatric Center Wellness and Recovery Services
- Jayette Lansbury, NAMI
- NYC Department of Mental Health
- Carla Rabinowitz, Community Organizer, Community Access
- Janet Susin, President, NAMI-NYS

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***Isaac Brown, Director***  
**Baltic Street, AEH**

Baltic Street, AEH, is a peer-run corporation that started in 1996. It is now the largest employer of mental health recipients in NYS, providing housing, employment, training, entitlements, education, and empowerment and self-help skills. Mr. Brown noted:

- Pleased to see recovery and resiliency themes throughout the Plan
- Desire to see movement from the biological model to a human rights perspective
- Peers needed in emergency departments and as first responders
- More holistic alternatives are needed to medication and to help reduce morbidity and mortality associated with mental health challenges
- Attention to stigma and discrimination needed
- How can we expand peer services?
- Challenges OMH to create pockets of self-help and recovery around the State

***Leah Gitter, NAMI NYC Metro Criminal Justice Support Group Facilitator  
212-431-7276; leahgitter@yahoo.com***

My name is Leah Gitter. I am a family member with a loved one who was recently released from prison after serving 12+ years for three D crimes. I am the facilitator of the NAM- NYC Metro Criminal Justice Support Group and I am a member of Rights for Imprisoned People with Psychiatric Disorders and Mental Health Alternatives to Solitary Confinement. We all are vigilant in trying to stop the damage and chaos that erupt when family members are ignored and treatment is inadequate in the prison system.

I am here today to bring your attention to the problems that family members have in ensuring that their loved ones in prison receive appropriate mental health treatment from OMH.

OMH proclaims that families are a critical part of the mental health care team. In fact the OMH website states that “mental health treatment outcomes can be dramatically improved when families are active partners in mental health treatment. The unique strengths and knowledge that family members can contribute to the treatment process can benefit everyone—the patient, the practitioner, and the family members themselves.”

Family involvement is no less as important when the person with mental illness is in prison nor is the family member less concerned or less knowledgeable about their loved one’s conditions. Yet, I regularly hear from family members about the difficulties they have in communicating with and receiving assistance from OMH staff in the prisons. Family members usually know more than anyone else how their love one can be helped and made more calm and how their symptoms can be controlled. Except for a few exceptions, most mental health teams purposefully ignore the family members concerns and input. As a result advocacy becomes a very difficult task because there is no one to turn to for help and the person with the mental illness does not get proper care. There are many stories told by family members of inappropriate responses and treatment from the mental health teams for those who are area showing symptomatic behaviors from their illness. I know this very well from my own experiences.

Family members need to be heard and listened to. We don’t need to be opposed by the treatment providers. We need to work together with the mental health teams in the prisons so there is consistent continuation of care for our loved ones. It is very painful to watch someone deteriorate and know it could have been avoided if someone paid attention to what was being said by the family members. Who gains when so much pain is inflicted?

To remedy the situation family members would like 1) to meet with Commissioner Hogan so he can hear firsthand what horrors happen to our loved ones when we are ignored; 2) we would like to be able to speak to the primary mental health counselor and psychiatrist who is in charge of treatment; 3) we would like to have a liaison person hired who will assist the family member

when there are urgent psychiatric concerns. Many ill people are suffering right now, and their families are going through the torment of not being heard. They can help OMH deliver care to their loved ones, reduce their symptoms, and improve their behavior. We hope this issue can be addressed immediately.

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***Beth Wendy Grundfest***  
**Rockland County**

I see two glaring omissions from this plan. . . .

One is that of the issue of religious differences within the realm of cultural competency. If you serve pork chops for dinner to a Muslim or a Jew that practices their faith in dietary restrictions and declare that they are not cooperating with their treatment for refusing said meal then you are setting back their recovery. Religion is just as important to cultural competency as race or ethnicity and indeed is also an area of minorities which are discriminated against widely. It may not be politically correct to speak of such discrimination these days, especially against Muslims but it happens every day.

The other is the dual diagnosis realm that is physical and mental illness. It is spoken of in terms of a side effect from a medication or smoking but more and more I am seeing people who have physical handicaps that are not in these categories. Like those with spinal conditions who have a relatively healthy body weight (30 or less pounds overweight). I am also encountering those who have physical or developmental disabilities that were not discovered until they entered the mental health system. Some of who have thusly had what was their second yet more debilitating condition undertreated or not treated at all.

I am currently helping to begin an organization whose aim is to cover the entire mental and physical health continuums beginning with the mental health component. This organization People Uniting Rockland Recreating it Simultaneously (PURRS) will encompass an organic farming component, a healing arts center component (origami to line dancing, spirituality to opera) and an artists' consortium.

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***Gary Klemuk, Director***  
**South Beach Psychiatric Center Wellness and Recovery Services**

- Access to and flexibility with approved funding is needed to form recovery-oriented partnerships in the community. Having accessible, flexible funding would enable the Wellness and Recovery Center to develop contracts with excellent providers such as Baltic Street AEH.

- The New York Makes Work Pay web site is a gold mine of information and very helpful to providers.
  - OMH should become a registered Employment Network in the Ticket to Work program.
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**Jayette Lansbury**  
**NAMI**

Families of forensic patients need to be listened to and need to be included in the treatment process. We also need OMH to provide support systems for forensic families. We need to be listened to! We need family support services. We need to be able to talk to the treatment teams. We need treatment teams and administration to be more family friendly. We need forensic centers to be more family friendly. We need forensic patients to be able to move on, to transform.

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***NYC Department of Mental Health***  
**Trish Marsik, Assistant Commissioner, Bureau of Mental Health**

We are pleased to see that the plan incorporates principles of recovery, employment, health/wellness, focus on serving people with co-occurring disorders, and integrated housing, all of which are priority areas for us as the City's Bureau of Mental Health. However, we would like to submit the following comments and clarification questions for your consideration:

***General Comments***

- The document does not mention plans to address racial/ethnic disparities in treatment and engagement which we think is an important issue to be included.
- There is no mention of the challenges in financing (especially federal funding via the block grant) resulting from the narrow interpretation by the federal government of "medical necessity" and "qualifying services" to be reimbursed under Medicaid.
- There appears to be little about the proposed State Medicaid Plan Amendment to cover additional or different services and the progress of that request to the Centers for Medicare and Medicaid Services (CMS).
- While housing is mentioned throughout the document as a priority area, it would be good to include specific recommendations that relate to the future of housing for people with mental illnesses.
- When discussing access to services, the plan refers almost exclusively to treatment and does not mention other service types. It would be good to clarify when the use of "treatment" means a number of service types and which ones.
- We would welcome even more data on access, capacity, utilization and need as well as baseline indicators and qualitative/ quantitative goals.

- Lastly, some of the mental health language used in the document and the heavy use of acronyms may present a challenge for the average reader.

### ***Chapter 1: Recovery and Resilience: The Foundation for Planning***

- It would be helpful to include in this section some discussion the need to prioritize services during a time of shrinking resources.
- Page 6 states that “In 2003, NYC police officers responded to a call dispatched as involving a person with mental illness every 6.5 minutes.”
  - We believe that this statistic has been misinterpreted and is presented incorrectly in the referenced source document. This applies to the police term for “Emotionally Disturbed Persons (EDP)” which can include any person involved in an emotionally charged situation such as domestic violence and not just those with mental illness. It is important to make the distinction that EDP is not the equivalent of a person with a mental illness.

### ***Chapter 2 Facilitating Recovery and Resilience***

- We strongly urge language that clearly states that housing, education, employment and relationships are at least as important as treatment. These four variables are both goals and tools for recovery.
- There is no mention of education or literacy as an important component of recovery. Many people with mental illnesses experience an interruption in their education and have low literacy levels which impact their capacity to work or live independently.
- More details regarding how programs should operationalize recovery in their practice would be useful.

### ***Chapter 3 Adult Services***

- The employment section could benefit from an articulation of the value of competitive wage employment vs. volunteering and internships. It also does not highlight the barriers that many public benefits present for individuals to work while maintaining needed supports such as Medicaid.
- In the PROS section, there is no mention of program goals including metrics, indicators and expected outcomes to monitor success.
- A reference to the recent Substance Abuse and Mental Health Services Administration (SAMHSA) study on Self Directed Care would inform the discussion about Person Centered Planning.
- We believe the document needs more discussion of retention in clinics.
- Although various pilot programs are mentioned in this chapter, there is no mention of plans to disseminate them across the state.

### ***Clarification Questions***

1. Chapter 1, page 2: Is “deficit mentality.” an accepted term or phrase and what does it mean?

2. Chapter 3, page 50: mentions of a decrease in inpatient beds with an implication that the reduction in beds led to more efficiency.
    - a. Are there more consumers in need of inpatient care than in previous years?
    - b. Are there regional differences?
    - c. There is reference to gains in access to inpatient care. Is there any data for NYC that would support this?
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**Carla Rabinowitz, Community Organizer**  
**(212) 780-1400 x7726; [crabinowitz@communityaccess.org](mailto:crabinowitz@communityaccess.org)**

I would like to thank the NYS OMH for providing this opportunity to comment on the 2010 Statewide Comprehensive Plan.

For 36 years, Community Access has provided high quality affordable housing and support services for people diagnosed with psychiatric disabilities. We operate more than 1,000 units of affordable, supportive housing in 18 housing projects in Manhattan, Bronx and Brooklyn. Community Access also operates a mental health recipient led employment training center, Howie the Harp Peer Advocacy Center, which has assisted hundreds of formerly homeless and incarcerated recipients move into human service careers.

This testimony will focus on urging OMH to:

- ✓ Promote blended funding to create integrated mental health housing
- ✓ Redirect Medicaid spending from institutional care to community-based services
- ✓ Expand peer employment training and create pathways for expanded peer employment
- ✓ Create a Managed Care/Single Payer mental health system

All of these proposals are either cost neutral or would produce substantial long-term savings for the State of New York.

***Point One: Blended Funding for Integrated Housing***

We applaud the 2009 Statewide Comprehensive Plan for Mental Health Services (“The Plan”) for recognizing the lack of affordable housing as a major cost to the state and obstacle to mental health recipients’ wellness: “...the lack of adequate and safe housing creates a serious barrier to a decent life, and particularly for persons with psychiatric disabilities.”<sup>1</sup> We thank OMH for listening to mental health recipients who sought to make housing a priority as noted in the 2010 Draft Statewide Comprehensive Plan for Mental Health Services (The Draft).<sup>2</sup> And we

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<sup>1</sup> The Plan at 26.

<sup>2</sup> The Draft at 31 OMH reversed the order of the Basic Needs in the OMH’ s Strategic Plan to begin with housing .

appreciate that OMH understands that the lack of housing for those with serious mental illness is currently a crisis.<sup>3</sup>

Not only do we need more housing, we believe housing should be integrated to the maximum extent possible. Toward that end we have developed several affordable housing projects that serve both formerly homeless tenants in recovery from mental illness and families with children. To further this goal, it's critical that all the state's available resources are available to housing developers. As an example, in June of 2009, OMH partnered with the State Division of Housing and Community Renewal (DHCR) and the Housing Finance Agency (HFA) on Community Access' most ambitious project to date: a 105 unit development on Cedar Avenue in the Bronx that will include 50 units for tenants referred from OMH transitional housing programs, and 55 units for low income Bronx families with children.

Integrated housing furthers the goals of the Americans with Disabilities Act in moving mental health recipients into the broader community and promotes tolerance, another issue identified in The Plan, wherein "...9 in 10 service users reported the negative impact of stigma on their lives."<sup>4</sup>

As a community organizer for 7 years, I have met over 600 mental health recipients. Housing is by far the number one priority. Too many of the volunteers I work with are homeless, have been homeless, live in untenable situations or adult homes that are not suited for their level of development.

Community Access' integrated housing program is working. I have met many tenants who Community Access is integrating into society, which OMH notes correlates to a better "well being," "life satisfaction" and sense of "empowerment."<sup>5</sup> At one site you can see tenants who are mental health recipients' interacting as any good neighbor would with other tenants' children.

One tenant has been going to Community Board meetings with me and now is a public member of Manhattan Community Board 3's Human Services, Health, Disability, & Seniors/Youth & Education Committee. Other tenants are making use of our vocational services and are registering for our peer led employment training center.

### ***Recommendation***

Community Access strongly encourages OMH to continue its work of collaborating with other agencies to develop housing that integrates mental health recipients with families and other community tenants. Community Access urges OMH to continue to move mental health recipients forward into the broader community while providing supports recipients need.

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<sup>3</sup> The Draft at 48 "housing for New Yorkers with serious mental illness is the epicenter of the nation's housing crisis."

<sup>4</sup> The Plan 14-15.

<sup>5</sup> The Draft at 27.

***Point Two: Greater Flexibility in Use of Medicaid***

The NYS's Medicaid spending exceeds \$60 billion, more than most states' entire budget, and the highest per capita rate in the country. Much of this spending is for institutional care that could be delivered cheaper, and at a higher quality, in community-based settings.<sup>6</sup>

NYS OMH has specifically recognized that mental health recipients are overusing inpatient hospitalization stays. We are pleased that OMH is trying to limit these inpatient stays.<sup>7</sup>

Hospitalizing those with mental health concerns is not a recovery oriented remedy to mental illness. We know NYS OMH recognizes the importance of moving mental health recipients out of institutional care and into the community. OMH remains grounded by its core mission to reform resources to a recovery-focused system of care.<sup>8</sup>

The lack of alternative intensive community based care, like respite care, is causing this overutilization of hospitalizations. NYS OMH acknowledges that “access to care has become even more challenging” due to “limited intensive community services.”<sup>9</sup>

Respite care can reduce these costly and dignity stripping hospitalizations. And we know that NYS OMH recognizes the benefits of “alternative models” of crisis care for those people who have “costly and ineffective repeat hospitalizations.”<sup>10</sup>

And there is a mechanism for funding this care. It is a waiver under Section 1915(i). Nearly five years ago, Congress amended Medicaid by adding Section 1915 (i), intending to increase community-based services instead of institutional Medicaid services by permitting greater flexibility than waivers permit. Unfortunately, NYS has not taken advantage of this plan.

In enacting the Affordable Care Act (ACA) in 2010, Congress made a number of additional changes which are extremely important to the disability community. However, unless NYS opts to take advantage of these changes, mental health recipients will not gain the benefits.

***Recommendation***

Community Access urges OMH to apply for the 1915(i) waiver so Medicaid could reimburse community services for less than 30 days, like respite care. Not only will respite care save the state money, but people will be spared the indignities and suffering of being repeatedly hospitalized.

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<sup>6</sup> The Draft at 39 noting budget reductions forced the state to transform care from “costly inpatient care to less costly residential care.”

<sup>7</sup> The Plan at 23 “addressing the overutilization of inpatient care” is a goal.

<sup>8</sup> The Plan at 23.

<sup>9</sup> The Plan at 27.

<sup>10</sup> The Plan at 25.

### **Point Three: Expand Peer Training and Employment Opportunities**

Employment of mental health recipients reduces health care costs.<sup>11</sup> Employment provides a person with: a reason to stay out of a hospital, a “sense of self-esteem,” and a better “quality of life.”<sup>12</sup>

OMH recognizes the importance of employment.<sup>13</sup> People with mental illness want and need to work.<sup>14</sup> OMH has also noted the value of peer employment training, praising Community Access’ Howie T Harp Peer Specialist Program three times in OMH’s 2009 Statewide Comprehensive Plan.<sup>15</sup> The 2010 OMH Draft Plan confirms peers “often play a pivotal role in helping others in their recovery journey.”<sup>16</sup> Beyond training, peers need jobs. Unemployment rates for people with psychiatric disabilities exceed 90%,<sup>17</sup> forcing people to live in abject poverty for their entire adult lives.<sup>18</sup>

#### **Recommendations**

1. Create a Peer Employment Task Force to a) identify best practice models in the country for effective training placing peers in competitive employment, and b) identify existing sources of funds to be used to expand peer training programs throughout the State.
2. Mandate that all OMH-funded programs affirmatively hire qualified peer candidates.
3. Advocate with Vocational and Educational Services for Individuals with Disabilities (VESID) and Department of Labor to reform outdated training models that promote menial labor and dead end, low paying jobs.

### **Point Four: Medicaid Managed Care for Mental Health Services**

The payment system for mental health services encourages duplicative and unnecessary services<sup>19</sup> and promotes institutional,<sup>20</sup> emergency care<sup>21</sup> over community-based care that is more cost-effective and less traumatizing for recipients.

Many states and localities throughout the country have adopted managed care systems to rationalize spending and focus on those services that promise long-term health and recovery. Many of these communities now feature peer-run crisis centers, wellness services, respite housing, and in-home crisis supports to prevent trips to emergency rooms. In short, single-payer and managed care systems promote services that are both less expensive and produce better long-term outcomes.

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<sup>11</sup> The Draft at 7 and the Plan at 5.

<sup>12</sup> The Draft at 22.

<sup>13</sup> The Draft at 22 to 23.

<sup>14</sup> The Draft at 23

<sup>15</sup> The Plan at 11, 6 and 29.

<sup>16</sup> The Draft at 51. Also see the Plan at 10.

<sup>17</sup> The Draft at 23 placing unemployment rates of people with disabilities at 80 to 90%.

<sup>18</sup> The Draft at 22, one of the most devastating effects of serious mental illness is poverty.

<sup>19</sup> OMH’s 2009-2010 Update and Executive Budget Testimony, “The payment system for Medicaid inpatient psychiatric care remains antiquated, flawed and arbitrary.”

<sup>20</sup> The Plan at 5 noting that NYS is “biased” toward inpatient and episodic care. The Plan at 24 reporting that patients in NYS Psychiatric Units stay longer and are readmitted to hospitals at a much higher rate than the national norms.

<sup>21</sup> The Plan at 5.

### ***Recommendation***

We encourage OMH to begin advocating for a top-to-bottom reform on the mental health services system by promoting legislation to create a non-partisan mental health systems commission with authority to mandate binding recommendations, similar to the commission on hospital closures. Entrenched special interest groups have thwarted reform efforts for decades, resulting in a mental health system of care that is both the most expensive in the world, and generally ineffective in promoting health, wellness, and personal growth.

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***Janet Susin, President***  
**NAMI-NYS**

Thank you for the opportunity to present today. Let me first say I am enormously impressed with the comprehensive vision for the future that you have set forth in this plan and your approach of highlighting promising and proven practices that have evolved from the bottom up, not the top down. We greatly appreciate your including two of NAMI's innovations in the plan: our *Breaking the Silence* school education project which educates young people about mental illness and The Friendship Network, a unique approach to overcoming the social isolation and withdrawal that so often accompanies mental illness.

In addition, we would like to see you highlight three NAMI programs that are widely used in NYS. Family-to-Family for families with mentally ill adult relatives and the newer, NAMI Basics for parents whose children became ill before the age of 13. They are free psycho-educational classes, taught by trained family members that provide up-to-date information about mental illness and treatments, teach coping strategies, foster empathy, and create a support network. Although you make reference to the importance of family-centered care and engaging families, it is only when speaking of parents of children and youth that you give examples of how this can be accomplished. Family members with loved ones of any age need to be seen as partners in recovery. I'd also like to call your attention to NAMI's rapidly growing *In Our Own Voice* program that trains consumers to tell their stories of recovery effectively to counter stereotypes and change hearts and minds. This year alone consumers have made a total of 116 presentations to 2,036 attendees.

We also greatly appreciate your recognition of the tremendous toll mental illness takes on the overall health and productivity of racial and ethnic minorities and the importance of cultural and linguistic competence. Establishing Centers of Excellence for Cultural Competence at Nathan Kline and NY Psychiatric Institute are innovations that will no doubt bear fruit in the future as they provide direction for adopting best practices in these areas.

Finally, I want to call your attention to a part of the system of care that is not addressed in your plan, our two forensic Hospitals, Kirby and Mid-Hudson, which are in serious need of OMH's

attention. Families refer to the patients there as "the lost people of NYS." We would like to see the Plan include a vision for improving conditions in this system of care.

### ***Additional Testimony Submitted***

#### Innovative NAMI Programs

- *In Our Own Voice: Living with Mental Illness*

This NAMI national signature program trains consumers to educate the public and mental health community about mental illness and recovery. As consumers share the lived experience of mental illness with audiences they learn what can be achieved with appropriate support and access to care. In the process attitudes are changed and preconceived notions and stereotypes fade away. Research by Dr. Patrick W. Corrigan, Professor of Psychiatry at Northwestern University, and Executive Director of the Center for Psychiatric Rehabilitation at Evanston Northwestern Healthcare, indicates that the "best practice" for reducing stigma is through this kind of direct and personal contact.

The number of *In Our Own Voice* presentations increased significantly from 2009 to 2010 as well as the size of the audience. In all of 2009 there were 1,443 attendees compared to 2,036 in just the first seven months of 2010. NAMI-Metro and NAMI-Westchester have done a particularly stellar job of using this training to change minds and hearts. In the first 7 months of 2010 NAMI-Metro consumers made 44 presentations and NAMI-Westchester 38. Both are on track for doubling those numbers by the end of the year.

- *The Parent Matching Program*

This NAMI-Metro program connects, by telephone, experienced parents of children with mental health issues with parents of children who have been recently diagnosed or who are facing new challenges. *Parent Matching* offers parents the opportunity to talk to a parent who has "been there" and who can offer emotional support, coping strategies, the benefit of experience in negotiating the mental health and special education systems, and connection to community resources.

- *Your Child's Mental Health*

Sponsored by NAMI-Metro is a series of monthly lunch-hour conference call presentations for parents and other interested individuals. Every month a local expert provides a live presentation on a mental health topic or resource related to children. Topics include attention-deficit disorder/attention-deficit hyperactivity disorder (ADD/ADHD), depression, bipolar disorder, schizophrenia, anxiety disorders, autism spectrum disorders, special education, summer camps, and other community resources. After the presentation, parents have the opportunity to ask questions. Calls are held both in English and Spanish.

- *NAMI Basics*  
NAMI-Metro reports a unique use for this six-session education program for parents of children who showed signs of mental illness before the age of 13. They have been using NAMI Basics to educate caregivers of children in foster care as well as parents whose children are under the Administration of Children's Services (ACS) and report that the program is particularly helpful for these groups.
- *Emotionally Disturbed Persons Response Team (EDPRT) Rochester*  
Led by Don Kamin, Chief of Clinical and Forensic Mental Health Services in Monroe County, this team educates officers and first responders about mental illness and available resources as well as training them in de-escalation techniques to reduce and prevent the incidence of harm to the individuals involved. NAMI-Rochester family members and consumers put a human face on the lived experience of mental illness as part of the training. *(Not a NAMI program, but in participation with NAMI.)*

## Multicultural Issues

### *Question #1:*

*Do the profiles of programs and agencies provided in the plan shed light on the services and support that are making a difference in the lives of New Yorkers diagnosed with mental illness and their families?*

Yes! "Life is Precious" is a bilingual/bicultural suicide prevention program for young adolescent Latinas in the South Bronx that has expanded into Brooklyn due to its success. This program is saving lives and is centered on suicide prevention that is sensitive and relevant to language, culture and family.

### *Question #2:*

*Are there gaps in reporting about the services and supports that lead to the best outcomes for young children to older adults engaged in treatment and support services and families?*

Yes! The "SPEAK" tool kit on suicide prevention that is available in different languages needs to be provided to the staff in prison and jails. Mental health services and support for families from mourning through bereavement should be available as a follow up to all suicides reported in the system.

### *Question #3:*

*Does the Plan reflect a direction toward strengthening the system of care at all levels so that it promotes recovery and resiliency for children, adults, and families?*

Language is the "People First" line of communication. Non-English speakers need mental health services that are linguistically sensitive and relevant, Bilingual/bicultural staff, translators and certified interpreters are needed at all levels to meet the needs of this expanding population. All three of the commissioner's advisory committees (1) Family Advisory Committee (2) Recipients Advisory Committee and (3) Multicultural Advisory Committee need to have sub-committees that address the needs of language access.

## Research

Research is a critical element in assuring that the citizens of NYS have access to the latest, evidence-based treatments for serious psychiatric disorders. The research being done at NYS's two prestigious research institutes—Psychiatric Institute in NYC and NPI in Rockland County—play critical roles in the discovery and implementation of effective treatments to offer the hope of a better quality of life for consumers and for their families.

## Housing

The Plan honestly acknowledges the tremendous gaps in housing availability while highlighting a few success stories. Everyone agrees that housing is basic to recovery, yet provisions are not being made to prevent a new wave of homelessness when aging families die or are no longer able to care for a loved one at home. We would like to see a family committee established to work with OMH in identifying potential solutions to this challenging problem.

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## Syracuse Testimony/Written Comments

- Johanna Ambrose, Director, NYS Region Compeer
- Todd Benham, PsyD, Chief, Fort Drum Behavioral Health Department
- Sarah Stimm, Board Chair, Healthy Alternatives through the Healing Arts (HA-HA)
- Debra Heintz and Debbi Stark, Rochester Psychiatric Center
- Debra Heintz and Debbi Stark, Rochester Psychiatric Center Schwarzkopf CMHC

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***Johanna Ambrose, Director***  
**NYS Region Compeer**  
**[jambrose@compeer.org](mailto:jambrose@compeer.org)**

Good afternoon. Thank you for your support of Compeer in NYS, and for this opportunity to input into the 2010 Plan.

The Plan looks at some programs offering hope, opportunities for change and growth.....and better lives for New Yorkers coping with and recovering from mental illness.

To this point, there is already a valuable resource in New York—Compeer—providing hope, support, and making the likelihood of healing and recovery through community connections real for nearly 3,000 adults and youth.

Compeer programs provide community volunteer supportive relationships to individuals in mental health recovery. Because Compeer services are community-based, they are also cost-effective, averaging \$1,275.00 per match annually.

The Compeer supportive model today continues to make good on its promise of “Making Friends. Changing Lives.” Compeer friends meet in the community. They meet for coffee and conversation, they walk together—they do the things friends do.

There are currently 21 Compeer locations in the state serving 23 counties. We believe there is a need for Compeer in every community.

The Compeer model is adaptable to different demographics. Earlier this month, the Compeer program in Utica serving Herkimer and Oneida Counties began piloting a Vet2Vet program, using the supportive friendship model to serve the returning military.

We know that human connection is the foundation of recovery and hope.

A volunteer from Chautauqua County Compeer recently defined why she loves being in a supportive friend relationship. “I have two wonderful Compeer friends who are an important part of my life. We have shared in each others’ lives, gotten to know each others’ families, and experienced lots of good times and a few hard times together. And I guess that’s the point: we did it together.”

The 5.07 Plan states: Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

People involved with Compeer know that a Compeer friendship is a healing, transformative, reciprocal journey that changes the lives of all who participate.

Compeer is committed to providing cost-effective, community-based services that are culturally and linguistically competent, and that empower people to live in the community with dignity and respect.

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***Todd Benham, PsyD***  
**Chief, Behavioral Health Department, Ft. Drum**

Dr. Benham thanked those in attendance at the hearing for the care and concern shown to military personnel and veterans and their families.

While we often hear of the negative effects of combat, Dr. Benham did note that deployment actually has positive impacts that result from the bonding and mutual support that take place during the process.

Dr. Benham noted the importance of education for individuals who come into contact with returning military personnel and veterans. It is crucial that instructors in community colleges, for example, and first responders in communities be educated about post-traumatic stress disorder (PTSD) and traumatic brain injury so they are able to provide support or make appropriate referrals for assessment and treatment, when indicated.

Often, people returning from war do not have diagnoses, but they may need help with accepting the changes in their lives that have resulted from their military experiences. They may also need help in understanding the relationship between behaviors and feelings (e.g., self-medicating with alcohol). Being able to intervene appropriately and assist military personnel and veterans with readjusting to civilian life are crucial.

More educational opportunities are also needed to prepare clinicians adequately to utilize evidence-based practices in treating PTSD and other disorders. Dr. Benham noted the importance of training opportunities such as the one held recently at the Institute for Disaster Mental Health in New Paltz. The conference provided training to nearly 1,000 clinicians via classroom and distance learning technology in one of the most effective evidence-based treatments for PTSD-cognitive processing therapy (CPT). The training took place over two days and provided instruction in use of this cognitive behavioral treatment which has been successfully applied to veterans, refugees, and survivors of other traumas. The training was led by the developer of CPT, Patricia A. Resick, PhD, and Director of the Women's Health Sciences Division of the National Center for PTSD at the Veterans Administration Boston Healthcare System.

Dr. Benham indicated that the Veterans Administration and the Department of Defense also have strategies for the dissemination of effective treatments for PTSD.

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**Sarah M. Stimm, EdM, Board Chair**  
**Healthy Alternatives through Healing Arts (HA–HA), Inc.**  
**Director, Senior Services, Compeer of Greater Buffalo**  
**(716) 883-3331 or sarah@compeerbuffalo.org**

HA–HA has been helping people learn about holistic alternatives to help them to maintain good physical and mental health since 2001.

HA–HA’s team consists of a volunteer board of directors. 51% are former or present recipients of mental health services. HA-HA provides services designed to further the holistic healing goals through informational services related to the body, mind and spirit.

The annual conference and workshops provide hands on information of the various alternative therapies available by trained professionals. Conference attendance includes mental health practitioners, mental health recipients, family members, and professionals, youth and children.

HA–HA believes that we can no longer depend solely on the doctors to cure us—we need to help ourselves. We need to incorporate good healthy activities into our lives. Many of the alternatives that HA–HA offers at the annual conference and mini conferences throughout the year and been shown to help people with their mental and physical health.

HA–HA does not want people to stop receiving regular medical and mental health help. We want them to learn about the holistic alternatives and work with their doctors and or therapists in incorporating these into a healthy lifestyle.

Although some people with mental health problems recover using alternative methods alone, most people combine them with other, more traditional treatments such as therapy and, perhaps, medication.

Ha–Ha is aware that many of these holistic alternatives can be expensive. That is why HA–HA is here. We try to bring knowledge of these alternatives to people who can’t afford them.

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

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

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

- Feng Shui  
Gain an understanding of why clutter is in your life and why it collects where it does in your home. Learn to feel good about your surroundings.
- Yoga  
Yoga is a holistic science and a guide to living. People learn the importance of breath and gentle stretching to release tension
- Drumming  
Group drumming is all about: empowerment, enjoyment, opportunity, exercise, rhythm, mastery, enlivening, nurturing and transcendence
- Change Your Words, Change Your Life  
Words have the power to change your life. Learn how to listen to what you say to and about yourself. Stop giving yourself negative messages!
- EFT—Emotional Freedom Technique  
Learn how tapping on meridian points—mostly on the face—can heal you physically and emotionally.
- Qi Gong  
This is a powerful system of healing and energy medicine from China. It is the art and science of using breathing techniques, gentle movement, and meditation to cleanse, strengthen, and circulate the life energy.
- Tai Chi  
The ancient art of tai chi uses gentle flowing movements to reduce the stress of today’s busy lifestyles and improve health.
- Food Allergies, How to Eat Healthy on a Budget, Color Choices and Your Mood, Create Your Personal Superhero, and Rid Yourself of Limiting Labels are a few others.

### **Testimonials**

- Carol  
“I was a little nervous to start yoga. I had never done yoga before, but the instructors were so welcoming, I quickly felt comfortable in the class. The teachers are very knowledgeable in what is happening with your body and mind. They explain what the different postures are doing and how to do them correctly and safely.”
- Monique  
“Since starting to learn about Yoga, my life has really opened up into so many wonderful experiences. My relationships have become much better. Yoga has supported me through many challenges and has taught me to find peace, balance and strength from within.”
- Tom  
“I do yoga to be able to be a better me.”

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

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***Debra Heintz, Clinic Manager, and Debbi Stark, Acting Chief of Service***  
**Steve Schwarzkopf Community Mental Health Center, Rochester Psychiatric Center**

Thank you for the opportunity to speak today. The OMH in Monroe County encouraged us to speak because our new clinic has been very successful at meeting the needs of the community.

At Rochester Psychiatric Center (RPC), we opened what we believe to be a new innovative community mental health clinic that we operate based on the concepts of the Pre-Paid Mental Health Plan (PMHP), which provides much more than a funding source. It is a model that presents opportunities for community integrative services in which we walk beside our clients on their journeys of recovery.

We strive to provide evidence-based practices both within the confines of a building and the community at large. More than 75% of our contacts occur within the community. We have a very dedicated staff that is committed to this ideal.

Currently we serve those individuals in our community who have been identified as difficult to engage and have very complex needs and challenges to address. Their complex challenges go beyond mental illness and/or substance abuse and include personal and system barriers they have experienced with effective linkages. We strive to provide these community integrative services despite the fact that some of our clients do not qualify for PMHP funding parameters.

We work very closely with many community sources including the NYS OMH Field office and Monroe County OMH, Adult and Child Protective Services, Providers for the Older Adult population, community mental health providers, community residential providers, medical practitioners, families, and many non-traditional resources in the community.

We have a strong belief in resilience in recovery. Although we work with adults now, we would love to be able to provide the same opportunities to the children and youth in our area as well. We also have a vision that takes advantage of having an onsite physician available and begin

more aggressive approaches to address our folks' medical challenges as we work to help them become established in the community and build their circle of resources.

We have been limited in our vision and journey by the availability of resources. We have been able to come this far, nonetheless, because the progression toward peer-sponsored recovery centers and while discontinuing of psychosocial clubs has allowed us to re-deploy resources to this next generation of mental health services.

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## **Albany Testimony/Written Comments**

- Maclain Berhauff, Supportive Housing Network of New York
- Katherine Coons, Rensselaer County Department of Mental Health
- Eva Dech, Mental Health Empowerment Project
- Families Together in NYS
- Lauren Tenney, the Opal Project
- Kimberly Williams, Director, Geriatric Mental Health Alliance of New York

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***Maclain Berhauff, State Advocacy Director  
Supportive Housing Network of New York***

I am the State Advocacy Director for the Supportive Housing Network of New York. Thank you for the opportunity to offer comments today on the NYS OMH 2010-2014 Statewide Comprehensive Plan for Mental Health Services. The Supportive Housing Network represents over 200 non-profit agencies engaged in building and maintaining many of the 39,000 units of supportive housing throughout NYS. Supportive housing is permanent affordable housing linked to on-site services that help low-income and formerly homeless individuals and families with a range of disabilities to stay housed and live more independent, healthy and fulfilling lives. It is the single most effective, cost-efficient and humane way to reduce homelessness.

***Continue Capital Development of Integrated Supportive Housing***

The Network supports the collaboration between OMH, the State Division of Housing and Community Renewal, the Office of Temporary and Disability Assistance, and the Housing Finance Agency in developing mixed-use/integrated supportive housing. OMH has been a leader in the development of integrated supportive housing and should consider expanding the capital development of integrated supportive housing.

***Protect the Commitment to New York/New York III (NY/NY III)***

Under the NY/NY III Agreement, production of 9,000 units of supportive housing over 10 years is under way but behind its development timeline targets. NYS should maintain its commitment to the development of all the NY/NY III units and ensure that these capital development funds continue.

***Unfreeze Development Pipeline***

In 2007 OMH issued a request for proposals (RFP) for the development of approximately 1500 units of supportive housing. In 2008 the RFP was put on hold. We urge OMH to unfreeze this development pipeline and begin implementation of this multiyear effort.

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***Katherine Coons, LCSW***  
**Rensselaer County Department of Mental Health**

Ms. Coons spoke about challenges faced by the Rensselaer County Department of Mental Health. Among points she made were:

- While the County has a strong family and children’s clinic, it does have a need for affordable housing for families where the parents are identified as having mental illness.
- Homeless families are living in hotels because shelters are overrun. The increasing rate of homelessness in the County is proving very challenging in the current fiscal environment.
- Parents in homeless families often have dual diagnoses, from one to three, affecting mental health, developmental abilities, and substance use. These individuals are difficult to engage and sustain in care.
- There is a greater need for youth peer advocacy within the County. The newly hired youth advocate serving the Hudson River region has already begun to work with County outpatient services.
- Within the County Mental Health Department much work is under way to have more integrated treatment for mental health and substance abuse issues (e.g., drug-free clinic for adolescents). The goal is to have integrated care whether a person comes in through mental health or through the substance abuse doors. This is particularly important, given the many youth in the County with co-occurring disorders.
- While clinic restructuring aims for better integration of care, it appears that Office of Alcoholism and Substance Abuse Services (OASAS) is moving toward its own coding systems, making it hard to integrate care.
- Rural mental health issues are crucial ones to address (e.g., the lack of adequate transportation as a barrier to effective mental health care).
- OMH should consider a task force to examine unique rural mental health issues.

***Eva Dech***  
**Mental Health Empowerment Project**

Ms. Dech highlighted a number of areas for attention:

- There is a great need for a change in culture to one that is rooted in the philosophy, values and practices of trauma-informed care.
- There should be no restraint and seclusion.
- There should be more recognition of the needs of parents with psychiatric disabilities, and training that enables staff to work effectively with parents.
- The rights of parents with psychiatric disabilities must be protected.
- Promote peer and community support for parents with psychiatric disabilities.
- There needs to be more attention to the physical health and well-being of peers, with a greater emphasis on proactive approaches that help to reduce the higher-than-normal rate of mortality among individuals diagnosed with mental illness.
- Do not blame the victim for not being well.
- Reverse the discrimination seen in medical settings, where people with psychiatric challenges are treated differently than people identified as not having such challenges (e.g., tendency to attribute physical symptoms to psychosomatic illness without closely examining the full range of possible causes for symptoms).
- Transformation of the service system requires greater training and accountability for all OMH-funded services and programs.

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***Families Together in NYS***  
**Comments on the OMH's 5.07 Plan**

OMH continues to lead the way in transforming the children's mental health system into one that keeps children and their families at the center of the system of care. The focus on Child and Adolescent Service System Program (CASSP) principles and System of Care values that the Children's Division of OMH promotes are values that families have been advocating for over the last 20 years.

OMH in partnership with the Council on Children and Families (CCF) has led the way in developing a truly integrated, cross-system plan for moving forward with these values. The Children's Plan. This plan, endorsed by the nine commissioners from the Commissioner's Committee for Cross-System Services for Children and Youth, must be *THE* plan for OMH's children's services, and should be at the forefront of the chapter on children's services.

In addition, Families Together in NYS agrees with the 5.07 Plan's and Children's Plan's stated goal "that every action should strengthen our capacity to engage and support families in raising

children with emotional health and resilience” The *Strengthening Family Support* section rightfully points out that family support services are adaptable to family needs, cost effective, serve as a natural link to mental health services, increase parent engagement, and lessen parental stress and isolation.

Given this goal, the family support section should be moved to the front and integrated throughout the chapter. We fully agree that family support services should expand and would like more details in the section as to how this will happen. We are committed to working with OMH to implement this plan. Family support services must be incorporated into everything that OMH does.

We fear that the current financial situation and the move to make services Medicaid billable are causing a funding crisis for independent family support throughout the state. The work of the Ambulatory Restructuring Committee with its proposed improvements to waiver, case management and SPOA should be able to help support and expand family support programs throughout the state.

In addition to promoting family support, Families Together fully supports OMH’s efforts to enhance the youth voice to increase peer support.

The plans to increase community-based services in Brooklyn and throughout the City and develop a residential treatment facility for youth in the juvenile justice system are ambitious and worthwhile goals. We look forward to working with OMH and the Office of Children and Family Services to ensure the youth and family voice is included as these plans are finalized.

In the summary section, the plan states “OMH will focus on ... efficient treatment provision.” We believe that the focus is better defined as promoting a holistic approach to promoting social and emotional wellness through integrated and effective services and supports, based in individualized care, one family, one plan. As OMH has been a leader in transforming children’s mental health, we know the Children’s Plan continues to guide our work towards this new system. We believe that independent peer to peer family support engagement and empowerment are essential components of any system for children’s mental health.

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**Lauren J. Tenney, ABD, MPhil, MPA, MA,**  
**Psychiatric Survivor**  
**(516) 319-4295, [LaurenTenney@aol.com](mailto:LaurenTenney@aol.com), [www.TheOpalProject.org](http://www.TheOpalProject.org)**

Thank you for gathering public comment on the NYS OMH 5.07 Plan 2010-2014.

I write as a human being who was subjected to, mostly survived, and continues work to overcome psychiatric atrocities I experienced, witnessed, was threatened with, and in the present day, avoid.

I also write as someone who has spent decades enrolled in higher education trying to understand how what is designed – funded – implemented – regulated – and evaluated by NYS OMH can literally “get away with” what it does to some people – and what it withholds from all New Yorkers. Withholds, in terms of what could be done for support in these incredibly difficult times, with an annual budget in the range of six billion dollars. I cannot see it as anything but representing deep human rights violations perpetrating crimes against humanity.

The power structures, which the fields of organized Psychology and organized Psychiatry create, one person with power, one person with none, are nothing new. These institutional and structural practices are well theorized and somewhat documented in the public record of information. Whether it was Pussin and Pinel in the 18th century or Goffman, Foucault, Laing and Szasz in the 20th century – there have always been voices of dissent from some professionals within these fields who speak out. If they are not silenced, rejected, or ejected from their positions of power – they are thought of as great voices of change and revolutionary – they are thought of as people who cared – and they were people who were loved by those they came in contact with.

The Opal gives us great insight into the present-day situation. The Opal (1851–1860) is a ten volume journal written, edited, and printed by the inmates of the first state-operated institution, the Utica State Lunatic Asylum which is today's Mohawk Valley Psychiatric Center. In fact, in the 1850s – a decade referred to as the "impending crisis" (Potter, 1976) and "political crisis" (Holt 1978), terms such as “recovery” and “liberation” were used by those involved with the NYS Asylum System and the then Commission on Lunacy.

Read the Asylum's Manager Logs (1851–1860) housed at your Nathan Kline Institute or the Oneida County Historical Society and other materials at the NYS Archives and you will see many of the same arguments we have now concerning procedures such as forced drugging, restraint, seclusion, and forced treatment – we had then. You will see some of the then-policy makers of government controlled, state-sponsored services for those in need of help arguing to regulate and eliminate these practices – while others, who over time have largely been tied to, or influenced by psychiatric industries, justified what was questioned, and unfortunately prevailed.

Who will be the prevailing voices of the 21st century?

It is good that the Plan has shown a high priority for “treatment that is not forced” by moving that item to the top of the list under “Mental Health Treatment and Supports” (p. 31). However, it should be rephrased from a priority for treatment that is not forced, to just “no force.”

Additionally, I would like the Plan to go further by adding “No force” to the values propelling the State’s efforts on page 30.

What we need is a System of Support that bans – with enforcement and penalty – any services that are not true voluntary supports. Further, it should promote services that are fundamentally Alternative. It should exist as an entire system that at its core is culturally and linguistically competent, trauma-informed, non-violent, offering non-pharmaceutical solutions. If a person chooses psychiatric pharmaceuticals as a course of action for her, or himself, it should be within the Plan of OMH to ensure it is only done with true informed consent and informed choice. It should not be in the Plan to create programming that goes against the priority of treatment that is not forced, by creating programs of force.

Psychiatric Slavery and Psychiatric Torture persist in NYS and are violations of Article 4 and Article 5 of the Universal Declaration of Human Rights (1949) and violations of the Convention on the Rights of Persons with Disabilities. Survivors of the Asylum/Psychiatric Systems and professionals have discussed psychiatric Slavery and Torture for centuries (Chamberlin, 1985; Davis, 1855, 1860; Minkowitz, 2008; Szasz, 1971; 2004; Trull, 1891; Weitz, 2008).

In this case, psychiatric slavery persists in the forms of forced, court-ordered, and coerced psychiatric “programming” such as the NYS OMH “Assisted Outpatient Treatment” program which creates a job for a “mental health” professional and forces a human being to be within that “professional’s” reign. To further complicate the matter, there are deep and disturbing patterns of institutional and structural racism and classism in the implementation of this program (New York Lawyers for Public Interest, 2005; Schwartz, et al, 2009; Tenney, 2008) – and programs like it, such as Assertive Community Treatment, psychiatric detainment, and institutionalization (OMH Patient Characteristic Survey, 2010).

State-sponsored programs of force, court order, and coercion usually require compliance with psychopharmacological regimens without full informed consent and informed choice, which translates to Involuntary Outpatient or Inpatient Torture.

I do not use this term, torture, lightly. The United Nations Special Rapporteur on the Convention Against Torture (2008) has written that some of organized psychiatry’s practices including forced electroshock, forced drugging, restraint and seclusion may constitute torture or ill treatment. It is important to keep in mind torture is defined as how a person experiences something done to them.

The 5.07 Plan acknowledges the difficult economic period we are currently in – and particularly in times of economic down turn it is of vital importance to take stock of what is actually being invested in. The NYS OMH must stop paying for State-sponsored abuse, torture, and slavery. This will save New York taxpayers millions of dollars that can be better spent redistributed to community efforts including Alternatives, thereby creating natural supports in communities where people live, work, and play in this very modern world.

The use of "Peers" for purposes of "outreach and engagement" and the institutionalization of "peer support" through Recovery Centers are dangerous courses of action. First, making a peer relationship – which in its true sense is to be an equitable meeting of minds subject to similar oppressions and subsequent understandings – "Medicaidable" goes entirely against the grain of why true peer support works. Peer support is not something that can be attained through a prescribed, paid relationship. Second, the attempt to create large recovery centers in some ways replicates the faulty thinking motivating attempts of "tent therapy" (Caplan, 1967), an early milieu therapy, which initially was a response to a crisis where both people in the facility and working for the facility sense of power was to some degree, equalized by uncertainty. When professionals who found out about it and began replicating the moving of people from living inside other facilities to living in tents outside of those facilities (because those were the circumstances of the original crisis) it became a mass-produced institutionalized failure and I can see this happening with the Recovery Centers.

Assistance and support ought to be given to projects and organizations run by users and survivors of psychiatry – but I truly believe institutionalizing the efforts will destroy the precious and meaningful relationships that make them work.

Concerning technical points of the report, the language still reflects a severe and unfounded bias toward the medical model – and a medicalization of the human experience. This needs to change. I remain with deep concern for the adoption of terms such as "recovery and resilience" as long as they are couched within the model of medicalized organized psychiatry and equate to a person going to program and complying with 'treatment'. At least once, concerning the conversation on parity that remains deeply problematic as long as forced psychiatric practices are covered, the Plan refers to "biologically based mental illnesses" (p. 39). Where is the proof of this statement of "biological mental illness" and sentiments like it?

OMH must go beyond this medicalized explanation of the human condition – and begin to take seriously the implications of physical, psychological, social, economic, and other environments people are living in and under, including physical, sexual, psychological, and emotional abuse and other trauma, poverty, and oppression based on race, gender, religion, sexuality, and thought – political or otherwise.

Decades of research show that the majority of people involved with psychiatric institutions have childhood or adult histories of sexual, physical, psychological, and emotional abuse. Yet, the

retraumatization of people by organized psychiatry is consistent and real (i.e. forced electroshock, forced drugging, restraint, seclusion, not treating people as experts of their own experiences). Why are trauma-informed efforts not deeply reflected in the plan? OMH continually acting as a proponent of the Medical Model of Organized Psychiatry is unacceptable. The motivations for doing so must be questioned and challenged. For real success of what OMH is trying to do, the medical model cannot remain privileged in the Plan and its tactics.

When OMH does get involved in actual medical circumstances, in attempt, for instance to address the Morbidity/Mortality Report (NASHMPD) it offers little more than a neo-liberal approach to a problem of grave concern representing the ultimate unfreedom (Sen, 1999). This condition of unfreedom is accomplished through the mass robbery of life – causing denial of a full lifespan by 25–30 years per person, while nearly tongue in cheek – the “program” offered LifeSPAN, concentrates only on individual choices while ignoring durable negative effects of poverty, -isms, and most significantly, the detrimental effects of both short- and long-term use of psychiatric drugs.

Alternatives must be made available for all people, of all ages, regardless of their position or social role. What is being done to children and young people – from drugging to electroshock to not providing trauma-informed interactions remains horrifying. As someone who was subjected to this system as a child and teenager more years ago than I like to admit (I am 38 now) I think, at least then, it was not common for young people to be involved in the system. Efforts like RAISE are deeply problematic. The guide OMH puts out for acceptable age limits for drugging children is criminal – Haldol for a three year old?

The use of electroshock on minors must be banned – now. The use of restraints and seclusion were already supposed to be eliminated. Worst of all, what is occurring, the destruction of a young life with messages of organized psychiatry instead of messages of healing, trust, and hope – is unconscionable.

In closing, it should not cost anything extra to protect and promote our human rights – it should not even be something we should have to ask for State-sponsored services to do. I cannot tell you enough – and with full passion: STOP! Stop forced treatment, stop the medicalization of the human experience. Create Alternatives to protect and promote Human Rights, now!

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**Kimberly Williams, LMSW, Director**  
**Michael B. Friedman, LMSW, Honorary Chair**  
**Geriatric Mental Health Alliance of New York**

We are writing on behalf of the Geriatric Mental Health Alliance of New York (GMHA-NY) in response to OMH's solicitation of input in developing the 2010 Statewide Plan for Mental Health Services. As we have shared previously, the new planning focus on recovery and resilience is a dramatic shift from previous OMH plans, and we have concerns about the impact it will have on older adults.

As we have shared in the past, the strategic planning framework is a much broader orientation to addressing the needs of those with psychiatric disabilities, implying the importance of *addressing all needs* of older adults with mental health challenges and not just their mental health needs. It captures many of the critical components to promoting a recovery orientation; however, we want to elaborate on some additional specific items critical to the recovery of older adults:

- Providers, in addition to needing cultural competence, should have appropriate generational competence in serving various groups across the lifespan including elders. Given that aging people with serious, psychiatric disabilities often have chronic health conditions and are vulnerable to being placed in institutions, it is important that housing integrate appropriate health services so that this population can age and thrive in the community.
- While opportunities for work, education, and/or community activity goals are relevant for older adults, it is important that they be given choice so they have the opportunity to be productive in new and different ways in later life.
- It is also vital that community supports outside the mental health system, such as aging service providers, long-term care providers and the like, have the appropriate skills, knowledge, and resources to work effectively with older individuals with psychiatric disabilities.
- OMH's attention to family caregivers, who are a vital source of support for many older adults with mental health needs, should include individuals caring for aging family members, grandparents raising grandchildren, as well as aging parents caring for adult children with psychiatric disabilities.

As for local programs that have been successful in helping people meet their life goals, the ten OMH funded geriatric mental health demonstration programs around NYS are important examples of programs that are successfully delivering integrated physical health and mental health care to older adults or operating community gatekeeper projects. Each of the programs has implemented a unique model of care that addresses the needs of elders with mental health problems in their local communities. Sharing information about the vital work these programs are conducting will be an important example of the work OMH is doing to improve the lives of elders with mental illness.

With regards to educating the public, OMH should support successful efforts to overcome stigma as it is important for gaining acceptance of people with mental illness in their communities. According to an article in *Schizophrenia Bulletin*, "Service Systems Research," written by Steinwachs, et al. Vol. 18, No. 4, 1992, some of the most effective interventions for educating the public about mental illness include efforts to overcome discrimination and to change the public's attitudes and behavior by bringing people with mental illness together with the general public.

OMH can also play a vital role in helping other systems of care support older adults with mental health conditions. For instance, the concept of recovery is often not recognized in other systems where older adults with mental illness are cared for. The long-term care system, where many people with co-occurring physical and mental health conditions are getting care, is conceptualized solely in terms of the needs of frail older adults and of people with physical disabilities. It seems to us that the concept of recovery should apply to all people with psychiatric disabilities regardless of where they are getting care. (For more information about the concept of recovery in long-term care, read our article from *Mental Health News*.)

In addition, many local communities are now engaged in efforts to prepare for the growth of the older adult population by making their communities better places to grow old. These efforts, known as "livable communities" and "age friendly cities" focus on needs and amenities such as appropriate housing, accessible high quality health and social services, accessible and affordable transportation and more. Unfortunately, these efforts often do not pay adequate attention to the mental health needs of older adults. For this reason, we have developed a mental health guide for livable communities that includes the key components of addressing geriatric mental health in these efforts. (The guide can be found on MHA of NYC's website: <http://www.mhaofnyc.org/media/1251/agefriendly.pdf>). It seems that OMH could play an important advisory role to these local planning efforts in ensuring that localities understand mental health and substance use problems among older adults and that adequate supports and services for elders with mental health problems are in place.

***At the public hearing, Ms. Williams offered the following additional comments on the Draft Plan.***

I am the Director of the Geriatric Mental Health Alliance of New York, an advocacy and education organization with over 3,000 members. We were formed in January 2004 by the Mental Health Association of NYC to promote improved geriatric mental health policy and practice. We appreciate the opportunity to comment today regarding the OMH statewide plan.

We are pleased with OMH's continued commitment to addressing the mental health needs of older adults in NYS, which is reflected in the inclusion of "older adults" in its new revised mission statement, in the continued work of the Interagency Geriatric Mental Health and Chemical Dependency Planning Council, in the continued funding and oversight of the nine geriatric

demonstration programs, and in the recognition of the importance of mental health in the efforts to make communities better places to grow old.

However, with the Interagency Leadership of the Geriatric Mental Health and Chemical Dependency Planning Council, OMH and the other state agencies are missing an important opportunity to develop a long-term plan regarding the geriatric mental health needs of the residents of this state and recommendations to address those needs.

A comprehensive children’s plan was completed within just one year, which demonstrates what OMH can do when it decides to do it. We hope that OMH will show that level of commitment to older adults. We understand the hesitation around planning given the challenge of the current fiscal climate, but, once complete, the plan does not need to be implemented immediately. Rather, the state can get it ready, so that it is poised for implementation once the economy turns around. Without appropriate planning, service expansion, and workforce development, the older adult population growth over the next quarter century will result in a vast increase in the number of untreated older adults with mental illness.

The lack of a plan is demonstrated by having no chapter devoted to older adults. It is very important that OMH’s planning efforts address the differences in the needs and developmental challenges of older adults from those experienced by younger adults and that the concept of recovery for older adults, which is just as important for them as younger populations, be modified to reflect those differences. We hope OMH will take these recommendations into consideration as it develops the final 2010–2014 plan. We look forward to continuing to work together to address the mental health challenges of elders in NYS.

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## **Closing Remarks to Hearing by Commissioner Hogan**

Dr. Hogan provided comments in relation to themes he heard during the meeting and he responded to a few questions by attendees of the hearing.

- The most substantive opportunities we have are in two areas:
  - Increase employment for persons with mental illness, and encourage much more affirmative hiring of peers throughout the system of care. Many peer-run organizations have done a good job of this and in addressing some of the perceived barriers (e.g., confidentiality, health insurance). The opportunity is to do more to improve care in OMH facilities and offer opportunities to persons with “lived experience.”

Beginning October 1, while clinic restructuring will be introduced, the outreach and engagement services—“mobile services”—may not be available. Right now, we are in conversation with the Centers for Medicare and Medicaid re: federal approval to

- bill for such services. Once we obtain approval, families and peers could have a role in providing these services and having access to peer support services. The goal is, whether within or in an adjacent setting through an affiliation, to have peer support be a billable clinic service.
- Increase housing opportunities for people with serious mental health conditions. In June, OMH, through its Center for Practice Innovations, hosted a multi-stakeholder roundtable focused on the status of housing and recommendations for moving ahead. This issue is one that OMH will take everyone working together, particularly because of a wider gap between affordability and price.  
We do have some resources in the pipeline and we are looking toward public-private integrated housing approaches. Typically, for this to happen, multiple sources of financing are required. We continue to work closely with the Division of Housing and Community Renewal and look forward to positive outcomes from this partnership.
  - Alternatives to care should be better supported. While hoped-for solutions are hard to attain, local solutions (e.g., Compeer) hold promise for helping to meet needs holistically.
  - In a time of dwindling resources, advocacy will be exceptionally important.
  - With Medicaid, we face a number of constraints. We are encouraged by the new leadership and possible solutions to some of the immense challenges.
  - While providing medical treatment, more holistic approaches that incorporate medical care are important to pursue. There are very few cases where medication alone will solve the problems and a re-balancing is needed with more attention to talk therapy and supports.
  - Peer support is crucial. OMH is selecting a statewide organization to provide technical assistance to organizations desiring to become “recovery centers” that will offer a full range of supports and help peer organizations to develop.
  - When asked about respite care, the Commissioner acknowledged the difficult financial challenges facing the State. He looks forward to hearing about local solutions to such need. Perhaps, for example, as Recovery Centers become operational, respite care could be an offering.
  - When asked about law enforcement training in crisis intervention, the Commissioner noted that where this has taken hold, there have usually been champions among law enforcement. OMH supports the sequential intercept model. Law enforcement leadership is important for improved crisis intervention responses.
  - The type of innovation taking place at the South Beach and Rochester Psychiatric Centers is the type we wish to see more of. We are encouraging and welcoming more efforts by Psychiatric Centers in filling local outpatient services gaps. The goal is to complement the array of community resources, not to compete with them.