

# Recovery and Resilience: The Foundation for Planning

Last year's *Statewide Plan for Mental Health Services* opened with consumer/survivor<sup>1</sup> Dr. Pat Deegan's compelling question: How do we create hope filled, humanized environments and relationships in which people can grow?<sup>2</sup>

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

Transformation of the mental health delivery system rests on two principles articulated in the 2003 New Freedom Commission on Mental Health final report. The first is that services and supports must be more clearly centered on the person and family<sup>3</sup> members engaged in care, rather than oriented toward the "requirements of bureaucracies." This is no small task in a time when insurance coverage—especially Medicaid—has become how most care is paid for. The second is that services and supports cannot just help with symptoms, but must also enhance abilities to cope successfully with life's challenges, facilitate recovery, and build resilience.<sup>4</sup>

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

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

hoods are also resilient, providing supports for their members.<sup>6</sup>

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

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

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

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

## Mental health is an intricate part of overall health

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

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

### Family roundtables empower, inspire confidence, and improve services

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

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

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

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

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

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

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

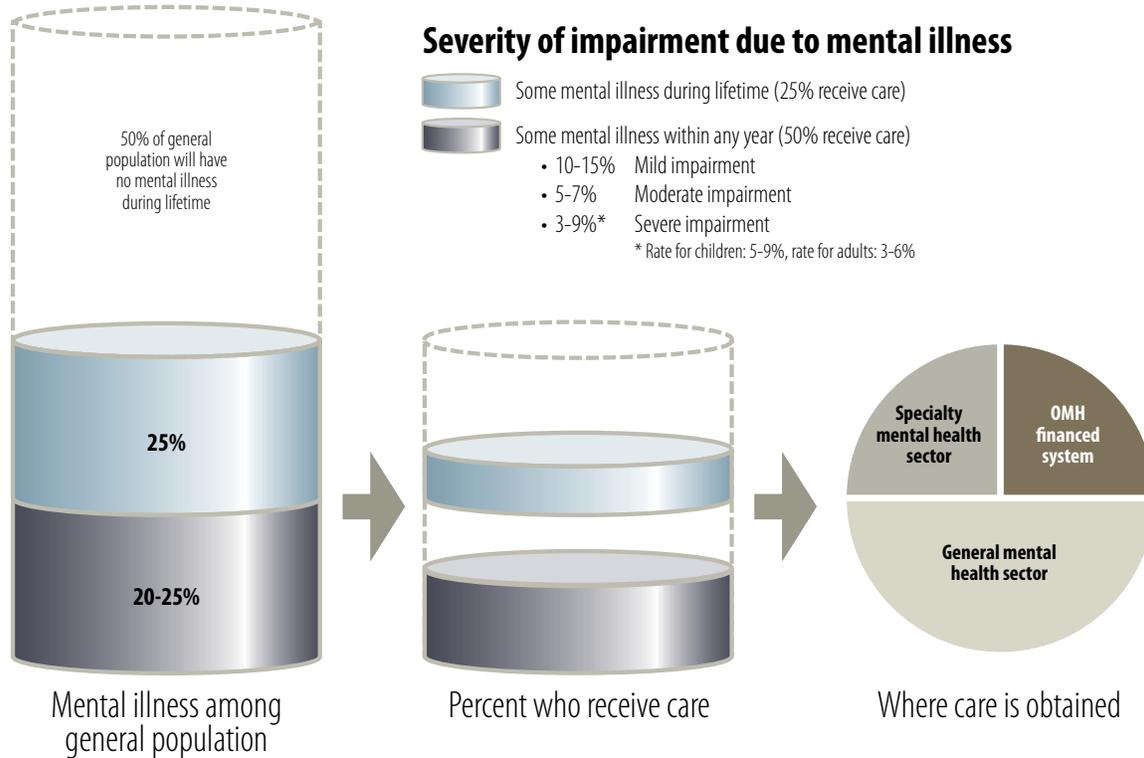
able to interact and, in a safe and welcoming environment, address myths, misconceptions, or misjudgments they may have about one another. This is a win/win for everyone. The families become more knowledgeable and in turn more empowered. This makes the families better partners, which is helpful to the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

To learn more about the Roundtables, contact

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



## Patterns of Mental Illness and Mental Health Care



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

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

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

### Mental health problems are widespread and troubling

Widespread and troubling, mental health problems affect about one in four Americans ages 18 and over and similar numbers of adolescents each year. Even though mental disorders are prevalent, the most intense burden of illness is concentrated in a much smaller proportion of adults—about one in 17—who have serious mental illness.<sup>9</sup> We are also learning that mental health problems begin earlier—and are often more serious for children—than was long understood. Recent results from a national survey tracking the rates of common mental disorders among children ages 8 to 15 found that 13% of respondents met criteria for having at least one of six mental disorders within the last year, with attention deficit hyperactivity disorder, depression, and conduct disorder ranking at the top.<sup>10</sup> And for the half of us who will experience a mental illness in our lifetime, 50% will experience the first symptoms by the age of 14.<sup>11</sup>

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

ness or serious emotional disturbance.<sup>12</sup> Of these individuals, nearly 20% were children below the age of 18.<sup>13</sup>

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

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

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

Suicide is the 11th leading cause of death in the U.S., with 34,598 reported suicide deaths in 2007, and 1,396 in NYS.<sup>17</sup> About every 15 minutes, a person dies in our nation from suicide<sup>18</sup>—a preventable and tragic form of death. While treatment for depression is effective 60 to 80% of the time, less than one-quarter of people with depression receive appropriate treatment.<sup>19</sup> Mental illness is also a major contributor to physical illness and premature death due to cardiovascular and pulmonary diseases associated with psychiatric medication side effects (e.g., diabetes, obesity), smoking, poor physical health care, and substance use disorders.

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

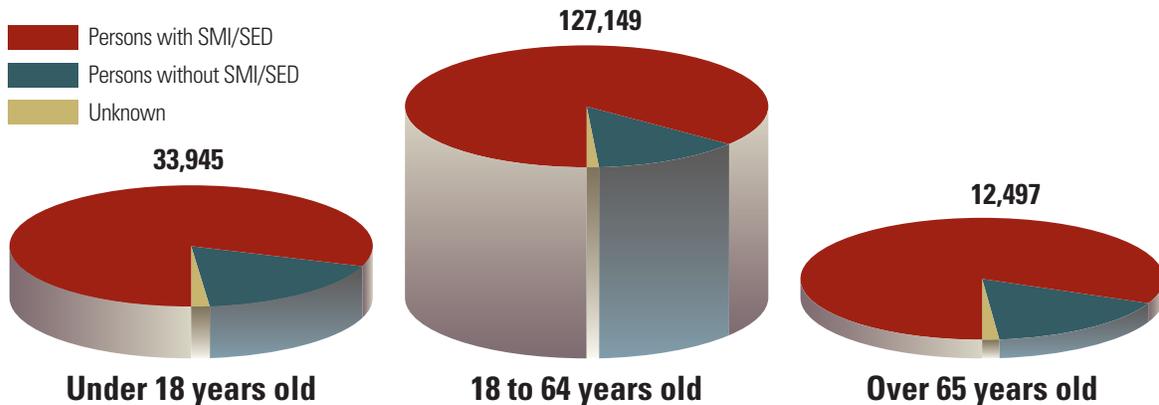
disorders in older persons are associated with significant disability and impairment, including a compromised quality of life and ability for community living, cognitive impairment, increased caregiver stress, increased mortality, and poor health outcomes.<sup>20</sup> Moreover, the unmet needs, poor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

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

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

World Health Organization

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



Source: NYS OMH Patient Characteristics Survey

## Diversity, inclusiveness and hope

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

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

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

Now in its second edition, *Enhancing Cultural Competence: Welcoming Lesbian, Gay, Bisexual, Transgender and Queer People in Mental Health*, has become a "living and breathing" document, reflecting the developers' intent for the LGBTQ toolkit to evolve and improve over time. The latest edition, for example, contains enhancements to the section addressing transgender issues. Each toolkit user is encouraged to participate in the ongoing development of the toolkit by suggesting edits, additions, etc. It is available free online at [http://www.mhainulster.com/Attachments/2ndEd\\_LGBT\\_KIT\\_11-07final.pdf](http://www.mhainulster.com/Attachments/2ndEd_LGBT_KIT_11-07final.pdf).

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

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

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

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

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

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



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

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

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

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

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

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

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

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

## What does good mental health care look like?

### Good care is accessible

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

### Good care is personalized, continuous, and integrated

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

Another essential element to recovery is having care based on continuous, healing relationships such as professionals and peers. Recovery is enhanced by providers and peers<sup>27</sup> who sustain hope, incorporate wellness into care, work at the healing relationship continuously, and communicate respect and hope.

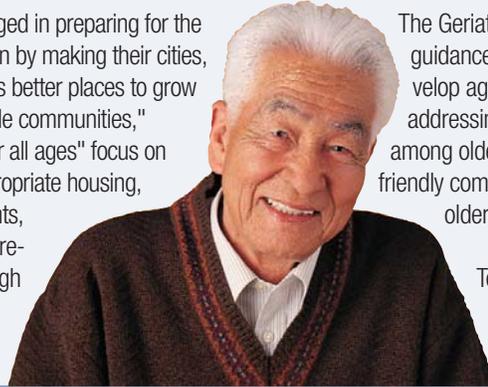
*Although there are many pathways to recovery, several factors stand out. They include a home, a job, friends and integration in the community. They also include hope, relearned optimism and self-sufficiency.*

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

## Caring for older adults with mental health challenges

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

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



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

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

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

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

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

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

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

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

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

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



Source: NYS OMH Patient Characteristics Survey

## Breaking the silence

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

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

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

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



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

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

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

To read more about the evaluation or for further information about Breaking the Silence, go to [www.btslessonplans.org](http://www.btslessonplans.org).

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

### Good care rests on the principles of cultural and linguistic competence

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

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

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

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



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

## Summary

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

### Chapter 1 endnotes

- 1 People who have first-hand experience with mental health services use a number of terms to describe themselves, for example, consumer, survivor, ex-patient, patient, client and recipient. In this Plan, these terms may be used interchangeably, with an emphasis on the use of people-first language.
- 2 Deegan P. (1996). Recovery and the conspiracy of hope. Presented at the Sixth Annual Mental Health Services Conference of Australia and New Zealand in Brisbane, Australia. Available at <http://www.bu.edu/resilience/examples/index.html>.
- 3 Drawing upon the NYS Council on Children and Families definition of family, in this Plan “family” and “parent” describe persons who are bound together over time by mutual consent, birth, and/or adoption or placement. This definition of family emphasizes not only what families look like, but also equally, what they do in assuming responsibility for

care, socialization, and support of one another. It is a definition that acknowledges and respects heterosexual and same-sex couples; lone-parent families; extended patterns of kinship, stepfamilies, and blended families; couples with children and those without. New York State early childhood plan: Ensuring a great start for every child, 2009.

- 4 New Freedom Commission on Mental Health. (2003). Achieving the promise: Transforming mental health care in America. Final report. Rockville, MD: Department of Health and Human Services Pub. No. SMA-03-3832. Available online at <http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf>.
- 5 Substance Abuse and Mental Health Services Administration. (2005). National consensus statement on mental health recovery. Available online at <http://download.ncadi.samhsa.gov/ken/pdf/SMA05-4129/trifold.pdf>.
- 6 New Freedom Commission on Mental Health. (2003). Achieving the promise: Transforming mental health care in America. Final report.
- 7 World Health Organization. (1948). Preamble to the constitution of the World Health Organization. Geneva: Switzerland, Author. Available online at <http://www.who.int/governance/eb/constitution/en/>.
- 8 U.S. Department of Health and Human Services. (2000.) Mental health: A report of the Surgeon General. Chapter 2, page 45. Available online at <http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c2.pdf>.
- 9 Kessler RC, Chiu WT, Demler O, et al. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 62, 617-627.
- 10 National Institute of Mental Health. (2009, December 14). National survey tracks rates of common mental disorders among American youth. Available online at <http://www.nimh.nih.gov/science-news/2009/national-survey-tracks-rates-of-common-mental-disorders-among-american-youth.shtml>.
- 11 Kessler RC, Berglund P, Demmler O et al. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62, 593-602.
- 12 Adults with serious mental illness are persons ages 18 or older who currently have, or at any time during the past year, have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-RE) and the diagnosable disorder must result in functional impairment that substantially interferes with or limits one or more major life activities. Children with serious emotional disturbance are persons ages 17 or younger who currently have, or at any time during the past year, have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to

- meet diagnostic criteria specified within the DSM-IV-TR and the diagnosable disorder must result in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.
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