

January 2011

## Message from the Commissioner



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### Tough Realities Ahead

*by Michael F. Hogan, OMH Commissioner*

There is no doubt that the forecast for New York's mental health system seems gloomy. Two major developments will disrupt our lives, affecting almost everyone who receives services or works in our vast system. Both of these developments (Medicaid Redesign and the most challenging budget in years) will force change, upset the status quo, and force us to think hard about priorities. There's nowhere to hide from these realities. My view is that we have to engage, adjust and adapt.

The Medicaid Redesign effort grows from the reality that New York spends far more on Medicaid than any other state, but does not get better results. This affects the OMH-directed mental health system because--like most states--New York has used Medicaid to pay for almost all mental health care, even that which used to be a pure state responsibility. So changes in Medicaid mean changes in mental health care. And the only crystal clear direction for Redesign is less spending.

When we look at New York's OMH-coordinated specialty mental health system, we see that we need a big safety net in large measure because of the systematic failure to address mental health problems in the general health system--the place where almost everyone goes first when they think they might need some help. The data show that although the average age of first mental health symptoms is 13, the average delay until getting care is 9 years. About half of all MD's report they are comfortable with diagnosing and treating depression--the most common and reliably diagnosed mental illness. And this weakness on mental health care exists across the general health system from primary care to health plans.

In the long run, we see a positive direction of change. Assuming health reform is not rolled back, almost everyone in America will eventually have health insurance, and essentially all insurance will include parity for mental health care. This is good. In the short term, however, we face the difficult challenge of advocating for improved mental health care in the overall health system--and especially for children--when we know there is little chance to expand anything. We do see an opportunity to improve coordination of mental health care, and we know many people use high amounts of emergency and inpatient care because they do not have a good overall plan of care.

Our position is that better care coordination is needed now, and that is better done by specialists in mental health care (so called Managed Behavioral Health Organizations--MBHO's) than by regular health plans--whose track record and experience with mental health is not very good.

I urge all mental health stakeholders to [submit ideas for improving Medicaid](#)  to the Medicaid Redesign web site.

In terms of the state budget, we face a difficult time. In recent years, OMH has increased access (admissions) to our inpatient programs while reducing capacity and costs--OMH staffing is down by 1,000 FTE's in the past 2 1/2 years. And we have held onto our community care capacity. Even this pace of downsizing will not be enough in the very difficult two years that are ahead. Forced reduction of OMH inpatient capacity is inevitable, and we may have to consolidate hospital programs. Whatever challenges we face, we will draw the line on protecting the quality of care as measured by accreditation. And we are resolved to emerge from all of these challenges as the best and most substantial state mental health program in the country.

## Share Your Ideas

## Medicaid Redesign Team Seeking Public Input



Governor Andrew Cuomo recently formed a Medicaid Redesign Team, established by [Executive Order](#) , to find ways to reduce costs and increase quality and efficiency in the Medicaid program. The Governor invited OMH Commissioner Mike Hogan to be a part of this team and as part of its work, [team members](#)  are seeking ideas and suggestions for improvement from all New Yorkers.

To enable and support public participation in the process of improving Medicaid in New York, the Governor also recently established a [Redesigning the Medicaid Program website](#)  that will be an integral part of the reform process. The site includes [electronic forms for people to suggest reforms](#)  to the system, and will also include listings of the team's public hearings and prepared reports.

All New Yorkers, including service providers, service recipients, their friends and their loved ones, are encouraged submit their ideas for reform and improvement of the Medicaid system.

## Medical Updates



### Wellness, Recovery and Medication

*by Cassis Henry, MD, Columbia Public Psychiatry Fellow, and Lloyd I. Sederer, MD, OMH Medical Director*

As consumers strive to be successful in their recovery, they consider, in collaboration with their doctor, their choice of medication-- medication not simply to reduce symptoms but as one crucial tool in recovery. The "recovery gap," the difference between where a consumer wants to be and where he or she actually finds herself, can be closed when the best medical treatments complement wellness, rehabilitation, and peer and family support.

OMH clinicians have already been focused on ways to improve the prescribing of medications as a means to enhance recovery. Current OMH quality goals include decreasing polypharmacy (the use of multiple medications), decreasing unnecessary use of medications with a high risk of causing weight gain, pre-diabetes (called insulin insensitivity) and diabetes, heart disease and hypertension, and high cholesterol and other lipids. We want to work more closely with consumers to promote medication as an element of health and wellness.

When you consider a medication, you and your doctor should select a medicine that is known to be highly effective in treating the issues that trouble you. For many people with serious mental illness, this will lead to the choice of an antipsychotic medication; this choice could range from medications that have been available for some time to newer medications. For those people who have not fared well on the commonly used antipsychotic medications and whose illness is characterized by ongoing, serious symptoms, there is one medication that has been proven more effective than any other—namely, clozapine. Clozapine has a long track record of helping people who have not responded to other medications, enabling people to improve their functioning and become more engaged in their recovery. Like every medication, clozapine has side effects that need to be understood and successfully managed. In recognition of these issues, OMH clinical leaders are now working on two projects aimed at improving prescribing practices at OMH, in order that consumers receive the most effective, most appropriate medication to support their recovery.

The first of the initiatives underway is an antipsychotic medication 'checklist,' a set of questions which can help clinicians keep their focus on the best practices known to guide the use of antipsychotic medications. This tool underscores the importance of maximizing the

effectiveness of the medication of choice, reducing side effects, reducing the use of multiple medications, close monitoring for new and existing health conditions, and shared decision-making. This tool, which at its outset we called SHAPEMEDs (but may be renamed as it is revised with stakeholder feedback), is currently in the pilot phase at 7 OMH psychiatric centers (both inpatient and outpatient sites in adult, child, and forensic settings). Our goal is to refine this checklist so that it is used throughout OMH-run clinical sites as a standard quality practice.

As we begin the second of our initiatives, our review of OMH current practices indicates that about 14% of OMH recipients of care (and 6% of NYS consumers covered by Medicaid) are taking clozapine, with very few people starting on this medication each year. While we don't know what is the 'right' frequency of use, we wonder if this medication may currently be underused in our consumer population, and an opportunity for improved functioning and recovery may be missed. OMH clinicians will be considering how to assess whether clozapine is the appropriate and safe medication of choice for those in whom it has not been tried, or not tried successfully to date. We will pursue this by developing a plan with peer and family leadership, grounded in the latest clinical knowledge, and with a focus on the use of this medication as an important element in overall wellness. Some areas we are discussing include: training and education for consumers, families, & clinical staff; peer leadership; peer support groups; integration of prescribing into consumer wellness and self-management activities; and, of course, monitoring of outcomes to see if OMH recipients are more successful in their recovery goals when a more potentially effective medication is part of the picture.

As we progress with these two quality efforts, and others related to them, OMH will report further on our efforts. We welcome your [feedback and comments](#).

## From the Field

### Engaging Reality

*by Douglas Drew, Recipient Affairs Specialist, OMH Long Island Field Office*



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New Years' always promise something for all of us to look forward to; it's why we celebrate with such enthusiasm. One new initiative that offers promise, is the New York State Clinical Record Initiative (NYSCRI). With trainings scheduled and implementation not far behind, the benefits of a standardized record-set will be realized in New York State in 2011. Trainings scheduled throughout New York State this winter. The focus here is on the mind-set and values we can employ to help individuals who use our services.

Like any tool we use, the NYSCRI record-set is not going to make us a better practitioner, clinician or professional. What makes us effective is the training and skills we use, our creativity and our ability to understand the person in front of us, that is, the man, woman or child who is looking for answers. We do not understand the person we are trying to help as simply a set of symptoms, deficits and problems, we do try to understand “Bob”, or “Mary”, or “Sasha” as someone who is experiencing real distress, fear, anger and/or disorientation, but more importantly as someone who strives to live a full life (not unlike any of us). There is an interpretation necessary, though, to document the work we do, between the complex life of the individual we are working with and the demands of our regulations and payers. We are a bridge between the two realities.

That is the key: we are the *bridge* between the world of diagnostics, symptoms, medical necessity, audits, Medicaid, etc. and the real experiences of the people we serve. The training we have helps us understand the world of medical necessity, but it is our creativity that can help us bridge the two realities. The person using or receiving our services is not looking for a cure for a diagnosis as much as they are looking to be able to live their life in a meaningful and productive way. The paperwork demands cool-clinical-precision, Bob, Mary and Sasha demand and deserve understanding and a thoughtful plan of action they can support.

The goal of the practitioner, with regard to the NYSCRI record-set, is two-fold: First is to find a way to fit (interpret) the complexities of the individual’s needs and goals into the record-set, and second (and more importantly) create a plan of action that the person in front of you can understand – a plan of action that speaks to” Bob” in language that he understands – his reality. This does not mean we’re hiding that cool-clinical world from people it does mean that the focus is on delivering a service that is going to be beneficial for “Bob”. Collaborative documentation is one way we can include people in on the documentation process and a way to keep people engaged in the service. This may be a hidden strength of the NYSCRI record-set.

The hidden strength offered by the NYSCRI record-set for the individuals we serve, and ourselves, is as a template for a plan of action. At the core of the 50 plus forms this may seem like an intimidating number that are available through NYSCRI, is an archetype that both the powerful and humble had used throughout history and today.; At the core of the record-set are 3 very basic components: 1) Personally meaningful, positive goals 2) The barriers that impede progress toward the goal, and 3) Personal and

community resources (e.g. personal skills/strengths, a viable treatment/action plan, school, family, friends, etc.). We can use this simple and universal template to engage people and give them confidence in our services. This template can also be used by Bob, Mary or Sasha to create their own plan of action to pursue personally meaningful goals.

When we engage reality on its own terms we, ultimately, enable the people we are serving to pursue the successes they seek in life.

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## **Supporting Recovery NYSCRI Webinars Now Available from OMH Website**

*from the Office of Quality Management*

Links to replay a series of three 1.5 hour webinars about the New York State Clinical Records Initiative (NYSCRI) are available on the OMH website. Originally shown in December, 2010, the webinars are designed for leadership to gather information about this voluntary demonstration project aimed at standardizing the clinical records used by New York State Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS) licensed providers.

Topics covered in the [Project Overview webinar](#) <sup>☞</sup> include:

1. NYSCRI overview;
2. The NYSCRI Data Elements and Forms Processes: How Did We Get From There to Here?
3. Why Would You **Not** Want to Use the NYSCRI Processes - Benefits at the Local Level; and
4. NYSCRI User Website and Training Manual Resources.

Topics covered in [The Compliance Challenge & the NY Standardized Documentation Initiative](#) <sup>☞</sup> include:

1. Compliance and Quality;
2. Medical Necessity – What is It and How Do I Demonstrate It?
3. Key Findings from NYS Chart Reviews;
4. NYSCRI Support for Compliance; and
5. NYSCRI Support for Person Centered and Person Driven Services.

The third webinar, [Maintaining the Golden Thread & Collaborative Documentation](#) <sup>☞</sup>, covers:

1. Review: Documentation Linkage - The Golden Thread;
2. What do we do when the clinical situation changes?

3. NYSCRI support for maintaining the Golden Thread
  - Progress Notes
  - Assessment Updates
  - Diagnostic Updates; and
4. NYSCRI support for Collaborative Documentation (the “real Golden Thread”).

The PowerPoint slides from the webinars are available in the Manuals/Support Materials section of the [OMH's NYSCRI webpage](#). You will also find the clinical records form set through the same link.

Please note that when accessing the webinars, you will be asked to enter your name and email address, and then immediately will be given access to the selected webinar.

## Promoting Cultural Competence

### **Suicidal Ideation and Behavior Among Latina Adolescents**

*from the NYSPI Center of Excellence for Cultural Competence*

**Problem:** A previous suicide attempt is the strongest risk factor for completed suicide. According to the National Youth Risk Behavior Survey, in 2009 one in seven adolescents in the U.S. had seriously considered attempting suicide within the past 12 months and one in nine had made a suicide plan. Female adolescents of Latino descent (“Latinas”) consistently report significantly higher rates of suicidal ideation and behavior compared to non-Latina Black and non-Latina White female adolescents in New York State (See Figure). In addition, among youth who contemplated or attempted suicide, Latino youth of both genders are significantly less likely than White youth to use mental health services in the year of their suicidal ideation or attempt.

**Findings:** A variety of factors impact the high rates of suicidal ideation and behavior among Latina adolescents, including:

- **Low levels of mutuality (i.e. feelings of empathy, reciprocity) between mothers and daughters** Both Latina youth who attempted suicide and their mothers report significantly lower levels of mutuality than Latina youth who did not attempt suicide and their mothers. Low levels of mother-daughter mutuality is associated with internalized (i.e. anxiety, depression) and externalized (i.e. aggression, rule-breaking) behaviors which are linked to suicidal behavior.
- **Low levels of support, affection, and communication** Latina youth who attempted suicide report significantly less

support, affection, and communication with their mothers than Latina youth who did not engage in suicidal behaviors. Mothers of girls who attempted suicide also report less communication with their daughters than mothers of girls who did not attempt suicide.

- **Family conflict** Conflict between Latina youth and their parents is associated with low self-esteem and internalizing behaviors which in turn is linked to suicide attempts.
- **Generational status** Second and later generation Latina youth are more likely to attempt suicide than first generation Latina youth.

Emerging research suggests that suicide attempts among Latina youth follow a pattern in which attempts are often preceded by a triggering event followed by an intense flood of emotions. This event typically occurs within a context of instability and stress. Latina teens who attempt suicide identified four main sources of distress: changes in family structure, parental conflict, physical or sexual abuse, and bullying by peers.

**Strategies:** Latina adolescents should be assessed for suicidal ideation and behavior and at-risk youth linked to mental health services. It is important that suicide prevention and intervention programs involve the girls together with their families and target communication and conflict resolution within the family. Emotional regulation and impulsivity should be addressed and healthy coping skills taught and reinforced to handle intense emotions and distress. Additional research is necessary to more fully understand the high rates of adolescent Latina suicidal behavior and to develop effective, culturally competent prevention and intervention strategies.

*Comunilife*, a community organization founded by Dr. Rosa Gil, has developed *Life Is Precious*, a family-focused, culturally competent mental health and youth development program working to reduce suicide risk in Latina adolescents in Brooklyn and the Bronx. The Center of Excellence for Cultural Competence is collaborating with *Life Is Precious* to evaluate this promising program and to decrease rates of suicidal ideation and behavior among Latina adolescents in New York State.

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