

# Input from Advisory and Advocacy Groups

This Appendix includes input from advisory and advocacy groups. Of note, because OMH was involved in the procurement of BHOs (BHO) for Phase 1 of the implementation of the BHO initiative, the Office of Planning was unable to meet with a number of advocacy groups during the period of restricted communications. As an alternative, groups were invited to submit feedback in writing during this period.



## Mental Health Planning Advisory Council Recommendations

June 23, 2011

Office of Mental Health (OMH) Central Office Planning staff met with members of the OMH Mental Health Planning Advisory Council (MHPAC) to discuss the Council's planning priorities for inclusion in this year's Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from MHPAC members about impending changes to the system of care: behavioral health networks and behavioral health homes.

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

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

### PEOPLE FIRST

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

- Reflect more comprehensively in the agency strategic framework that children and families are central to the treatment and support provided within the public mental health system.
- Regard individuals who provide mental health treatment and supports for whom they are and the knowledge and experience they bring to their roles, rather than focusing on titles and the responsibilities (e.g., a "peer" is a person first and someone who brings vast knowledge and experience to his or her role in helping people recover).

- Serve children and youth in the context of their families, paying particular attention to services that build on child and family strengths, foster resilience, and promote family units where children grow up healthy and well.

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

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

- Provide a care environment that encourages people in care and their primary health care providers to develop trusting relationships that lead to open discussion of treatment options, and respect for choices that could produce less than optimal outcomes, giving people the opportunity to fail, with regard to safety, and using that experience to grow and be well.
- Recognize that in-home services by the Office of Children and Family Services (OCFS) are provided to about 4 in 10 persons 18 years and older who have serious mental health issues affecting their abilities to meet basic needs, do not engage in traditional mental services, and could benefit from flexible, nontraditional mental health services that would strengthen the capacity of OCFS to care for these individuals, most of whom reject or are unwilling to go to clinic and program sites.

### **RELATIONSHIPS**

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

- Call upon experience and authentic, skillful communication to engage people living with serious mental illness to find their strengths, tap into them, and be hopeful about recovery.
- Recognize families as the experts for their children/youth and engage them in care as fully as possible.

### **LIVING A HEALTHY LIFE**

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

- Understand that access to complementary and alternative therapies proven to be effective (e.g., meditation, yoga) is core to helping people identify and rely upon healthy strategies for maintaining mental health and well-being.
- Make sure that complementary and alternative therapies are accessible to enrollees and their health care practitioners in developing and putting in place plans for wellness and healthy living.
- Encourage people in health homes to identify supports for healthy community living, integrate them into a plan of care, and assess over time the helpfulness of the supports.
- Develop mental health screening for social- emotional wellness in pediatric practices and encourage pediatric health care providers to utilize such screenings as part of each

child's ongoing medical assessment and, particularly at the point the child is readying to enter school for the first time.

## **MENTAL HEALTH TREATMENT AND SUPPORT**

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

- Base mental health treatment and support upon the best medical evidence available and rely upon the most accepted therapies that are proven or informed by scientific evidence.
- While attention is focused on creating managed care options that will serve people receiving Medicaid, do not lose sight of the treatment and support needs of all New Yorkers diagnosed with mental illness regardless of who pays for services.
- Provide data on the use of electroconvulsive therapy.
- Recognize that the biggest stumbling block to effective treatment occurs at the point of care—the handoff—where an individual leaves inpatient setting and returns to the community, and use BHOs to bridge this gap.
- Ensure that BHOs have standards that specify when “warm touch” follow-up in the community occurs with a person who has been discharged, to assess how he or she is doing and aid in successful community living (e.g., help people navigate the system to obtain necessary supports and treatment).
- Make certain that BHOs set realistic standards, risk assessment and objective criteria for judging suitability for hospital discharge and monitor over time how well people do following discharge.
- Develop performance indicators that show outcomes following discharge and for monitoring engagement in treatment and supports (e.g., re-hospitalization rates).
- Be sure the values and principles upon which treatment and support are based are honored (e.g., advance directives indicate a focus on managing one's illness, treatment that is not coercive indicates respect for working closely with an individual to create a plan of care that keeps him or her safe and well).
- Specify the full range of resources (e.g., crisis services, diversion beds) upon which BHOs will rely to ensure that people return to the community with resources necessary for rehabilitation and recovery that foster successful community living.
- Develop a culture and safeguards under BHOs where the clinical experience and expertise of practitioners are respected and where the needs of the person in care are balanced carefully against the desire for avoiding costly, more intensive services so that the best outcomes are achieved effectively.
- Ensure that services are of the right intensity (e.g., in the same way as when visiting nurses follow up in the community for people who leave the hospital after open-heart surgery.)

- Ensure that services provided under BHOs for children, youth and their families are based upon the principles espoused in the Child and Adolescent Service System Program (CASSP) Guidelines.
- Make certain that children are not seen as “little adults,” and ensure that families are always involved in care.

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

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

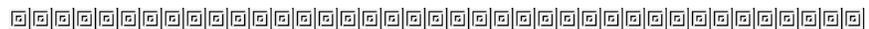
- Involve peers and case managers in assisting adults and children and youth and their families before they are discharged from inpatient settings and follow these individuals out into the community, helping to bridge the transition from hospital to community.
- Ensure that bridger services are offered in managed care benefits packages.
- Compensate peers with salaries/benefits commensurate with their responsibilities.
- In creating titles and job descriptions for “peers,” have a clear definition and understanding of “peer.”
- Recognize that for children services the notion of peer support is defined by the terms “family support,” “parent partners” or “parent or family advocates.”
- Support the development and recognition of family/peer credentialing.

#### **MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

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

- Provide more guidance to the field on the scope and authority of regional BHOs.
- Provide technical assistance to localities in identifying tensions and gaps in their systems of care and to find solutions to address them.
- Create effective mechanisms to help BHOs, State psychiatric centers and the communities to which people will return after hospitalization to reduce pressures (e.g., individuals whose independent living skills are not well developed) that make it difficult for people to live successfully in their communities upon hospital discharge.
- Invest in BHOs the authority to hold providers and localities accountable for quality discharge planning and community reintegration following hospitalization.
- Rely upon the experiences from other states in implementing Medicaid managed care for people with the most serious mental health challenges and use best practices in developing behavioral managed care arrangements and health homes.
- Have BHOs clearly articulate the process for and implement that process for grievances and complaints.

- Operate under the assumption that managed care is about managing care and outcomes first, not costs.
- Create incentives for positive outcomes into Medicaid behavioral managed care.
- Understanding that care to people with the most serious illnesses sometimes leads providers to avoid working with individuals with challenging conditions, ensure that providers receive incentives to serve these individuals and not turn them away.
- Be clear that care to children with serious emotional disturbance is challenged by the need to engage other service systems in a child's overall plan of care (e.g., individualized education plan).
- Recognize the tensions inherent in hospitals being pressured to discharge individuals and providers who are charged with post-hospital care and have processes in place to address issues that may arise from differing perspectives of the care needed.
- Ensure that in regard to health homes, the Department of Health (DOH) is respectful of regional variations in communities and not hamstringing localities, rather allow them to operate with flexibility in meeting the integrated health care needs of the people with serious mental illness and children with serious emotional needs and their families.



## **Recommendations Families Together in New York State**

June 22, 2011

Members from Families Together in New York State (FTNYS) met with members of the Office of Planning to provide feedback about impending changes to the system of care: behavioral health networks and behavioral health homes.

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

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

### **PEOPLE FIRST**

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

- Honor the distinctly different health care needs for children and their families by ensuring that the whole family is included in peer and family support services (i.e., adult peer

support does not necessarily have this requirement) and ensure that health homes develop contracts with community-based family support programs that are skilled in facilitating treatment planning.

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

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

- Ensure that families and youth are full participants in planning at the family, local, and state levels.
- Rather than investing in foster care, target dollars and resources toward the use of proven interventions that strengthen the family unit and parents' abilities to deal with challenging behaviors, be effective parents, and help their children to grow up emotionally and physically healthy and strong.

#### **RELATIONSHIPS**

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

- Because peer and family support foster healthy, trusting working relationships, strengthen community connections, and empower youth and families on their path to recovery, ensure that health homes develop contracts with independent peer and family support agencies.
- Knowing that continuous healing relationships are key to wellness and recovery, ensure that family support serves an important vehicle for continuity of care for the child and family.

#### **LIVING A HEALTHY LIFE**

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

- Ensure that health homes serving children provide access to a wide range of flexible services that provide parents with a foundation for fostering healthy growth and development (e.g., parenting education, family respite, evening and off-hours appointments for working parents, in-home visits, in-school behavioral services, school visits).

#### **MENTAL HEALTH TREATMENT AND SUPPORT**

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

- Provide children and their families with timely, affordable access to appropriate treatment services and supports.

- Develop within each health home a milieu that focuses on strengths rather than deficits, and make certain that services are consistent with strengths-based approaches to health care.
- Ensure that treatment services and supports are provided in a flexible, coordinated fashion across the systems of care.
- Make certain to maintain fidelity to the cross-systems Children's Plan.
- Recognize that peer support, including family support, is valuable in building trust, improvement engagement in treatment, and improving outcomes and make certain that peer and family supports (i.e., trained, credentialed, and supervised independent peer and family support specialists) are central to any coordinated health care plan.
- Preserve family support programs.
- Continue state funding in partnership with Columbia University and FTNYS for developing family support competencies expected of family support providers and the credentialing of these providers, which will enable them to bill Medicaid and private insurances for essential family support services.
- Ensure that planning for children's services under BHOs follows a path separate from adults, respecting the principle that children are not little adults, but rather they are individuals who require a much different approach than adults and require the participation of parents and families in treatment and support.
- Call upon the Commissioner and Department of Budget to reinvigorate at the county level the infrastructure once known as the Coordinated Children's Services Initiative (CCSI), while providing incentives for the delivery of integrated and coordinated treatment and supports across systems of care.
- Look to successful models of treatment and care coordination across the systems of care (e.g., Broome County) to identify elements that are essential to coordinated cross-systems care (e.g., invested leadership, key CCSI county and parent coordinators).
- Ensure the success of coordinated care cross-systems treatment and supports through joint funding by each child-serving system and having such funding managed by the Council on Children and Families.
- Reinvest funds in community services and supports for children and their families as inpatient and residential capacity is consolidated.
- Structure entry into children's services so that it occurs at one single point at the county level, in conjunction with CCSI, providing a foundation for well-integrated and coordinated treatment and support services across systems of care.

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

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

- Indicate preparations under way in anticipation of the threat to independent family support with Medicaid billing (i.e., already shrinking budgets and overextended family support staff working with needy families will be stressed to the point that these safety net services will no longer be available).
- While the transition to managed behavioral care is being made, continue to provide fiscal support for safety net family-run, peer-to-peer, and peer support services.
- While the transition to managed behavioral care is being made, continue to provide fiscal support for the work of Youth Power!, youth peer advocates, and youth leadership development for youth who not only provide peer-to-peer advocacy, but also provide agency Commissioners with direct access to the perspective of youth served across the systems of care.
- As the community system of care is strengthened with the transition to behavioral managed care, be sure that cross-systems respite care is included in the family support benefits package.
- Continue to work with the Peer Support Stakeholder group to provide the Medicaid Redesign Team (Proposal #541) with findings from the peer support survey to ensure the adoption of peer supports and services for families engaged in services.

## **MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

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

- Articulate how care financed by Medicaid for children and families will fit in with the Children's Plan and 5.07 planning and consider whether the health homes charged primarily with serving adults is the appropriate place for meeting the unique treatment and support need of children and families.
- Ensure that family interests are represented during deliberations of the Behavioral Health Reform Workgroup of the Medicaid Redesign Team.
- Work with DOH to understand the enormous value of child and family peer-to-peer services in delivering cost-effective services.
- Lay out plans for how children's services will fit in with other reform efforts (e.g., Spending and Government Efficiency [SAGE], which calls for co-location of mental hygiene Field Offices) and how input will be sought into this decision making.
- Require health homes to specify in request for proposals' responses and include in contracts with health homes how peer and family support will be incorporated into the array of service options.
- Ensure that peer and family services are a billable support service under health homes.

- Specify if the co-location of Field Offices is anticipated to affect the waivers in place under OCFS, Office for People with Developmental Disabilities (OPWDD), Office of Alcoholism and Substance Abuse Services (OASAS) and OMH.
- With the transition to BHOs and health homes, do not lose sight of the important needs of children and families and ensure continued funding for vital services (e.g., renew contract to fund regional youth partners set to end in December 2012).
- Ensure that joint child-serving agency funding for integrated, coordinated treatment and support via the Council on Children and Families goes to support parent and CCSI coordinators in each count, with disincentives for not participating in the collaboration.
- Create structures so that counties are incentivized to serve children in the community and discouraged from placing kids in out-of-home care (e.g., charge counties a larger share for each out of home placement).
- Make certain that entities charged with overseeing operations and the planning, assessment, delivery and evaluation of care by health homes include peer and family representation.



**National Alliance on Mental Illness – New York State  
Meeting Recommendations**  
June 2, 2011

Office of Mental Health (OMH) Central Office Planning staff met with Donald Capone, Executive Director, and Sherry Grenz, Board President, of NAMI –New York State (NAMI-NYS) to discuss the organization’s planning priorities for inclusion in this year’s Statewide Comprehensive Plan for Mental Health Services. The goal of the meeting was to obtain feedback from NAMI-NYS about impending changes to the system of care: behavioral health networks and behavioral health homes. In addition to providing feedback on NAMI–NYS priorities, Ms. Grenz and Mr. Capone provided input from their affiliates.

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

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

## **PERSON-CENTERED DECISION MAKING**

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

- Understand the role of families in caring for people with the most serious illness, many whose parents and caregivers are aging and ensure appropriate supports (e.g., respite care, transportation services) that enable successful community living.

## **BASIC NEEDS ARE MET**

**Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.**

- Promote access to decent, safe, affordable housing and access to appropriate treatment and support for New Yorkers with the most severe and disabling mental illnesses, thereby promoting the independence and dignity of these individuals.
- Provide decent, safe, affordable housing to individuals living with mental illness and having the greatest need, which will provide the stability required to enable people to receive in-home and community services and achieve better outcomes at a small fraction of the cost compared to emergency and institutional care costs.
- Do not appeal or delay the provision of appropriate housing and supports for adult home residents who desire and are able to move into community living.
- Institute funding to start in 2010, a New York/New York IV agreement that will enable 4,000 units of supportive housing per year over three years to become available for the growing number of homeless people living with mental illness who live on the streets of, or in shelters in, New York City.
- Understand that in the current economy, opportunities for employment for persons with the most serious mental illnesses who have not worked in years are very limited and seek to avoid providing assistance that may place individuals at high risk for failure (e.g., avoid creating false hopes and the attendant mental health issues created by them).

## **RELATIONSHIPS**

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

- Continue to correct the misperception that violence is more prevalent among people with mental illness by promoting public understanding of the reality that people who have mental illness are at much greater risk of being victims rather than perpetrators of violent acts.

## **LIVING A HEALTHY LIFE**

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

- Understand that education, early intervention and prevention are central to minimizing the effects of mental illness and, in all likelihood, to eradicating mental illnesses.

- Build upon proven and successful classroom educational initiatives that meet national health education standards, de-stigmatize mental illness and increase knowledge, awareness, and attitudes of mental illness and health.
- Incorporate mental health education in NYS school curricula.
- Understand that for individuals for whom taking a shower may represent a good day that the milieu offered by clubhouses provides individuals with the most severe illness the opportunity for socializing and receiving assistance with vital daily living skills.

## **MENTAL HEALTH TREATMENT AND SUPPORT**

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

- Continue to work toward the creation of a behavioral health managed “carve-out plan” that has at its core the integration and improved coordination of behavioral health (mental health and substance use) treatment services that are linked to appropriate health, housing and support services.
- Ensure that Medicaid managed care mental health dollars are directed toward the provision of treatment and supports by specialized health care providers that understand the complex needs of people with serious mental illness.
- Strive for a carve-out managed care model of treatment and support that ensure individuals and their families with access to quality, effective and focused care from specialized doctors.
- Do not make certain antipsychotic medications subject to a prior authorization requirement and do not lift the “prescriber prevail” protections currently in place.
- Provide unrestricted access to evidence-based psychiatric medications and do not eliminate fee-for-service reimbursement for pharmacy services.
- Ensure that case management focuses on helping people with the most serious illness to engage in and stay engaged in care and monitor how well engagement in treatment and services is occurring in health homes.
- Increase funding for mental health and medical treatment for veterans with serious mental illness and their families.
- Employ tools such as the Sesame Street videos and educational materials to aid families and young children in coping with the effects of deployments, re-deployments, homecomings, and grief secondary to the death of a loved one.
- Continue working toward full implementation of the special housing unit (SHU) bill so that people with mental illness who are incarcerated receive proper care for their mental illness, thereby not exacerbating psychiatric symptoms and breaking the cycle of going in and out of SHU because of psychotic breaks.
- Increase the number of mental health courts serving rural areas.

- Make certain that individuals with mental illness who are incarcerated and readying for release from jail/prison are linked to services before release (e.g., immediate access to medications upon release) and provided with strong transitional support services upon release.
- Ensure that the mental health treatment and support needs of children and families remain a top priority at the same time attention is focusing primarily on the care of adults in health homes.
- Make the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) available to community providers so they can better coordinate care.

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

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

- Involve family members in policy making at all levels of the system of care to the same degree that people who are engaged in treatment are involved.

#### **MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

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

- Continue to invest in the crucial biomedical, services, disparities and comparative effectiveness research to provide the basis prevention, recovery, and cure from serious mental illness.
- Require the NYS Veterans Affairs Commission to develop and update, in consultation with OMH, OASAS, DOH, and Department of Labor, a State interagency plan to improve outreach, assessment, and care for veterans and their families coping with mental health and/or substance abuse problems.
- Provide direction on how child and family mental health treatment and supports will be provided and coordinated in a Medicaid managed care environment and explain how this care will relate to health homes.
- Ensure that savings from the consolidation and closure of State hospital beds are reinvested into the provision of community treatment and support services that enable people to live independently and successfully in their communities.
- Ensure a full continuum of care in the community, funded by savings from the closure of hospital beds, particularly those services that help during crisis and avert emergency room and inpatient care.
- Work to increase the number of child psychiatrists by creating incentives (e.g., loan forgiveness) for child psychiatrists to practice in underserved areas.
- Make certain that the 1-800 line within OMH Central Office has Spanish-speaking capability (e.g., available access to Spanish speaking employee, create agreement with vendor such as LIFENET to take such calls).

- Provide social work students of the City College of New York with access to internships that not only benefit the students, but also the clients they serve.
- Understanding that health care costs must be controlled, be sure that critical services are not targeted for cost-cutting measures and that Medicaid provides the right services at the right time for the most vulnerable New Yorkers.



## **Recommendations from Coalition to Protect the Integrity of “Peer Support” Members**

June 16, 2011

A small group of members from the Coalition to Protect the Integrity of “Peer Support” met with members of the Office of Planning to provide feedback about impending changes to the system of care: behavioral health networks and behavioral health homes.

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

Ideas shared during the meeting have been turned into action statements and represent recommendations made by individuals participating in the meeting. Their points of view reflect individual perspectives and not necessarily the views of the Coalition as a whole. The following summary breaks down recommendations by the strategic framework content domains.

### **PEOPLE FIRST**

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

- Ensure that there is recognition on the part of providers that people are viewed as a commodity in the health market; provide safeguards to having people and their behavioral needs fall into becoming sources of revenue rather than be people who are provided with necessary health care when indicated.
- At every stage of health home development, make certain that the rights of people are taken into consideration, integrated into program design, and monitored through the use of performance indicators.
- Pay attention to what is being taught in academic institutions about mental health and recovery re: effective and proven alternatives and how they can complement traditional medicine.

- Respect people’s rights by doing away with restraint and seclusion and forced treatment and medication.
- Deal with the really tough issues surrounding the use restraint and seclusion and not allow this to be a practice of the public mental health system.
- Be sure to take into account gender identification for effectively meeting the needs of individuals.
- Urge anyone involved in the public mental health system to be guided by the work of the New Freedom Commission, which put emphasis on greater access to opportunities for people with disabilities, including civil rights as well as treatment concerns.

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

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

- Ensure that the values of a health home encourage a trauma-informed approach to care where the clinician does not start by determining what is wrong with a person and assigning a label, but first asks, “Can you tell me what is going on?”
- Ensure that families play a central role in the treatment of their children.
- Ensure that adults engaged in treatment have the right—to the degree they desire—to involve families in their treatment.

### **RELATIONSHIPS**

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

- Before instituting aggressive peer outreach, have providers start with families as the first step in the process of helping people diagnosed with mental health challenges to live successfully in their communities.
- Strive for true community integration, where services and supports are interconnected with entire communities (e.g., having people help to rehab a home in the community, live in that home, and maintain it as good citizens of the community).
- Be respectful of the different relationships and roles that families and people engaged in services play in advocating for what they desire to see in a mental health system, and provide opportunities at the state level for each constituency to advocate for their unique needs.
- Rely upon peer advocacy approaches based on Kretzmann & McKnight’s “Building Connections from the Inside Out” model,” which promotes individualized peer-to-peer outreach and support to individuals who may find it difficult to reach out and connect to community clubs and/or organizations that can promote their gifts, talents and skills and meaningful lives in the community.

## **LIVING A HEALTHY LIFE**

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

- Advocate strongly for changes in Medicaid that lead to reimbursement for holistic approaches to wellness.
- Ensure that people are aided in preparing advance directives and that the directives are respected by service providers.
- Be certain that people, particularly individuals who are hospitalized or in crisis, have access to independent peer services when requested, to help them in maintaining and preserving their rights (e.g., advance directives).

## **MENTAL HEALTH TREATMENT AND SUPPORT**

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

- Ensure that people who become engaged in behavioral health treatment and services in health homes not only have good access to treatment and services when indicated, but also good access to leaving treatment and services when they no longer are necessary.
- Examine how not to have medical homes become the primary source of behavioral support for individuals and rather become a vehicle for helping people to develop sources of community support that enrich their lives.
- Rather than having peer services be embedded in health homes where there will be a tendency to use peers to connect people to support services of the health home, structure peer services so they are provided through independent peer providers, with expertise in connecting people to appropriate supports and also helping people to connect to medically necessary treatment services.
- Ensure that health homes embrace a culturally competent, trauma-informed treatment and support philosophy.
- Make sure that structures are in place to fully integrate trauma-informed care within BHOs and health homes and not seen as an add-on service.
- When a person is about to be engaged in behavioral services offered by a health home, document whether the person has an advance directive and ensure that all team members have access to and use this information appropriately.
- Aspire to the philosophy of Dr. Dan Fisher not to create “medical homes,” but rather to build “green wellness villages, where whole health in the whole community is promoted throughout community members' whole lives under the motto "It takes a village to live a full life."
- Evaluate whether the Personalized Recovery Oriented Services program has truly created the shift in culture to a recovery-oriented approach and whether this program model is one that should be part of a health home.

- Determine how children will be served in a health home model (e.g., Medicaid waiver) so that sufficient, diverse treatment choices are available in the community.
- Advocate with the federal government for greater state flexibility in using client-directed services funding (i.e., Money follows the Person), which has the potential for individualized care that is community connected.
- Advocate with DOH for use of the Money follows the Person funding for people diagnosed with serious mental health conditions.
- Within health homes, track how often individuals are offered alternatives to traditional medical treatment as a way to raise awareness of effective alternatives and change provider behaviors.
- Ensure that we invest in keeping families together by supporting projects such as the Parents with Psychiatric Disabilities Project that is making a difference through provider education as well as crucial training to family court judges, social services workers.
- Hold dialogues across the state to reframe safety and risk by drawing upon the work of Mead and relying upon approaches that build on our strengths and not our deficits (e.g., seeking safety through mutually responsible relationships in which people feel safe disclosing discomfort and sharing risk).
- Look to the Nathan Kline Institute Center to Study Recovery in Social Contexts, particularly the work of Hopper, to inform approaches to safety and risk (e.g., the right to make choices and fail) and ultimately break down the connection between violence and psychiatric disabilities.
- For people identified as being at risk for negative consequences of not receiving mental health treatment (e.g., person with multiple admissions to an emergency room over a short period), strive to engage them meaningfully in services without the use of force or coercion.
- Ensure that the Health Insurance Portability and Accountability Act (HIPAA) guidelines do not become a barrier to services by ensuring that the person in care is involved in decision making related to confidentiality and privacy.
- Ensure that treatment is based on the rights and dignity of each person.
- Have BHOs and health homes work in collaboration with peer-run services providers to make sure that people have available a full continuum of treatment and support services and that independent peer services are valued for their role in promoting recovery and well-being.

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

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

- Ensure that peer support is the means of connecting people to their lives rather than the primary mode of connecting people to behavioral health services.

- Build in protections to individual rights to be certain that peer services are not a means to seeking compliance with treatment, but instead they enable people to exercise their rights in navigating the system of care and obtaining the best health care possible.
- While it is accepted that peer support can save health care dollars, be sure not to degrade the value of this critical service as simply a way to save money and make certain that peer advocates receive a living wage and health care benefits for the services they provide.
- Have BHOs and health homes build into their service options a peer-run respite home in each county.
- Recognize the crucial role of advocates who have incorporated living with a disability into their own lives of their contribution in inspiring hope, empowering people to work toward their own recovery, and building resiliency (e.g., respect begets respect).
- Examine the effectiveness of independent peer services (peer advocates) and peer services that are provided as part of a mental health program (peer specialists) and use these findings to procure and provide evidence-based peer support that truly connects people to lives in their communities.

#### **MENTAL HEALTH SYSTEM OF CARE, WORKFORCE AND ACCOUNTABILITY**

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

- Target funds for the design of recovery services at the State level to the regional BHOs, where the BHOs are charged with building capacity through formal request for proposals that lead to recovery services that meet the unique needs of their populations and geographic localities.
- Ensure that regional BHOs, and ultimately health homes, seek input from families and individuals served within these entities, so the voices of each group are heard and so they are represented in oversight (e.g., sit on boards) activities.
- Develop performance indicators to monitor the quality of peer services to and ensure that peers are true advocates for the people they serve and not experts in helping people to be compliant.
- Make certain that providers have incentives to promote the use of peers who understand free and informed consent and who understand how to support healthy decision making and support individuals in developing plans of wellness.
- Extend to state outpatient settings the same ability afforded state psychiatric hospitals to contract with independent advocacy agencies.
- Avoid merging the OMH and OASAS systems so that people who receive services for alcoholism are not stigmatized.
- Continue to conduct quality research into finding medications that have fewer side effects and examine the research base on the effectiveness of alternative medications and promote their appropriate use in managing symptoms.

- When peers are working as members of a team in a clinical setting, be very clear about their role and monitor how peers are functioning to be sure they are not being utilized inappropriately (e.g., serving in a case manager rather than in a supportive peer advocacy role).
- Investigate racial and ethnic disparities within the context of treatment options (e.g., Are white people underrepresented among people engaged in assertive outpatient treatment?).
- Monitor the effectiveness of engagement in care with a performance indicator that asks each person whether he or she feels coerced into treatment.
- Promote accountability of the mental health system by creating and employing a set of indicators based on the 10 principles outlined in the White Paper, [\*Infusing Recovery-Based Principle into Mental Health Services\*](#).
- Find mechanisms to hold providers accountable for care based on the OMH Strategic Framework.
- Foster a sense of public accountability from members of a network of care (e.g., hospitals, providers) by having them seek input formally from the individuals and families they serve and use that input to improve services and supports.
- Expect that BHOs will promote and fund at all levels independent advocacy aimed at quality services and supports.