

Facilitating Recovery and Resilience

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

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

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

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

A Recovery Framework for New York State

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

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

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

Cultural and Linguistic Competence

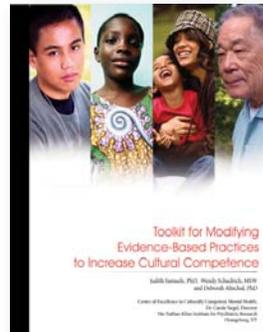
Cultural and organizational factors influence the use and delivery of mental health services.^{1,2,3} Culture affects how symptoms of mental illness are exhibited, the types of coping mechanisms used, social support received, and willingness to seek care. In addition, cultural and social factors, such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

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

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

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

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



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

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



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

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

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



Wellness

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

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



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

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

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

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



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

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

BAM! Body and Mind

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



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

Employment

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

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

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

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

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

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

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

Factors promoting a mentally healthy workplace

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

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

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

Supported employment is open to anyone with an interest.

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

Mental health and vocational services are integrated.

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

Benefit planning is comprehensive and ongoing.

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

Client preferences are important.

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

Competitive employment is the goal.

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

Job searches are rapid.

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

Follow-along supports are continuous.

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

Clients are supported when they make job changes.

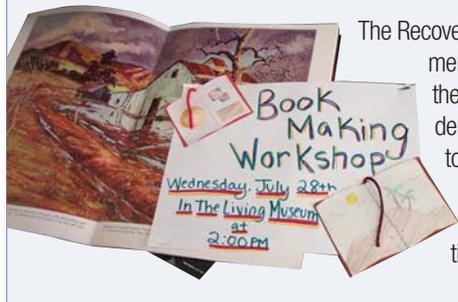
When clients lose jobs, they are supported in their choices by the employment specialists and mental health teams so they can learn as much as possible from the experience and obtain help with finding other jobs. Employment specialists also help clients with career planning and advancement.

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

Nurturing Recovery: The Recovery Center at Rockland Psychiatric Center

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

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



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

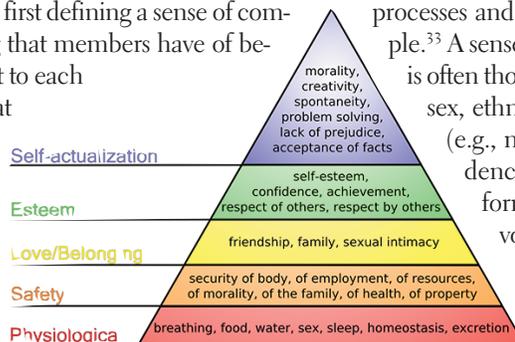
The Recovery Center focuses on employment and volunteerism, skills development, health and wellness management, access to community resources, and the creative arts through its Living Museum. The Recovery Center is peer run and structured around a series of recovery-oriented work units, co-led by staff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

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Community Connections

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

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



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

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

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

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

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



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

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

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

social networks are crucial for healthy functioning and longevity.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Strategic framework

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

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

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

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

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

Family support, friendships and community connections

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



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

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

weekly cultural discussion or socialization activity group. The Network enables its members to strengthen social skills, develop



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

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

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

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

What the Friendship Network Means to Me

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

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

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

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

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

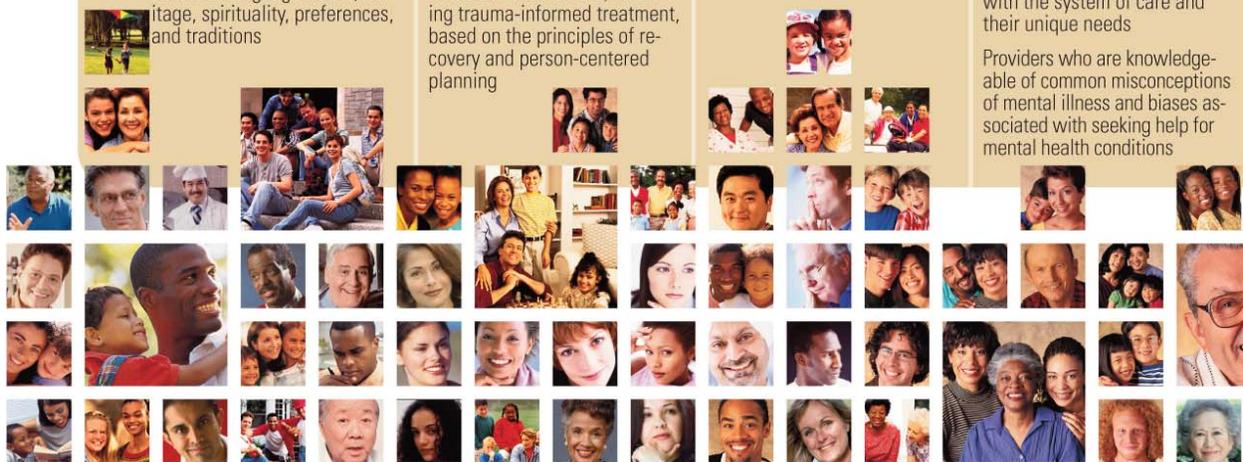
to promote stronger systems of care and advance integrated mental health services. Chapter 6 emphasizes directions for strengthening quality and accountability. As with last year's Plan, the final chapter provides more guidance in how we



STRATEGIC FRAMEWORK

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

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

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

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

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

Chapter 2 endnotes

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