Proceedings from the NYAPRS 5th Annual Executive Seminar on Systems Transformation: *A Life in the Community*

April 23 – 24, 2009

The New York Association of Psychiatric Rehabilitation Services (NYAPRS) is a statewide coalition of people who use and/or provide recovery-oriented community based services. NYAPRS is dedicated to improving services and social conditions for people with psychiatric disabilities or diagnoses and those with trauma-related conditions by promoting their recovery, rehabilitation and rights so that all people can participate freely in the opportunities of society.

For more information visit: [http://www.nyaprs.org/](http://www.nyaprs.org/)

The UPenn Collaborative on Community Integration is a Rehabilitation Research & Training Center Promoting Community Integration of Individuals with Psychiatric Disabilities, funded by the National Institute on Disability and Rehabilitation Research (NIDRR). For more information, please visit: [www.upennrrtc.org](http://www.upennrrtc.org)
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Introduction

Recovery means living a satisfying, fulfilling, and meaningful life in the community with or without symptoms. Recovery is real. Recovery is possible for anyone with a psychiatric disability. Recovery is facilitated by having the same opportunities as everyone else to live a self-determined life in the community.

People with psychiatric disabilities want the same things that everyone else wants – a home, a job, relationships and family, the opportunity to vote, hang out with friends, express religious beliefs and engage in spiritual practices, work out at a gym, have a pet, and generally experience a full meaningful life in the community.

The New York Association of Psychiatric Rehabilitation Services (www.nyaprs.org) held their 5th Annual Executive Seminar on Systems Transformation on April 23 – 24, 2009 in Albany, New York. This groundbreaking seminar focused on promoting “A Life in the Community.” Sessions were held in three tracks: Service Transformation, Integrated Care, and Community Integration.

The University of Pennsylvania Collaborative on Community Integration (www.upennrrtc.org) is proud to be able to partner with NYAPRS in bringing you a compilation of presentations from this event. The focus on promoting opportunities for “life in the community,” specific presentation topics, and quality of presenters and presentations was viewed as too significant to not share with the world.

We expect that you will agree.

We express our appreciation to those presenters who have shared their presentations for these proceedings. Please contact these national experts for additional information. We would also like to thank the staff at NYAPRS for their assistance in gathering the presentations and Pam Cousounis at the University of Pennsylvania for all her hard work in compiling them.

Yours in Promoting Life in the Community For All,

Harvey Rosenthal
NYAPRS

Mark Salzer, Ph.D.
UPENN Collaborative
Service Transformation

Service transformation sessions featured perspectives from national and state leaders on transformative program design and financing for psychiatric emergency services, clinics, continuing day treatment programs and Personalized Recovery Oriented Services (PROS).

Workshops

A Life in the Community: An Emerging Vision
Envisioning a Life Beyond Services
Federal Medicaid Incentives for Recovery: An Update
Innovations in Self-Directed Services
Outpatient Clinic and Ambulatory Services Restructuring: An Update
New York State’s Medicaid Infrastructure Grant
Transforming Psychiatric Emergency Services
Personalized Recovery Oriented Services (PROS): An Update
Envisioning a Life Beyond Services

When will I get to have a life instead of treatment?

Current Service Design
- Office / Site based focused on treatment in artificial milieu environments
- Driven by services offered as opposed to individual's desires
- Day care functions
- Focus on disability promotes and reinforces disability

Creating a “Spark of Life”
- Creating opportunities to discover / re-discover passions
- Linking passions with community opportunities
- Creating communities of zeal (fervor for a person, cause, or object; eager desire or endeavor; enthusiastic diligence)
A New Paradigm?

- Acute Inpatient Services
- Acute Outpatient Supports
- Mobile supports provided in vivo settings taking advantage of existing array of naturally occurring organizations
- Supports provided in home, before, during or after community program, based on individual consumer preferences

Faith Community In-vivo settings

- Types of Organizations
  - Churches
  - Synagogues
  - Mosques
  - Temples
  - Ecumenical / Interfaith Councils
  - Evangelical Leaders

Faith Community In-vivo settings continued

- Types of supportive options
  - Volunteer Possibilities
  - Faith Study (i.e. Bible / Torah / Koran study)
  - Single Mixers
  - Prayer Groups
  - Food pantry
  - Clothing Assistance
  - Dinners
  - Transportation Assistance

Community In-vivo settings

- Community Centers
- Arts Councils
- Hospitals / Nursing Homes
- Parks and Recreation
- YMCA / YWCA
- Library
- Schools
- Primary
- Secondary

Community In-vivo settings continued

- Self-help groups
  - AA
  - NA
  - Alumni
  - DTR
  - Toastmasters
- Volunteer Coordination Centers
- Special Interest Organizations
- Hobbies
- Crafts
- Arts / Theatre / Music

Community In-vivo settings continued

- Sports Organizations
- Civic Organizations
- Political Organizations
- Organized Political Parties
- League of Women Voters
- SPCA
- Red Cross
- Chambers of Commerce
Community In-vivo settings continued
- Ethnic / Culture Specific Groups
- Cooperatives
- Food
- Housing
- Food Pantries
- Safety and Security Concerns
- Local Police
- Domestic Violence Programs
- Gay / Lesbian / Bi / Transgender Support Groups
- Parenting Support Groups
- Museums

Community In-vivo settings continued
- Spirituality
- Yoga
- Meditation
- Drumming Circles
- Aroma Therapy
- Computer User / Support Groups
- Agricultural
- Garden Clubs
- 4H
- Cooperative Extension Service
- Virtual Groups

Opportunities to belong
- Organizational member
- Volunteer
- Employee
- Participant
- Student

A New Reality?
- A Life
  - Days spent engaged in the zeal of life
  - With supports and services as needed
New Medicaid State Plan Options:

1915(i) Home and Community-Based Services (HCBS)

1915(j) Self-Directed Personal Assistance Services (PAS)

1915(i) State Plan Home and Community-Based Services (HCBS) Benefit

State Plan HCBS — Key Features

- New section 1915(i) established by DRA of 2005. Effective January 1, 2007
- State option to amend the state plan to offer HCBS as a state plan benefit
- Unique type of State plan benefit with similarities to HCBS waivers
- Breaks the “eligibility link” between HCBS and institutional care now required under 1915(c) HCBS waivers

1915(i) Services

Any of the statutory 1915(c) services:

- Case management
- Homemaker
- Home Health Aide
- Personal Care
- Adult Day Health
- Habilitation

- Respite Care
- For Chronic Mental Illness:
  - Day Treatment or Partial Hospitalization
  - Psychiatric Hospital
  - Crisis Services

But NOT the 1915(c) “Other” flexibility to design unique HCBS waiver services

Who May Receive State plan HCBS?

- Must be eligible for medical assistance under the State plan
- Must have income that does not exceed 150% of FPL
- States must provide needs-based criteria to establish who can receive the benefit
- Must reside in the community

1915(i) Needs-Based Criteria

- Determined by an individualized evaluation of need (e.g., individuals with the same condition may differ in ADLs)
- May be functional criteria such as ADLs
- May include State-defined risk factors
- Needs-based criteria are not:
  - descriptive characteristics of the person, or diagnosis
  - population characteristics
  - institutional levels of care
Needs-Based Criteria — Who the benefit may cover

- The lower threshold of needs-based eligibility criteria must be "less stringent" than institutional and HCBS waiver LOC.
- But there is no implied upper threshold of need. Therefore the universe of individuals served:
  - **Must** include some individuals with less need than institutional LOC
  - **May** include individuals at institutional LOC, (but not in an institution)

State Options

- Option to not apply income and resource rules for the medically needy
- States can limit number of participants who may receive benefit
- States can limit services to specified State areas (option to not apply state-wideness)
- Self-Direction

Self-Direction in 1915(i)

- State Option
- Modeled on 1915(c) application
- May apply to some or all 1915(i) services
- May offer budget and/or employer authority
- Specific requirements for the service plan

Quality Assurance in 1915(i)

- As a State plan service, no review & 3-5 year renewal needed as in waivers
- But unlike other State plan services, there is a QA requirement. States must ensure that HCBS meets Federal and State guidelines
- State quality improvement strategy

Under 1916(i)

States are to provide:

- Independent Evaluation to determine program eligibility
- Individual Assessment of need for services
- Individualized Plan of Care
- Projection of number of individuals who will receive State plan HCBS
- Payment methodology for each service
- Quality Assurance

Similarities: HCBS Under 1915(i) State plan & 1915(c) Waivers

- Evaluation to determine program eligibility
- Assessment of need for services
- Plan of care
- Option to limit number of participants
- Quality Assurance requirements
- Self-Direction option
- Ability to not apply state-wideness
- Option to not apply income and resource rules for the medically needy
<table>
<thead>
<tr>
<th>Differences: HCBS Under 1915(i) State plan &amp; 1915(c) Waivers</th>
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<td>Financial Eligibility Criteria</td>
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<td>Comparability/Targeting</td>
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<td>Program eligibility</td>
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<td>Institutional care requirements</td>
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<td>Length of time for operation</td>
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<td>Financial estimates</td>
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<td>Services</td>
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<thead>
<tr>
<th>Financial Eligibility Criteria</th>
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<tr>
<td>1915(c)</td>
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<tr>
<td>- Eligibility group must be in State plan</td>
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<tr>
<td>- Option to use institutional deeming eligibility rules (special income level group)</td>
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<tr>
<td>1915(i)</td>
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<tr>
<td>- Must be eligible under State Plan</td>
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<tr>
<td>- 150% of FPL</td>
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<tr>
<td>- Uses community deeming rules</td>
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<tr>
<td>- Option for medically needy only if use institutional deeming rules</td>
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<tr>
<th>Waiver of Comparability (Targeting)</th>
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<tr>
<td>1915(c)</td>
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<tr>
<td>- May waive comparability</td>
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<tr>
<td>1915(i)</td>
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<tr>
<td>- May not waive comparability</td>
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<tr>
<th>Program Eligibility</th>
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<tr>
<td>1915(c)</td>
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<tr>
<td>- Must target by institutional LOC</td>
</tr>
<tr>
<td>- May additionally target by population characteristics</td>
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<tr>
<td>1915(i)</td>
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<tr>
<td>- May not target by population characteristic</td>
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<tr>
<td>- Must establish needs-based eligibility criteria</td>
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<tr>
<td>- May have needs-based criteria for each HCBS</td>
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<th>Level of Care</th>
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<tr>
<td>1915(c)</td>
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<tr>
<td>- Participants must meet institutional Level Of Care (&quot;but for waiver services&quot;)</td>
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<tr>
<td>- Waiver Level of care must:</td>
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<tr>
<td>1915(i)</td>
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<tr>
<td>- Stronger than institutional LOC</td>
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<th>Needs-Based Criteria</th>
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<tr>
<td>1915(c)</td>
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<tr>
<td>- Eligibility is needs based, not led to institutional LOC</td>
</tr>
<tr>
<td>- But, institutional criteria must be more stringent</td>
</tr>
<tr>
<td>- Needs-based minimum eligibility criteria must be:</td>
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<tr>
<td>- &quot;Soo stringent&quot; than institution LOC</td>
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<tr>
<th>Length of Time for Operation</th>
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<tr>
<td>1915(c)</td>
</tr>
<tr>
<td>- 3 years initial</td>
</tr>
<tr>
<td>- 5 years upon renewal</td>
</tr>
<tr>
<td>1915(i)</td>
</tr>
<tr>
<td>- Indefinite</td>
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2007 - 2009

- Iowa State plan HCBS
  - Approved April 5, 2007
  - Includes case management and habilitation

- Nevada State plan HCBS
  - Approved October 31, 2008
  - Includes adult day health, habilitation, and for
    persons with chronic mental illness, day
    treatment/partial hospitalization

Possible Challenges for States using 1915(i)

- Regulation not yet final
- Eligibility determined by needs-based criteria
- Only 1 HCBS Benefit available per State
  - Deciding how to best use the option; competing priorities
  - Cross-agency collaboration

State plan HCBS: Resources

- Regulation published as NPRM April 4, 2008
  (comment period ended June 3, 2008);
  Complete proposed rule, CMS224P at
  http://www.cms.hhs.gov/MedicaidGenInfo08_
  Medicaid/Propositions.asp

- State Medicaid Directors Letter released
  April 4, 2008

- Draft State plan HCBS application available
  through CMS regional offices

State plan HCBS: Contact Information

- CMS Region 2 Office:
  Mike Cutler  Michael.Cutler@cms.hhs.gov

- CMS Central Office:
  Kathy Poisal  Kathryn.Poisal@cms.hhs.gov

1915(j) Self-Directed Personal Assistance Services (PAS)
State Plan Option

Section 1915(j) Key Features

- Section 6087 of the Deficit Reduction Act of
  2005
- Amends §1915 of SSA – new 1915 (j)
- Effective 1/1/07
- States may elect to provide self-directed personal assistance services (PAS) in the State
  Plan so demonstrations and waivers would not be necessary
1915(j) Key Features

- Can target populations, itself numbers and limit by geographic area
- Require assurance:
  - safeguards to protect needs and wishes to ensure transparent accountability
  - individuals are evaluated by the state for their need for personal care
  - Participation is voluntary and individuals are informed of feasible alternatives to the Risk program
  - Support system is available prior to and throughout enrollment
  - Annual report
  - Triennial evaluation of impact on health & welfare

1915(j) Key Features

- Individuals have both employer and budget authority:
  - can hire, fire, supervise and manage workers capable of providing the requested tasks
  - can purchase personal assistance and related services
- At State’s discretion:
  - Can permit hiring of regularly state- related
  - Can permit individuals to purchase items that increase independence or substitute for human assistance, to the extent that expenses would otherwise be covered by the human assistance
- Services may not be provided to individuals residing in properly funded, operated by a provider of services not related by blood or marriage

1915(j) Key Features

- Individuals have an approved self-directed service plan and budget
  - Individuals exercise choice and control over budget, planning and purchase of PAS
  - Individuals’ needs, strengths, preferences for PAS are assessed
  - The plan for services and supports is developed using person-centered planning process

1915(j) Key Features

- The budget is developed based on the assessment and plan, and a methodology that uses valid, reliable cost data
  - Amount is expected cost of service if not self-directed
  - May not restrict access to other medically necessary care & services not included in budget

1915(j) Key Features

- Quality assurance and risk management techniques are in place
  - State may employ a financial management entity to make payments to providers, track costs, make reports, payment at the 90% admin rate

1915(j) Key Features

- Financial Management Services:
  - Activities include payroll, tax reporting, payment of taxes, monitoring and accounting for individual budget expenditures
**State Medicaid Director Letter and Preprint**
- SMD Letter, with preprint, issued September 13, 2007
- Provides guidance to States about the 1915(i) option:
  - Administrative
  - Prospective cash disbursements at State's option
  - Voluntary and Involuntary Disenrollment
  - Quality Assurance and Improvement Plan to be described
  - Risk Management System to be described

**Current Status**
- Final Regulation published in October of 2008
- Five States have approved 1915(i):
  - Alabama
  - Oregon
  - Arkansas
  - Florida
  - New Jersey

**FYI**
- Of the 5 approved SPAs:
  - Offers self-direction of P03 State plan benefits:
    - AR, FL, NJ
  - Offers self-direction of 1915(c) waiver services:
    - AL, AR, FL, OR
  - Offers self-direction:
    - AR, FL, AL, OR
  - Offers the cash option:
    - AL, AR, NJ, OR

**FYI**
- Of the 5 approved SPAs:
  - Offers the option to hire legally liable relatives:
    - AL, FL, NJ, OR
  - Limits the number of individuals:
    - AL, AR, FL
  - Offers state plan:
    - AR, FL, NJ, OR
  - Populations include:
    - Elderly – AL, AR, FL
    - Adults with physical disabilities – AL, AR, FL, OR
    - Persons with traumatic brain injury – FL
    - Persons with developmental disabilities – AL, FL

**For Further Information about 1915(i)**
- Carrie Smith, Technical Director, D/HH & Elderly Health Programs Group, CMS: Phone: 410-786-4465
  - carrie.smith2@cms.hhs.gov
- Debra Culley, Health Insurance Specialist, Division of Medicaid & Children's Health, CMS Region 2: 212-616-3421
  - michael.ohare@CMS.HHS.GOV

**Additional Resource**
- National Resource Center for Participant-Directed Services
  - www.participantdirection.org
Self-direction in Mental Health: What’s the current state of play?

Vidhya Alakeson
Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

Mental health behind other disability groups
- All States offer consumer-direction for other disability groups
- Mental health is behind because:
  - No easy Medicaid funding vehicle
  - Personal care and employing family members not the main focus for MH
  - Skepticism and stigma

In the next 15 minutes…
- Which states are involved in SDC
- Snapshot of current evidence
- Medicaid financing options

Which States have SDC programs?
- For adults with serious mental illnesses:
  - Florida
  - Iowa (pilot completed)
  - Maryland
  - Michigan
  - Oregon
  - Pennsylvania (pilot to start summerfall 09)
  - Tennessee
  - Texas

Which States have SDC programs?
- For children with SED and their families:
  - Florida
  - Pennsylvania

No one model of SDC program
Texas Self-Directed Care
- Run by North Texas Behavioral Health Authority in its 7-county area, incl. Dallas
- $7000 budgets to cover all plan services, except crisis and inpatient
- Combining Medicaid and state general revenue
- Managed care company acts as fiscal intermediary and maintains provider network
- Visa cards issued to consumers for other purchases

Empowerment Initiatives, OR
- Run by consumer organization
- $3000 a year for 1 or 2 years
- County and state grant funding
- Purchase top up services to kick start recovery or transition to independent living
- Traditional mental health services unchanged

Self-determination, MI
- Concurrent Medicaid 1915(b)(3) waiver
- 1915(b)(3) supports range of alternative services
- Consumers can request to see their annual budget for community mental health services
- Opportunity to switch individual elements within budget if replacement less expensive eg. hire employment assistant to replace supported employment

Service utilization by category: Florida SDC

Satisfaction with services improves

SDC changes patterns of service use
Features consumers value
- Advocacy and support as important as the budget
- Recovery orientation
- Greater flexibility in meeting needs
- Experience of peers
- An expert guide through the public system
- Different relationship with providers

Promising early outcomes
- Florida: Pre and post study of 106 SDC participants shows:
  - Higher number of days in the community versus hospital days
  - Higher scores on Global Assessment of Functioning Scale
  - Less in paid employment or training
- New Jersey: Among 256 mentally ill, disabled adults in
  Cash and Counseling demonstration those directing
  their own care:
  - Less likely to fall
  - Home respiratory infection
  - Develop social ties where they have problems
  - Have lived sence, U1 or spend a night in hospital or nursing home

Medicaid Funding: The holy grail
- HCBS Waivers - 1915(c)
  - Institutional level of care and IMD exclusion
  - States determine institutional level of care - can make it more BH relevant
  - 4 states with 1915(c) for MI – CO, MT, WI, CT

CT's 1915(c) waiver for MI
- Institutional level of care: The individual will be required to meet at least one level of care and have three or more critical needs or deficits in the following activities of daily living: bathing, dressing, toileting, transfer, meal preparation, administration of medication, ambulation, or four or more cognitive deficits and require daily supervision for behavioral health problems including wandering, abusive/assaultive behavior, unsafe/unhealthy hygiene or habits, and impaired judgment with threats to self/harm, etc.
- Waiver services: ACT, Community Support, Peer Support, Supported Employment, Home Accessibility Adaptations, Nonspecialized Transportation, Recovery Assistant, Short Term Supervision and Support, Specialized Medical Equipment, Transitional Care Management
- SDC component: Recovery Assistant can be participant-directed

State Plan HCBS, 1915 (i)
- State option to amend the state plan to offer HCBS as a State plan benefit
- Breaks the "eligibility link" between HCBS & institutional care
- Must be eligible for medical assistance under the State plan
- Must have income that does not exceed 150% of FPL
- Approved to date: Iowa and Nevada

State Plan HCBS, 1915 (i)
For Chronic Mental Illness:
- Day treatment or Partial Hosp.
- Psychosocial Rehab
- Clinic Services
- Not yet tested for SDC by any states
- NOT the 1915(c) “Other flexibility to design unique HCBS waiver services
Managed care options – 1915 (b)

- CMS paper on SDC within managed care forthcoming
- 'In lieu of clause within 1915(b) waiver commonly used to provide alternative services
- Promising vehicle for SDC. Could be used to justify broader range of alternative services eg. gym memberships, peer services etc.
- 'In lieu of' combined with individual budget could provide flexibility and cost control.

Thank You
vidhya.alakeson@hhs.gov
Implementation of Self-Directed Care Initiatives

NYAPRS 4/23/03

Business Transformation

Health and Human Service Transformation

Self Direction Implementation Issues

• Financing – sources of funds and flexibility of use of funds
• Service planning and budgeting
  ○ Person centered v. self-directed care
  ○ Quantifying plans
• Role of case management
• Training of staff, consumers and providers
• Accounting and administration

Financing

• Limited flexibility of Medicaid funding
• Scarcity of state/county funding
• Reinvestment funds in PA
• Role of certified providers
• State regulations
• Importance of rate setting for personal budgets

Service Planning and Budgeting

• Self-direction starts with person centered planning
• Expanded array of services including goods in lieu of services
• Setting initial budgets requires transparent pricing
• Monitoring budgets
Role of Case Management

- Need to separate the planning function from psychosocial rehab, access and support services
- Using peer support in lieu of case managers
- Who manages whom?

Training

- Training Recovery Coaches to budget for services and be coaches
- Consumer education and support – this is different
- Existing providers need training
- Alternative providers need training

Accounting and Administration

- New claims and accounting systems or processes needed
- Tracking a personal budget in real time
- The lure of debit and smart-card technologies
- Added administrative layers may be unavoidable during transition

Questions

and

Thank You!
Clinic Restructuring Presentation

Gary Weiskopf
New York State Office of Mental Health
April 2009

Purpose of Presentation

- Review the key elements of the clinic restructuring plan
  - http://www.omh.state.ny.us/omhweb/resources/pu
    blications/clinic restructuring
- Status update

Key Objectives of Clinic Restructuring

1. More responsive set of clinic treatment services and greater accountability for outcomes
   - Clinic is defined as a level of care with specific services
2. Redesign Medicaid clinic rates and phase out of COPS
   - Rate payments to services and policy objectives
   - Modifiers and payment weights to reflect variations in cost
3. HIPAA compliant procedure-based payment system
4. Provisions for indigent care
5. Address Medicaid/HMO/State Insurance plan underpayments

Where Are We Now?

- Workgroup met last year
- Services descriptions drafted
- Staffing requirements drafted
- Licensed staff will be required for therapy services
- Revised draft CPT codes
- Developing service weights
- Developed clinic restructuring implementation plan
  - Clinic Restructuring FAQ on OMH web
    - http://www.omh.state.ny.us/omhweb/mental_clipart.html
  - Anticipated implementation January 2010

What Are the Services?

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<td>Mental Health Treatment Diagnostic/intake and Treatment Plan Development</td>
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<td>Physical Assessment</td>
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<td>6</td>
<td>Psychiatric/Community Support Services</td>
<td>7</td>
<td>Psychological Testing</td>
</tr>
<tr>
<td>9</td>
<td>Facility/Comprehensive Care Coordination</td>
<td>10</td>
<td>CPTHCPC Codes: Clinic services billed using CPTHCPC codes</td>
</tr>
</tbody>
</table>

- Non Face-to-Face: Bill for non face-to-face time spent coordinating care for complex patients
  - Time spent must be medically necessary and documented in the patient’s chart
- Multiple Same Day Services:
  - Reduce the need for consumers to make multiple trips
  - Minimize missed appointments
  - Some limits will be established
- Physician Billing: Some services the physician component will be billed using the physician fee schedule
What Does This Look Like?

Draft Clinic Services Billing Codes and Rules

The New Payment System

APGs (“Anticipatory Patient Group”) replace “unpredictable visits”
- Uses CPT codes to consolidate related procedures.
- Establishes procedure weights based on factors affecting resource use
  - Diagnostic service duration, location, positioning, qualifications.
  - OB/GYN procedure weights will be based on the minimum qualifications for staff to be permitted under state regulations to perform a particular procedure:
    - Obstetricians
    - Psychologists
    - Microbiologists
- UOAPG, UOMAPG, and UOAPG-A: identical to MAPG, except coded and
  - Both primary and secondary procedures are coded

The New Payment System

Establishes peer group base rates:
- Peer groups share similar cost and service structures.
- Peer group could be all mental health clinics in the state, clinics in each OMM region, clinics serving mostly children, etc.
- APG payments are the service weight times the peer group base rate then bundled, consolidated, and discounted as appropriate.

The New Payment System

Other payment adjustments for:
- Complex visits;
- Visits in a language other than English;
- Visits delivered outside of normal business hours; and
- Visits provided in off-site non-licensed locations
  - Restricted to services for children up to and including age 18 and for the homeless.
  - Outreach and engagement will also be done off-site.
- Anticipate ongoing supplement for Medicaid/Medicare cross-over clients.

Transition

Phased-in over time
- 4-year phase-out of COPS with phase-in of new payment methodology
  - 1st year: 75% old, 25% new
  - 2nd year: 65% old, 35% new, etc.

Provisions for Indigent Care

DOH has proposed a Medicaid waiver to
- Draw down matching federal dollars
- Expand the O&TG indigent care pool to include Article 31 clinics
- 2009-2010 Executive Budget provides OMH some funds for an uncompensated care pool
Medicaid HMO Underpayments

- Medicaid managed care plans (including F-HMO) underpay for mental health clinic services.
- About one-third to one-half of actual cost.
- Survey data show Medicaid managed care represents approximately 12% of clinic visits and continues to grow.
- OHM is currently looking at ways to address this issue.

Rate Setting Decisions Remain

- Finalize procedure weights
- Determine available funding – how much is needed and available for
  - Managed care tuning
  - Uncompensated care funding needs
- Establish provider peer groups

Major Implementation Tasks

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<thead>
<tr>
<th>Task Name</th>
<th>Description</th>
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<tr>
<td>Task 1</td>
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<td>Description of task 4</td>
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<td>Task 5</td>
<td>Description of task 5</td>
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</table>

Factors that Can Affect Clinic Viability

- Percent of clients that are privately insured
- Child health care agency and parent perceptions of child health care available
- Percentage of the clinic's Medicaid/FFS
  - Medicaid payments have a reimbursement rate approximately 60% of the usual rate and cost
  - States will be adjusting rates affecting access across all provider groups
- Probability - varying numbers of visits per year per client
- Percentage of visits that are uncompensated
- Percentage of visits that are uncompensated
- Support from the state, public, and private funders to meet some percentage of uncompensated care
- Access to the state, public, and private funders to meet some percentage of uncompensated care
- Supports for clients with a primary language that is not English
- Services that provide more than basic therapy to clients who receive higher payments from third-party carriers (e.g., couples therapy, anger management, complex care management, languages other than English, etc.)
Crisis Services Are in Crisis

- Our nation’s psychiatric emergency system is in crisis. Community mental health resources across the nation have become progressively scarcer in the past several decades and people with psychiatric disabilities have increasingly turned towards emergency rooms (ER’s) at a great cost to society both fiscally and socially.

ERs at the Breaking Point

- Some go to ER’s to obtain psychiatric medication refills as they cannot get earlier appointments from their psychiatrists or primary care physicians.
- Some present at emergency rooms to address other personal needs simply because there is nowhere else to go after other resources in the community close after 5pm.
- In addition, the number of US inpatient beds for psychiatric patients has dropped by two thirds, from 4 per 1,000 in 1964 to 1.3 per 1,000 in 1980.

2008 Health Affairs Study

- 4.1% increase per year in ER wait times between 1997 and 2004
- Ethnic minorities, women and people in urban ER’s are forced to wait longer than others.

The Tragedy of Esmin Green

- On June 18th 2008, Ms. Esmin Elizabeth Green died waiting for help in Kings County hospital’s Psychiatric Emergency Room (CPEP).
- This tragic event spurred a strong outcry for government, mental health providers, and consumers of services to reevaluate the way we view and deliver psychiatric crisis services.

NYAPRS 2008 Regional Forums on Psychiatric Emergency Care

- Bringing together
  - local and state officials
  - Providers
  - Peers
  - Advocates and experts
- To jointly assess the effectiveness of local crisis service systems, and
- To identify strategies to improve those services based on local, state and national input.
NYAPRS 2008 Regional Forums on Psychiatric Emergency Care

- Long Island
- New York City
- Buffalo
- Rochester
- Syracuse
- Plattsburgh
- Binghamton
- White Plains (pending)

Feedback from the Forums

- Unfriendly Services
- Overreliance on Police and Use of Handcuffs in Transport
- Hopelessness
- Being Treated for Psychiatric Conditions When Reason for Visit Was Physical
- Over Reliance on Medication Without Regard to Patient Choice
- Use of Restraint and Sedation

Feedback from the Forums

- Extremely Limited Access to Caring Support from Family Members/Natural Supports in Person or by Phone
- Being Unaware of Rights about Crisis Care and Hospitalization
- Lack of Information about What to Do in a Psychiatric Crisis, Not Enough Information about Wellness Self Management and Advanced Directives
- Lack of Proper Discharge Planning
- No Alternatives to the Hospital System As Caring Support from People in Their Own Communities Who Have Also Gone Through Psychiatric Crisis
- Emergency Rooms Were Not Furnished Comfortably, No TV/Radio, Extremely Uncomfortable Chairs

Long Wait Times at ERs

- Large numbers of people who present at ER's for non-emergency reasons; homelessness, lack of food or other necessities, nowhere to get medication refills after 5pm, people who need support but not crisis care
- Large numbers of people who present simply because they do not have health insurance
- Lack of primary care physicians (especially in rural areas)
- Lack of psychiatrists (more in rural areas, greater shortage of child primary care and child psychiatric
- Lack of resources, "CPEPS always run in the red"

Long Wait Times at ERs

- Not enough space
- Lack of inpatient beds/Limited capacity
- Not enough financing to make physical plant improvements
- Staff turnover
- No real connection to outside services, poor care coordination and the resulting complicated discharge process

County Challenges

- Lack of resources
- Lack of care coordination
- Lack of flexibility in existing funding and regulatory mechanisms
Innovative Peer Emergency Room and Crisis Diversion Programs

- PECPLPe's Peer Crisis Diversion Continuum:
  - In Home Peer Companion
  - Hospital Diversion House
  - Peer Emergency Room Services
  - Clinic-based Peer Advocates
  - Nights Out
- Recovery Innovations
  - The Living Room
  - Restart
  - Psychiatric Center West

Forum Recommendations

Enhance Peer Services

- The creation of sustainable alternatives to psychiatric hospitalization such as peer-run crisis respite settings to help consumers make a transition from crisis to wellness.
- The establishment of peer-run 'warm lines'—pre-crisis lines on which people who are entering a crisis can talk to avoid a full-blown crisis.
- The implementation of increased peer support, such as peer-run recovery and wellness centers.
- Additionally, peers are needed who can provide in-home support for persons not wanting to leave their home.
- Peer advocates being hired to be part of the emergency room and crisis team staffs to ensure that the rights of consumers are protected at all times they are in contact with emergency rooms and crisis teams.

Forum Recommendations

Emergency Room Improvements

- Ensuring that patients are clearly informed of their rights, among which is the integrity of their possessions and body.
- Enhancing the education of the emergency room staff to improve their skills and attitudes toward people with psychiatric disabilities. This education should involve people in recovery.
- Improve the physical plant: softer lighting, comfortable couches, soft music, separate and larger facilities; more privacy.

Forum Recommendations

Inpatient Care

- Decrease admissions from ER: increase appropriate diversionary referrals
- Improve knowledge of patient rights and the recovery process.
- Improve discharge planning and have in place the necessary transitional supports, including peer bridges.

Forum Recommendations

Police Response

- Training police to approach persons in emotional distress in a more informed, respectful manner that includes de-escalation techniques, improved assessment skills and information to make appropriate referrals.
- From 'EDPs' to 'Persons with Mental Illness'
- Consider incorporating Memphis styled 'Crisis Intervention Team' approaches

Forum Recommendations

Providers and Peers

- Providers to expand their hours to include evening and weekends, implement person centered planning, including fostering the development of personalized crisis plans and referrals to peer groups to foster WRAP plans.
- Peer training on how to anticipate and manage crises, how to develop and use a personal crisis or WRAP plan.
Forum Recommendations
Across All Settings

- Improve cultural sensitivity and competence, Hire more bilingual staff
- Teach health, wellness and recovery
- Institute culture shift to focus on recovery and rights centered approaches
- Don’t over-medicalize crisis: look at broader context
- Boost complaint processes and reviews in all settings
Integrated Care

Integrated Care sessions featured innovative practices and systems integration initiatives addressing including integrating health and behavioral health, criminal justice and mental health systems, integrating addiction and mental health services, and a special Commissioners’ Panel focused on their efforts to overcome state agency barriers to promoting a life in the community for all people with disabilities through the Most Integrated Settings Coordinating Council (MISCC).

**Workshops**

- Initiatives to Integrate Criminal Justice and Mental Health Services
- Launching the NYS Center for Excellence the Integration of Care (CEIC)
Initiatives to Integrate Criminal Justice and Mental Health Services

NYAPRS Executive Seminar
April 23, 2009

- Prakasha Bhakta, Esq.
- NYS Office of Mental Health
- LaMisa M. Patel
- NYS Office of Mental Health
- Wendy Vogt, Apra
- NYS Office of Mental Health
- Michael Vincent
- NYS Division of Probation and Correctional Alternatives

Presentation Overview
NYS Office of Mental Health Division of Forensic Services
Division, Re-Entry and Community Education Unit (DRACE)

- Principles underlying work of DRACE
- Diversion and Community Education Initiatives
- Re-Entry Initiatives
- Connect Project with DPCA and NYAPRS
- Summary

Criminal Justice Flowchart (2007)

New York State: Mental Health Operating Regions

Initiatives to Integrate Criminal Justice and Mental Health Services (2007)

Community

- Complexity – geography, demographics, governmental structures and levels
- Diversity – resources, cultures, values, styles
- Autonomy – counties, providers, people
**Problem**
What strategies can be used to provide program development, training and technical assistance in diversion, re-entry and community education to the state of New York?

**We can't solve problems by using the same kind of thinking we used when we created them.**

*Albert Einstein*

**Strategy**

Reframe Problem as:
What thinking should I apply to find new strategies for our work?

*We have to think outside the box.*

**What is ‘The Box’?**

![Image of a thinking person]

**OLD SCIENCES**

**Copernican Revolution**
- the sun is the center of the universe – not the Earth (Aristotle/Ptolemy)

**Newtonian Physics**
- produced very accurate results and predictability for the macro world
NEW SCIENCES

*Quantum Physics*
the study of the sub-atom world
Systems are too complex to accurately predict their future

“Anyone who is not checked by quantum [theory] has not understood it.”
-Niels Bohr
Physicist

Old Science | New Science
--- | ---
Parts | Whole
Things | Relationships
Rules | Guidelines
Predictability | Possibility
Hierarchical flow | Participation
Information as a thing | Information as fluid
(information age)

Making our Boxes Visible

Making our boxes visible to us so that we can think differently requires examining assumptions, beliefs and attitudes that shape our boxes.

Diversion Initiatives

**Forensic Training Program**
- Police Mental Health Recruit and In-service Instructor Development Courses partnering with NYS OCDS
- Suicide Prevention and Crisis Intervention for Jails and Police Lock-ups Instructor Development Course partnering with NYS OCDC
- Technical Assistance - MH-CI cross-systems resources and education to NYS localities

Diversion Initiatives

**Law Enforcement-Mental Health Crisis Response Summit**
- Statewide Summit sponsored by DCJS in June 2009
- 11 NYS counties participating: facilitation by National GAINS Center (PRA)
- DR & CE committed to working with counties following Summit on jail diversion initiatives (e.g., CIT)

**DEF/DFE Veterans**
- Training of law enforcement and corrections officers to identify signs of combat-related trauma and the role of adaptive behaviors
- SAMHSA: Paving the Road Home
  - Statewide Action Plan
  - Forensic Training Program VA Presentation
  - Gary Ladouceur, NYS Division of Veterans Affairs
  - 911 Dispatch Training
**Diversion Initiatives**

**Guiding Principles for Diversion Initiatives**

- Cross-Systems Collaboration
  - Onsite/remote technical assistance to facilitate cross-systems partnerships and problem solving
- Information and Autonomy
  - Forensic Training Program: sharing of information with counties/CJ agencies/training directors

**Diversion Initiatives**

**Personal Story of Recovery and Hope**

Eric Weaver
Former Sergeant, Rochester Police Department

**Re-entry Initiatives**

**Re-entry Guiding Principles**

- Engage the community-based mental health system in providing pre- and post-release services to inmates with mental health needs
- Promote access to benefits as an important step toward ensuring continuity of care and promoting full community reintegration
- Promote systems integration and coordination

**Re-entry Initiatives**

**Project Caring Community**

- Community-based providers: Herksee, Health & Housing; Hospital, Harp Advocacy Center
- Criteria for admission
- In-Reach: Services: 3 months prior to release
  - Individualized treatment, group work and release planning
  - Enrollment Specialist
  - Peer Support
  - Intensive Case Management: 6 – 12 months post-release with goal of transitioning to long-term case management
  - Part-time Psychiatrist
  - Peer Specialist

**Re-entry Initiatives**

**Forensic Supported Housing**

**Demonstration Project**

- 20 supported housing beds: 4 in Monroe County; 4 in Orange County & 12 in NYC
- Criteria for admission
  - "Transitional" or "temporary" housing
  - Partnerships and linkages among multiple providers: NYS/Forensic/ICM Team, dedicated Parole Officers, county MH agencies and non-profit providers

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**Re-entry Initiatives**

- CUIC Community Reintegration Initiative
  - Technical Assistance to Prison-Based Mental Health Units
    - Facilitate meeting between Pre-Release Coordinator & local DDD & SSA Office
    - Provide on-site support & consultation re: successful application preparation

- COBP Entitlement Specialist
  - SSDI/SSD, Medication Grant Program (MGP), Medicaid, Veterans Benefits, NYS Supportive Housing
    - 62% life of project approval (recently developed a system for presumptive eligibility and rates increased to 100%).

- Regional Trainings
  - Best practices/guidelines for Pre-Release Coordinators on how to do an effective SSDI/SSD application, NYC Supportive Housing Application, SPOA Case Management/ACT, Medicaid & MGP.
  - Tools: IDEA, discharge summary templates, psych evaluations, supporting documents, how to emphasize points that DDD looks for (e.g., diagnosis alone is not sufficient)

---

**The Connect Program: State Support for Local Solutions**

- Connect is a staff development and technical assistance project to improve outcomes for adults who are seriously mentally ill and under probation supervision:
  - Extensive structured needs assessment process
  - Probation staff statewide
  - Consumers involved with probation

- Developed by the NYS Office of Mental Health in partnership with the NYS Division of Probation and Correctional Alternatives and NYAPRS

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**Connect Implementation Strategy**

- **Self-selection** with minimal requirements – (e.g., collaboration of local mental health, probation and peers)

- **Self direction** and autonomy in local planning and program design

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**Connect Components**

- **Staff Development**
  - Fundamentals
  - Supervision
  - Cross training for service providers

- **Wellness and Recovery**
  - Training and Consultation – NYAPRS

- **Systems Change**
  - Adjustments to policy, procedures and activities to be more recovery-oriented
  - Increased cross-system collaboration

---

**Incorporating a Peer Perspective**

- **Story of Recovery/ Wellness & Success**
  - Dedicated probation officer
  - Change in supervision strategies:
    - Trust vs. Resistance
    - Rehabilitation / Support vs. Punishment
  - Probation Collaborative Group
  - Community corrections as a “partner” in Recovery
Impact of Connect
Incorporating peer perspective into community corrections

"Nothing about us, without us"
Jacki McKinney

Summary of Current Strategies for Community Change
- Peers and consumers as key informants and decision-makers
- Family members involvement
- Cross-system collaboration
- Integration of health and mental health
- Participation
- Information and autonomy
- Shaping influence

Summary
- These strategies have been viewed as optional based on Old Science but are essential based on New Science.
- Diversion, re-entry and Community Education that applies the ideas of new science in our work by emphasizing
  - Relationships
  - Participation
  - Information
  - Guiding principles
**Introduction**

- **Title:** Center for Excellence in Integrated Care
- **Funded by:** New York State Health Foundation
- **In Coordination with:**
  - New York State (NYS) Offices of Mental Health (OMH) and of Alcoholism and Substance Abuse Services (OASAS)
- **Amount:** 3.2 million dollars
- **Location:** NDRI
- **Start Date:** November 1, 2008
- **Period:** 4 years

**Target Audiences for CEIC**

- New York State Providers
  - 1,200+ Mental Health & Substance Abuse Outpatient Clinics
- Regional and County leadership
- Service Delivery Staff
  - Consumers of service
  - Family and significant others

**Clinical Care Goals**

- **General:** to increase the capacity of addiction and mental health outpatient programs to provide integrated clinical care for individuals with co-occurring mental and substance use conditions and, thereby, to improve the health and well-being of persons with co-occurring conditions statewide.
- **Specifically:** to implement:
  - A uniform and standardized approach to screening,
  - A comprehensive or component approach to assessment,
  - The use of selected evidence-based practices,
  - The delivery of care in a recovery-oriented, person-centered, culturally competent manner.

**Vision for Recovery Across Systems**

- Believe that recovery is possible, even from the most tragic circumstances or disabling conditions
- Transform through critical
- Uncover abandoned hope, dreams, and aspirations
- Discover our personhood through culture, strengths, values, skills, and support
- Engage our communities as life sustaining forces
- Re-authoring the way we see ourselves
- Reclaiming a meaningful life and role in society
**Vision for Recovery Across Systems**

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- Discover our personhood through culture, strengths, values, skills and supports
- Engage our communities as life-sustaining forces
- Re-authoring the way we see ourselves
- Reclaiming a meaningful life and roles in society

**Themes to Consider**

- Quality of life orientation as well as symptoms
- Use of interventions beyond medication and general psycho-educational curricula
- Discharge planning with a focus on peer and natural supports
- Moving from specialized tracks to fully integrated services
- Peer supervision models to build hope and address counter-transference

**Program Structure**

- Mission reflects an integrated vision of recovery oriented towards quality of life
- Moving from specialized tracks to fully integrated services
- Program services are focused on quality of life outcomes as well as overcoming clinical barriers

**Program Milieu**

- Welcoming and orienting to services
- Emphasizing belief that recovery is possible
- Offering explicit information about areas of programmatic flexibility
- Informing about personal rights and how to exercise them
- Asking questions that elicit cultural and linguistic preferences

**Program Milieu (continued)**

- Intentional use of the physical environment to send recovery messages
- Pictures, value statements, rights and quality of life resource information
- Quality improvement suggestion boards/balloons in waiting rooms and high traffic areas
- Dynamic program design based on dynamic needs of people receiving services
- All aspects of the program reflect inclusive principles and practices for people with COP
- Staff and participants offer encouragement to each other to build and sustain a hopeful culture

**Stages & Correlates of Recovery**

- Hope
- Empowerment
- Self-Responsibility
- Meaningful community roles

- Level of risk
- Level of engagement
- Level of skills and supports
The Dual Diagnosis Capability in Addiction/Mental Health Treatment Index

DDCAT / DDCMHT

What are the DDCAT & DDCMHT?

- "DDCAT" stands for the "Dual Diagnosis Capability in Addiction Treatment" Index, and is a validity instrument for measuring dual diagnosis treatment program services for persons with co-occurring (i.e., mental health and substance-related) disorders.
- "DDCMHT" stands for the "Dual Diagnosis Capability in Mental Health Treatment" Index.
- The DDCAT indicates that programs should be evaluated in 7 dimensions:
  1. Program Structure
  2. Program Acceptance
  3. Treatment
  4. Continuity of Care
  5. Staffing
  6. Training

DDCAT & DDCMHT (3.2)
7 Dimensions & Content of 35 Items

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Content of Items</th>
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<tr>
<td>I</td>
<td>Program Structure, Program mission, structure, financing format</td>
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<tr>
<td>II</td>
<td>Program Acceptance, physical, social, and cultural elements</td>
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<tr>
<td>III</td>
<td>Assessment, access, entry, screening, assessment and diagnosis</td>
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<tr>
<td>IV</td>
<td>Treatment, process and interventions including psycho-social</td>
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<tr>
<td>V</td>
<td>Continuity of Care, discharge, continuity of care and peer supports</td>
</tr>
<tr>
<td>VI</td>
<td>Staffing, prevention, role, and integration, supervision</td>
</tr>
<tr>
<td>VII</td>
<td>Training, training strategy and proportion of staff trained</td>
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TIP 42 Training-of-Trainees (ToT)

Purpose:
- To increase the knowledge and skills of clinical and supervisory staff.
- To build capacity for treating co-occurring disorders.

Date:
- begins in 2012, TIP 42 ToT two locations each year, developing a core pool of trainers who can provide direct training to mental health & substance abuse outpatient clinics.
- Participants commit to delivering subsequent training within their agencies or provider networks.
- In 2008, NDH staff held two TIP 42 ToT training sessions for 32 trainers.

Audience:
- individuals vs current State to RCOs, and others interested in training others on delivery and implementation of care to provide a high quality of care for individuals with mental health and substance abuse problems.
- College instructors

Some keys to Successful Implementation (ToT):

- Training
- Strong interpersonal relationships
- Intensity of contact
- Technical assistance (TA)
- Coaching
- Supervision
- Direct facilitation at delivery sites
Reach and Penetration

The potential reach and penetration to the 1296 outpatients clinics is based on the combination of five methods:

1. Regional and County roll-out.
2. Coordinating with various state, County and Municipal agencies and professional organizations (e.g., NYCCCMID, ASAP).
3. Multiple Efforts: Training of trainers, leaders, and staff to prepare new providers.
4. Synergistic Efforts: Coordinating with other initiatives (e.g., DOD, DODIE, etc.)
5. Expanding Efforts: Extending the influence of training and technical assistance by conducting conference or meetings at the regional/city level, which then extends to the service area.

Evaluation Plan

The internal evaluation plan focuses on outcomes and benchmarks and measures:

- **Provider level** — increases in the percentage of programs using the prescribed screening tools, assessment domains, and evidence-based practices.
- **State level** — increases in the percentage of programs with “Dual Disorder Capable” or “Enhanced” approach.

A comprehensive, formative, and summative evaluative process will assess the Center’s performance, provider agency progress, and consumer outcomes.

CEIC Status of Start-up Activities

- DODAT and DODAT - on-site on-going capacity surveys
- Development of Technical Assistance Products
- Supervision of the CEIC implementation steering committee
- Draft launch of CEIC — Albany Press Event (Jan 09)
- Stakeholder outreach to county and regional leadership
- Consultation with OAH and OASAS
- Website development
- Regional Leadership and Implementation teams: 5 Regions

Timelines: Nov 08 to Apr 10

Sustainability

1. Enhancing resources and existing expertise to enable technical assistance to be delivered from peer-to-peer.
2. Building upon and enhancing County infrastructure and Agency leadership to promote peer-based learning structures to extend the Centers reach and to sustain local capacity.
3. Institutionizing the Center’s infrastructure and functions within existing entities (e.g., OAH Advisory Group, DRGs, Training Division activities of the State).
4. Constructing new partnerships (e.g., Networks of Centers of Excellence, Regional Centers, coordinating with ATTC’s and Mental Health Transition efforts).
5. Anticipating and responding to the opportunities afforded by advances in Information Technology and Implementation science.
Conclusion

The New York State Center for Excellence in Integrated Care provides a unique opportunity to understand this initiative in which a targeted program of systems change can achieve the adoption of integrated services for CDO at more than 1,200 outpatient clinics.

The Center will document:

1. Implementation strategies, barriers, and their patterns of use as adapted to the needs and circumstances of treatment sites;
2. The relationships between adult and mental health treatment settings, and

the degree to which components of integrated care have been adapted as determined by self-monitoring and spontaneous external evaluation.

As such, the Center promises to be a model system of outpatient care for clients showing evidence of CDO.

References

Victims Recovery Across Systems


WHYCDP, Carol Bessick et al., Fundamentals of Mental Health Care, 2005.

Neil Adams, Clare M. Caldecott, Treatment Planning for Person-Oriented Care, 2005.

L. Davidson, O. Heddle, L. Boxall, Recovery from Severe Mental Illness: Research, Practice, and Implications for Practice, 2005.


Contact Information

Center for Excellence in Integrated Care (CEIC)

Center for the Integration of Research & Practice (CIRP)
National Development & Research Institutes, Inc. (NDRI)
71 W 23rd Street, 9th Floor
New York, NY 10010
TF 877.688.6677  ▶  tel 212.346.4400  ▶  fax 212.812.4850
www.nyshealth-ceic.org  ▶  www.ndri.org
Strategies to Support Community Integration

Community Integration for people with psychiatric disabilities was featured in an unprecedented and visionary keynote panel along with a series of workshop presentations by leading experts from across the state and the country with experience in statewide and local systems transformation toward increasing employment, economic integration, homeownership, education and parenting outcomes for people with psychiatric disabilities.

**Workshops**

Emerging Models of Integrated Health and Behavioral Health Care

WE Can Save! : Asset Development Strategies to Achieve Economic Self-Sufficiency

WE Can Work! : Innovative Programs to Improve Employment Outcomes

WE Can Own! : Strategies to Advance Self-Owned Community Housing

Interagency Efforts to Promote Community Integration

WE Can Go to School!

Supporting Consumer Operated Programs in Promoting Community Integration

WE Can Parent!
New York State Chronic Illness Demonstration Project (CIDP)

**CIDP Foundation**
- The contracting vision for this demonstration project is to establish innovative, equity-driven interventions for chronically ill NY Medicaid beneficiaries with various chronic conditions or life-limiting conditions.
- Program goals include improving outcomes for Medicaid beneficiaries with medically complex conditions.
- In support of this vision, the OptumCare model fosters interdisciplinary care coordination among medical care providers, behavioral health specialists, social workers, and others.
- Care coordination services are available to all beneficiaries through a team of care managers, case managers, and care coordinators.
- Interactions with the patients and their caregivers are frequent and include face-to-face interviews.

**OptumHealth Overview**
OptumHealth makes quality healthcare more accessible, affordable and effective for employers, health plans, public sector entities and the 7.6 million individuals we serve.

**Organizational Structure (New York Based)**

- **Executive Director**
  - CEO (Chief Executive Officer)
  - President and CEO
  - Senior Vice President
- **OptumCare Management**
  - Vice President, Operations
  - Vice President, Clinical Services
- **Health Management**
  - Vice President, Health Management
  - Director, Health Management
- **Behavioral Health Management**
  - Vice President, Behavioral Health Management
  - Director, Behavioral Health Management
- **Quality Management**
  - Vice President, Quality Management
  - Director, Quality Management
- **Financial Management**
  - Vice President, Financial Management
  - Director, Financial Management

**Discussion Points**
- New York Chronic Illness Demonstration Project
- OptumHealth Overview
- Internal Operational Structure
- Partner Role
- New York Partners
Provider Partner Role

OptumHealth works collaboratively with providers in the community to improve the health and wellbeing of New York citizens in the Chronic Illness Demonstration Project.

As an OptumHealth provider, you participate in the process jointly with OptumHealth in the following ways:
- Develop an integrated system of screening, assessment, and outreach-based interventions for patients with chronic illnesses.
- Identify and remove barriers in the care of patients with chronic illnesses.
- Implement a comprehensive care management program for patients with chronic illnesses.
- Participate in collaborative service planning.
- Develop guidelines and recommendations for service expansion.
- Participate in the planning process, consistent with other community and state/federal requirements.
- Designate a representative to participate in the facilitating program.

OptumHealth New York Partners

<table>
<thead>
<tr>
<th>PARTICIPANT</th>
<th>ROLE AND EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>Collaborate in the screening, assessment, and outreach of patients with chronic illnesses.</td>
</tr>
<tr>
<td>Non-Provider</td>
<td>Support collaborative service planning and guideline development.</td>
</tr>
<tr>
<td>Hospital</td>
<td>Provide comprehensive care management for patients with chronic illnesses.</td>
</tr>
<tr>
<td>Community</td>
<td>Develop guidelines and recommendations for service expansion.</td>
</tr>
<tr>
<td>State/Federal</td>
<td>Participate in collaborative service planning.</td>
</tr>
</tbody>
</table>

SOURCE: OptumHealth New York Partners
**NYC & Long Island CIDP Projects**

NYAPRS 4/23/09

**Background**
- Medicaid accounts for 47 billion in spending each year in NY.
- 20% of beneficiaries account for 75% of costs.
- These beneficiaries have multiple co-occurring conditions often including mental illness, substance use disorders and life threatening health conditions.
- Individuals lack access to coordination of care between multiple services systems.
- Consumers with serious mental illness die on average of 25 years earlier than those in the general population (NASEM, 2006)
- 80% of mortality is due to treatable and preventable medical conditions (i.e., diabetes, heart disease, respiratory problems, etc.)
- Often consume 2-3X more medical care, leading to acute hospital admissions that may have been prevented with strong primary care.

**Target Population**
- Adults with Fee for Service Medicaid identified by DOH as "high users" via an algorithm designed to predict increased use of health and related services.
- 57% are predicted to have a hospital admission in next year.
- Enrolled is likely to have multiple medical conditions as well as mental health and substance abuse disorders.
- Enrollment is voluntary.

**Chronic Illness Demonstration Project Goal**
- The goal is to use the highly developed expertise of the behavioral healthcare system to provide care management to individuals with chronic medical, behavioral health, and/or substance use conditions.
- The behavioral health partners will collaborate with participating primary care and hospital providers to improve the health status of a vulnerable population and to reduce the costs of both psychiatric and medical care.
- Participating behavioral providers will link program beneficiaries to supportive resources in the existing behavioral health system.

**Project Overview**
- Innovative project to coordinate care for 500 (in NYC), and 500 (in Nassau) "high users" of Medicaid identified using a DOH algorithm in selected zip codes in Nassau County, Brooklyn & Manhattan.
- Designed to link this group with quality medical and mental health treatment.
  - Each enrollee will be assigned to establish a medical home.
  - Enrollee will be offered behavioral health services and housing as necessary.
- Each enrollee will be provided case management by an agency care manager in collaboration with a nurse care coordinator.
- The project seeks to provide high quality care while reducing 2-3X per enrollee.

**New York City Project**
**Project Network - NYC**
- PCLMS Community
- The Bridge
- Stuyvesant, Manhattan, Bronx
- MSW HCW
- Behavioral Health Network
- Integrated Wellness Partners
- ND
- The Bridge
- NIP
- MSW HCW
- New York City Department of Health
- Health Network in Brooklyn
- Manhattan Medical
- IC
- Harlem Health Center
- Kingsbrook Jewish Hospital

**Organizational Chart**

**Project Operations**
- Each beneficiary will be linked with one of 4 care management teams.
- A care manager will take the lead in developing the health management and care plan in collaboration with the beneficiaries, health, PT and SA providers and the nurse case coordinator.
- The beneficiary will be referred, if they agree to a “medical home” in the PIVW network as needed.
- The beneficiaries will be advised and trained to use the 24/7 emergency call at service where the case manager is not available, where a nurse case coordinator will be on call.
- The project staff & treatment professionals will utilize a state-of-the-art care management software system.

**Role of 4 IWP Care Management Agencies**
- Each agency will operate a field care management team consisting of case managers and a peer.
- Teams will be responsible for enrollment and care management of all project participants.
- ICL & SUS will be primarily responsible for Brooklyn.
- FEES & The Bridge will be primarily responsible for the West Side of Manhattan.
- Disenrollment and 24 hour crisis services will also be offered jointly with VOS & Network Health Care Providers.

**Medical Homes**
- Project staff are now working with participating primary care and hospital providers to develop protocols for creating a “medical home”.
- Together, we will determine key changes needed in outpatient primary and specialty care services to improve health care outcomes and reduce unnecessary use of inpatient/EHR services.
- Project resources (care managers, nurse care coordinators and crisis/diversion services) will be available to network medical providers to facilitate admission and EHR diversion, discharge planning, patient follow-up, treatment adherence and outpatient urgent care.

**Role of Network Health Care Providers**
- Provide community based medical homes
- Provide specialty care as necessary
- Provide in-patient services as necessary
- Collaborate in ER/admission diversion efforts
- Provide access to database to locate enrollees, as permitted by HIPAA
Nassau Project

- FEGS: Prime Contractor
- Nassau University Medical Center (NUMC)
  - Hempstead CHC
  - Freeport CHC
  - Elmont CHC
  - New Cassel CHC
- ValueOptions

Table of Organization

Program Principles of Nassau CIPDP

- Enroll and engage 256 Nassau Clients
- Improve Health Status
- Improve Compliance with Medication Regimen
- Establish Medical Homes
- Provide Coordinated Care
- Facilitate Access to Appropriate Health Care Services
- Educate and Assist Clients
- Support Integrated Personalized Care Plan and Cellu Plan
- Utilize Community Resources
- Assist with Transportation
- Improve Access to Housing
- Outcomes: Decrease Cost of Health Care

Partner Background: NUMC
Nassau University Medical Center

- Committed to Medical Home Concept
- Full-Time Medical Providers Available at 4 Community Health Centers
- County Provider for Public Health
- Ambulatory Services has Reorganized
- Upgraded Facilities
- Has Strong Support from County DOH
- Liaison to County Corrections

Role of Value Options in both Projects

- Value Options brings its considerable experience in managing care for similar consumers in other states
- VO will provide
  - Medical care coordination
  - Supervision of care management teams via nurse care coordinators
  - Reporting & data analysis to network and government partners
  - Technology and information management
**IT Infrastructure**

Vitality Clinical Care Advance (CCA) is the software platform for the project:
- It is a fully web-enabled program that is accessible from any location with web access.
- Care advance integrates and organizes information about the member from various sources, including electronic medical, pharmacy, and behavioral health, wellness, provider, and provider records into a single data structure and database.
- Care advance is integrated with the following tools:
  - Can identify, track, and target members, and generate alerts regarding gaps in care.
  - Comprehensive Assessments
  - Evidence-based Clinical Practice Guidelines
  - Care Planning, Clinic, and Wellness Tools

**Potential Benefits**

- Improve health outcomes through more coordinated and timely health care delivery, disease management, and improved treatment adherence.
- Reduce medical costs by shortening and reducing inpatient admissions, diverting ED visits by more accessible delivery or ambulatory health care and significantly improving disease management and treatment adherence.
- Creating a replicable, cost effective model of service delivery.

- Supports the creation of an Individualized Care Plan, used to:
  - Develop short-term and long-term goals.
  - Identify and resolve barriers to treatment adherence.
  - Offer education and timely interventions to maximize goal attainment.
  - Can attach imported documents.
  - Develop a schedule for follow-up contacts and communications with the member.
  - Evaluate member progress through repeated administration of outcome measures.
**Integrating Health Initiatives in Behavioral Health Settings**

**Mind Your Health**

- Conference:
  - Focused on health, healing, and spirituality
  - Practical things like communicating with your physician, nutrition, and healthcare advocacy
- Consumer focus groups
- Partnership with internal partners and members of mental health community
- Mind Your Health Workshops:
  - Educate and motivate mental health consumers to make physical health care an integral part of mental health recovery

**Mind Your Health**

**ROUND ONE: Four Workshops**

- May 2007: Personal Empowerment
- July 2007: Stress Affects Wellness
- October 2007: Consumers and Staff Creating a Healthier Community
- December 2007: Medication Side Effects Matter

**Mind Your Health**

**ROUND TWO: Five Workshops**

- March 2008: Double Whammy: It’s not just about mental health anymore
- April 2008: Sex, Communication, and Safety
- July 2008: Medicaid Managed Care
- September 2008: Clearing the air: The facts about smoking and mental illness
- February 2009: Wellness is for Everyone: Improving physical & mental health of NYCHS culturally & ethnically diverse communities

**Mind Your Health**

- Feedback:
  - “Not what I expected. More consumer oriented, which is great. Very informative, not enough time for each presenter.”
  - “Excellent and very helpful for me. I work in a field where most of my clients smoke. I hope what I learn here will change their minds.”
  - Seminar was very informative, not only for my clients, but for myself as well. I liked how the community was involved.”

**Mind Your Health**

- 84% of respondents:
  - Quality of workshops high
  - Information presented relevant and useful
- 90% of respondents:
  - Interested in attending other workshops on physical and mental health
- Overall:
  - Feedback was overwhelmingly positive
Peer Staff Training

- Peer Staff Health Integration Intensive
  - Planning stages
  - Advisory group created
  - Six half-day training sessions over a six – nine month period
  - Train 10 – 12 peer staff on:
    - Smoking Cessation
    - Effective Communication with Prescribers and PCPs
    - Diabetes Self-management
    - Nutrition and Weight Loss
    - Physical Activity
    - Motivational Interviewing

Public Health Detailing

- Program began in 2003
- Modeled after pharmaceutical sales approach
- "Selling" good health and promoting public health interventions
- Brief, one-on-one interactions with health care providers and staff
- Total office call

Public Health Detailing Program

Goals
1. Promote preventive health interventions to health care providers in the primary care practice setting
2. Promote use of clinical systems to ensure that opportunities for care are not missed
3. Develop relationships and serve as a resource to practice staff

Approach
- Train knowledgeable and persuasive DOHMH Representatives
  - Disease content knowledge (DOHMH expertise)
  - Selling and communication skills
- The usual campaign: 10 weeks long; target is 2 visits per contact
- Assess current practice; tailor presentation to each contact
- "Sell" or promote key recommendations and offer supporting campaign-specific materials

Behavioral Health Care Setting
New York City

Contracted Staff:
- 4 field staff
- 1 field supervisor
Mental Health Sites:
- ~400 sites

Key Recommendations

1. Assess smoking status and readiness to quit at intake and at least every three months thereafter.
2. Prescribe medications and smoking cessation treatment to assist people in becoming tobacco-free.
3. Provide education and raise awareness about becoming and remaining tobacco-free.
Action Kits

- Clinical Tools
- Provider Resources
- Patient Education

Other
- Medications
- Health Bulletins
- Incentives (pens, post-it pads)

Clinical Tools

- Support delivery of evidence-based care
- Assist in implementing clinical preventive services and chronic disease management
- Time saving
- Targeted to an interdisciplinary health care staff

Provider Resources

- Peer reviewed articles and clinical guidelines on evidence-based care
- Provide health care providers and other clinical staff vital statistics
- Information on DOHMH interventions

Patient Education Materials (secondary)

- Prompts discussion with Health Care Provider
- Targeted to all literacy levels
- Available in multiple languages so there are no missed opportunities
  - English
  - Spanish
- Provides key patient message

Campaign Highlights

- Working in close collaboration with the Office of Health Integration and the Bureau of Tobacco Control
  - Key Recommendations
  - Revised Smoking Cessation Action Kit
  - Pre-campaign letter
  - Building relationships with sites
- Campaign coincided with NEW YEAR and time to Quit the Smoke
- "Domino Affect"

Campaign Barriers

- Sites are larger than originally anticipated
- Pre-call planning is needed
- More group presentations than one-on-one interactions
- Not enough materials
- Visits are taking 2-3 hours per site
- Not enough time for in-person follow-up
Follow Up Activities

- On-call reps to provide telephone and in-person follow up in July 2006
- Smoking prevalence question added to Consumer Perceptions of Care Survey (Fall 2006)
- Expand target to include Housing, Psychosocial Clubs
- Use learning community model to spread ideas
- Provide training for consumers and providers

Future Needs

- Many sites agreed it would be good to have “starter kits” of nicotine replacement therapy on site for distribution to their consumers.
- Throughout the campaign, there have been requests for a DVD specifically for the consumer both for use in the waiting room and for use with low literacy consumers.
- Mental health care providers are eager to learn more about Take Care New York and other campaigns such as hypertension, diabetes, obesity and HIV testing.

Contact Information

Jody Silver: JSilver@health.nyc.gov
212-219-5391

Markane Roll: MMRoll@health.nyc.gov
212-219-5386
Economic Empowerment Agenda

- Capacity Building
- Education and Training
- Research and Policy Development

Medicaid Infrastructure Grant (MIG)

- Remove barriers to employment and a better economic future
- Improve cross-agency sustainable, coordinated systems of supports and services
- Engage the business community in collaboration with government and employment service providers to recruit, hire, retain and advance

NYS Opportunities

- Developing relationships with United Way and financial institutions.
- Design and implement local Asset Development summits in selected cities.
- Create State level Asset Development Task Force to identify policy barriers

Medicaid Infrastructure Grant (MIG)

- Increase access to health care through the Medicaid Buy-In
- Expand informed choice and decision-making to make work pay
- Develop and expand entrepreneurship opportunities

NYS Additional Opportunities

- Select six communities to become demonstration sites
NYS Additional Opportunities

- Bring six part training program to peer support network in NYS.
- Educate state leaders about lessons learned from other states and develop a NYS economic empowerment agenda.
- Document system change and individual success stories.

Produce Results

- Restore and support hopes and dreams
- Raise expectations and build the capacity for sustainable change

NYS Additional Opportunities

- Replicate Start-Up New York to expand microenterprise and small business assistance.
- Link statewide potential lenders to improve access to capital.

New York Makes Work Pay
Partnering Organizations

Refine and Reframe the Focus!

- Focus on “Advancing Self-Sufficiency” and raise expectations beyond community participation.
- Focus on income production, saving and asset building to advance the level and scope of community participation.
- Focus across federal systems of support to access tools to preserve income and build assets.

Michael Morris, CEO
Burton Blatt Institute
Syracuse University
mmorris@blatt-institute.org
WE CAN SAVE
— United Ways and
Financial Stability

Mary A. Shahin
Vice-President
United Way of New York State

More than 30-years of services to our member
United Ways
Providing leadership, support and advocacy on:
• 2-1-1
• Success By 6
• Financial Stability
• Basic Needs

Financial Stability - Advocacy
• State EITC enacted in 1994
• Now valued at 30% of the Federal credit
Current efforts:
• Raising in predatory practices
• Examining asset limits that may preclude
  savings

Financial Stability – Community Impact
• Rochester, NY
• C.A.S.H: Creating Assets, Savings and Hope
  – began in 2002 to:
  • Increase income
  • Minimize financial erosion
  • Maximize financial assets

Where we were in 2004
It's about partnerships and collaboration
- Local University
- IRS
- Banks and credit unions
- Colleges and universities
- Foundations
- Local government & public agencies
- Human services organizations

Measurable Community Impact:
21 coalitions in 2008:
- 224 VITA sites
- 1,725 volunteers
- 120,788 volunteer hours
- 70,510 tax returns
- $30,200,820 in EITC refunds
- $82,280,066 in total refunds

About those we served:
- 7% filed joint returns
- 29% owned their own homes
- 50% graduated HS or had their GED
- 32% received public benefits
- 77% had bank accounts
- 26% had a disability
- 24% used refund to pay off/reduce debt
- 17% interested in workshops on getting out of debt

Beyond EITC – linking clients to other services:
- Benefits screening
- IDAs
- Financial literacy/education workshops
- Banks
- Financial coaching

Leader in asset development
C.A.S.H. Rochester – 2005 to date:
- 409 savings bonds
- 155 new bank accounts
- 344 direct deposit card accounts
- Offers money management education, credit counseling, financial coaching
Leader in asset development

CASH Buffalo:
- Income TAX
- Expansion in IDAs
- Self-sufficiency calculator
- Financial coaching
- Hope Center

Leader in serving individuals with disabilities

CASH Buffalo:
- Income TAX
- Special Populations Sub-Committee

Leader in serving individuals with disabilities

CASH of the Greater Capital Region:
- Disability Initiative Committee
- Asset Building Forums
- Disability Awareness Training for VITA volunteers

Emerging leader in serving individuals with disabilities

C.A.S.H. Rochester:
- Current level of services
- Deaf tax pilot
- REI Tour info meeting – 4/2/2009

What’s next?

Partner, collaborate, integrate:
- Connect to existing efforts
- Make sure they work for the people you serve

Where to go for more information?

- United Way of NYS: www.uwnys.org
- Your Money New York: www.osc.state.ny.us/yourmoney/index
Questions/further information...

Mary A. Shaheen, Vice President
United Way of New York State
155 Washington Avenue, 2nd Floor
Albany, NY 12210-2323
518.463.2522
shaheenm@uwny.org

Mission: To strengthen the capacity of United Ways to be leaders in achieving results that improve the lives of all New Yorkers.

Thank you
**WE Can Save!**

**Building Social Capital to Break the Cycle of Poverty and Psychiatric Disability:**

An Agenda for Asset Development Programming in New York State

Presented by
Oscar Frerichs, MPP

At the 3rd Annual Conference of the New York Association of Psychiatric Rehabilitation Services (NYAPRS)

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**Poverty and Psychiatric Disability**

- Since the 1950's studies have found higher rates of psychiatric conditions in low-income communities.
  - Studies have found a prevalence 2 to 9 times higher in poor communities (Hubin, 2002)
- Most recently, a Massachusetts study found that psychiatric conditions are three times as prevalent in low-income communities (Hubin, 2002).
- A Rhode Island study found that people of low socio-economic status have a times higher risk of major depression (Casan, 2004).

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**Mental Illness among Adults Aged 21 to 64 by Family Income**

- Serious mental illness is higher among those unemployed vs. persons who work full time (4.4% vs. 1.3%, respectively) (SAMHSA, 2002).
- Another study (Murphy, 2000) found that, compared to the insured, low-income uninsured populations had higher prevalence of:
  - One or more psych disorders (52% vs. 18%)
  - Mood disorders (38% vs. 16%)
  - Anxiety disorders (27% vs. 17%)
  - Alcohol abuse (17% vs. 7%)

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**Association between SES and Psychiatric Disability: Prevalence of psychiatric conditions across classes**


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**Socio-economic Status and Psychiatric Disability: The Massachusetts Study (Hubin, 2005)**

Source: Hubin (2005)
Does poverty cause psychiatric conditions?... or does psychiatric disability cause impoverishment?
Theses explaining the relationship between poverty and psychiatric disability

Social disruption theory:
Psychiatric conditions impair the ability to cope with stress, leading to increased unemployment and lower income levels, which exacerbate mental health issues.

Social selection ("drift"): A downward spiral of mental health problems and economic hardship, where those with poor mental health are more likely to experience poverty due to reduced earning potential.

Poverty as a cause of psychiatric disability: the role of SES and economic stress

- Socio-economic status (SES): A study found that SES has a direct and indirect impact on psychiatric disability (Stansfield, 2000), where SES is defined as:
  - Income: Household Income
  - Education: Years of education
  - Occupation: Occupational status

- Economic stress: Another study showed that economic hardship has a direct impact on psychiatric disability (Stansfield, 2000), where economic stress is defined as:
  - Unemployment
  - Poverty

Poverty as a cause of psychiatric disability: the role of unemployment

- A study of people born in 1947 in the UK found that poor mental health was associated with downward socio-economic trajectory over the course of life (Taffin et al., 2003).
- A study of people with schizophrenia found that the socio-economic status of the individual was more associated with the condition than the SES of the father, suggesting that schizophrenia may cause SES decline (Shurr, 1988).
Psychiatric disability as a cause of poverty:

Unemployment and poverty: A two-way street

How can we break the cycle of poverty and psychiatric disability in New York State?
Asset Development - Building Social Capital towards Economic Integration

- Social Capital:
  - Developing social norms and processes to promote social cohesion
  - Merging social properties and sustainability of social behavior
  - Increasing social capital through community development
  - Developing support networks to build skills and connections
  - Building personal relationships

- Economic Capital:
  - Employment: building about 60 opportunities
  - Employment supports: increasing a skill
  - Improving social economic opportunities
  - Building assets we can borrow
  - Developing assets that we can own

Addressing Poverty & Psychiatric Disability: A programmatic and policy agenda

- Asset development requires building social capital:
  - Social Capital (i.e., the network, relationships, connections that allow the flow of information and resources) is an essential ingredient of economic development.
  - Building social capital is a critical strategy given the isolation of people with psychiatric disabilities from asset development and anti-poverty communities.

- Data about socio-economic status:
  - Poverty and interventions must include measures of income and socio-economic status (e.g., education, type of occupation) to ensure the needs of those most vulnerable are addressed.
  - Measures will also help assess the impact of interventions in SED-related variables, as a proxy to MH recovery and quality of life.

What opportunities do New Yorkers with psychiatric disabilities have to build assets and become more economically self-sufficient?

The resources presented in this section are the result of research conducted by the NY-Medical Infrastructure Grant "NY Makes Work Pay".

Bibliography and resources


Tax Coalitions

- Bronx Cooperative and Urban Settlement P.C.U.
  http://www.citytax.org/
- NYC Tax and Benefit Disability Coalition
  http://www.citytax.org/coalition/medical-late-estimate-grant.html
- CASH Coalition of Rochester, NY
  http://cnytax.org/cashcoalition/homepage.html
- Food Change NYC Campaign
  http://www.foodchange.org
- United Way of St. John's & Erie County
  http://www.uwstjohns.org
- CA-STATE Coalition of the Greater Capital Region
  http://www.ca-statecoalition.org
- Syracuse - You've Earned, Now Keep It
  http://www.syracusecny.org/
Peer Providers and Traditional Staff Working Together Effectively: Understanding & Overcoming Challenges
Presentation to the NYAPRS 5th Annual Executive Seminar
April 23, 2009
Lauren B. Ganns, Ph.D.
Workplace Center
Columbia University School of Social Work

Peer Providers
Peer Providers are individuals with mental health conditions who are hired by a social service agency as part of the treatment team because of their experience with the mental health care system.

Importance of Peer Positions
- Contribute to quality of care and individual recovery
- Add to overall workgroup productivity and performance
- Provide meaningful work option for individuals with mental health conditions

Study Overview I
- Qualitative, exploratory study to learn what works and what does not work
- Funded by the New York Community Trust
- Confidential interviews at 27 social service agencies with executive directors, HR representatives, supervisors and coworkers (93 total)
- Focus groups with peer providers

Challenges to Inclusion
- Poorly defined jobs - Unreasonable expectation of peer
  - Support to clients
  - Support to other staff
  - Administrative

Challenges to Inclusion
- Role conflict and confusion
  - Peer staff as service providers and recipients of service
  - Peer staff as service providers and friends of individuals served
  - Non-peer staff as co-workers and counselors to peers
Challenges to Inclusion

Lack of clarity around issues of confidentiality
- Conflicting expectations around disclosure
- No process for managed disclosure by peer providers
- Poorly defined process for informed consent from recipients of service
- Lack of communication between peer and non-peer staff around treatment goals

Challenges to Inclusion

Lack of opportunities for support
- Exclusion from orientation and training
- No process for accommodation
- No opportunities for mutual support

Challenges to Inclusion

Persistence of stigma among non-peer staff
- Peers cannot be effective workers
- Employers do not want to hire people with mental health conditions

Study Overview II

- Pilot test strategies to promote peer inclusion
- Funded by the Langeloth Foundation
- Formative evaluation and pre-test/post-test assessment of intervention impact
- Training and consultation at six agencies in New York City

Workplace Strategies

Define Peer Staff and Nonpeer Staff Jobs
- Develop written job descriptions
- Formalize opportunities to share job descriptions and gain a mutual understanding of who does what
- Implement strategies for learning what each others' jobs entail – monitoring and job shadowing
- Offer agency-wide in-service

Workplace Strategies

- Reduce role conflict and confusion
  - Standardize recruitment and hiring practices
  - Clarify policies regarding staff/client relationships
- Apply policies consistently to peer staff and nonpeer staff
Workplace Strategies

- Establish policies and procedures around issues of confidentiality
  - Negotiate expectations with respect to peer staff disclosure at the time of hire
  - Develop a disclosure process
  - Provide training on informed consent

- Ensure support
  - Provide regular, on-going supervision
  - Offer peer staff orientation
  - Identify and set in place appropriate accommodations
  - Connect with mutual support systems

Workplace Strategies

- Respond to stigma
  - Show of commitment to peer staff by leadership
  - Implement inclusive recruitment and hiring practices
  - Structure job to communicate the value of peer staff

- Implications
  - Provide training and education for management, peer staff and non-peer staff
  - Establish effective lines of communication
  - Review diversity policies and practices to include any group of difference can enhance inclusion of peer providers
Together WE Can!
A Peer Support Model to Build Social Capital and Improve Employment Outcomes among People with Psychiatric Disabilities in New York State

Presented by
Oscar Jimenez, MPH

The Strength of “Weak” Ties:

- Close relationships (e.g., family, close friends) are linked to better health outcomes and emotional health.
- Acquaintances or “weak” ties (e.g., friend of a friend) have been shown in several studies to impact employment outcomes.
- Contacts outside of one’s own social network can allow access to greater number and diversity of information, resources and job opportunities (Granovetter, 1973).
- “Bridging”: A “bridge” in a network can bring in valuable information and resources (Scott, 1991).
- If a network has individuals with influential or formal relationships to others outside the network, that network will have “bridges.”

Social capital and employment outcomes:

- Social relationships are fundamental in getting jobs, getting better jobs and keeping jobs (Putnam, 2000).
- Between 40% and 70% of people find their jobs through contact persons in their social networks (Putnam and Feldstein, 2000).
- A study found that applicants with internal referrals were 20 times more likely to get the job compared to those without such links (Fernandes and Weinberg, 1993).
- A classical study of the 70’s found that employers prefer to have trustworthy information about prospective employees (Granovetter, 1973).

Social capital and employment among people with psychiatric disabilities:

- High unemployment widely reported for people with psychiatric disabilities (16% to 87% unemployment (OMH, 2006, ACS, 2007).
- People with disabilities seeking jobs find employment through employment programs; many find opportunities through social networks (Putnam George, 2000), suggesting limited (or unidentified) social capital for employment seeking.
- Research and anecdotal evidence suggests that people with psychiatric disabilities have:
  - Formal networks (who know who)
  - Networks with high “strength” (most people know each other)
  - Few “weak” ties (few connections that are not part of their network).
- Networks with high “redundancy” have been shown to be less useful in finding employment (because everyone in the network has access to the same information) (Connelley, et al, 2008).

Human, economic, and social capital for employment outcomes:

- HUMAN CAPITAL: Vocational programs are critical in teaching “hard” or “soft” skills, as well as interviewing skills, “appropriate” dressing, etc.
- ECONOMIC/COSTAL: Vocational and other social programs provide key access to wrap-around economic and material supports (e.g., work incentives, transportation, housing, work attire).

The challenge of mental health and vocational programs to build social capital:

Adapted from Putnam definitions of human, cultural, and social capital (1995, 2000).
The challenge of mental health and vocational programs to build social capital

**Addressing Social Capital?**
- Most programs do little or no programming to help people with disabilities build and maintain social networks (Contini-Benacquista et al., 2009).
- Most programs do not ask employment seekers about their connections (ongoing or recent) in assessment/planning process (Peters & Greger, 2009).
- Most programs do not identify strategies to expand the social networks of employment seekers.
- Peer support initiatives may indirectly foster segregated peer environments.
  - Many relationship-based opportunities are not work-related or not work-related enough to foster work-related connections.
  - Linkages could be strengthened by creating social networks with others and not merely more people but also the kind of meaningful bonds leading to new information and resources essential for finding and maintaining a job.

The role of social Capital in employment

- Improvements in social capital (e.g., membership, quality of social resources, having a ‘buddy’ for those with the least human capital (e.g., education level)) produce very significant improvements in the probability of becoming employed (by 23%) (Peters, 2009).
- Social capital networks appear to be more important for employment outcomes among people with disabilities than the non-disabled population (Peters, 2009).
- Social and human capital are very much interrelated and intervention programs ought to address both.
- As one of the most disadvantaged population groups, PWPD could experience important improvements in employment and economic outcomes and overall quality of life.

Building Social Capital: Improving Employment Outcomes

**Social Capital:**
- Emotional and social networks
- Emotional and social support
- Emotional and social capital
- Emotional and social bonds
- Emotional and social well-being

**Human Capital:**
- Support networks, grades, opportunities for personal growth
- Health and well-being
- Employment opportunities
- Income
- Transportation
- Personal support networks
- Living arrangements
- Interpersonal skills
- Social capital

**Togetherness WE Can**

A Peer Support Model: Building Social Capital to Achieve Employment

Components of a peer-based intervention aimed at building social capital

**Roles of peer support for employment**
- **Narrative change:** e.g., from ‘I can’t’ to ‘I can’, from ‘I’m a loser’ to ‘I can accomplish my goals’
- **Emotional:** e.g., reducing anxiety, and enhancement of coping skills and maintaining a job
- **Instrumental:** e.g., applications, childcare, transportation
- **Information and linkages to employment connections and resources:** e.g., benefit assistance, work-related, job/volunteering opportunities

Peer Support in Facilitating Narrative Change

- Strengthening and broadening social networks
  - Facilitating the development of new relationships (lasting or short-term) beyond casual work connections and peers to increase opportunities for employment, volunteering, etc.
Peer support in narrative change: inspiration...
What motivated me was support groups, when I went through that really big depression I was actually in bed for two years... when I started to get better I started to go to support groups. And going to support groups, I saw other peoples psychiatric disabilities that were working, that were volunteering. And when I saw them, they were my role models and even though I had been out of work for two years they were my inspiration to get me back. They really got my juices flowing and helped me to look into work and volunteering. It was going to support groups and seeing other people that were working and volunteering that got me back into the same. (Tania)

Supporting narrative change:
Core Competencies

Peer networks in building hope and emotional support...
...I get hope from a lot of things but it is the help I get from my friends, my therapeutic groups, and I can’t do it alone so I hope that there’s somebody that can help me you know, but yeah it’s just a lot to regain hope but I do it through therapy and my groups. That’s cool and hopefully somebody will want to follow me and that keeps me in a positive mood, you know, so that’s it! ....(Danny)

Peer networks as instrumental support and inspiration
I have a peer who helped me write my resume with me; this peer has been so helpful at different times, never judgmental, but above all being with them through their lowest points and then watching their success has been a source of inspiration, and then being able to go to them for advice... (Nicole)

Peer networks as instrumental support
This is a certificate that I’m very proud to have. It took a lot of work for me to get. I had to use a lot of my supports through my therapy, my group even some of the students that I went to school with. Because I was 40 years old going back to school and everybody was younger than I was. I wasn’t embarrassed; I didn’t feel out of place because those young people know everything about a computer and they helped me... (Danny)
Peer networks as instrumental support

I have a ten year old son who's name is Antonio and he's a special needs child so it's very hard for me to get back to work eventually I couldn't afford to pay the bills by staying at home with him so I found a really good friend who decided to watch him and it did work out for a year a year and a half she did really well also baby sit him for me I was able to get the job (Kiana)

Peer Support in Strengthening and Broadening Social Networks

Components of peer support networks aimed at building social capital for employment

- **Community-based**: Meeting places outside of mental health services. Groups are not the only means of connection (one-on-one, via phone, email, informal gatherings, etc.).

- **Open systems**: Needs of individuals are greater than the resources of network. Peer facilitation not to be the role “helps” but to help facilitate social connections. Members are encouraged and supported to meet people outside of network (e.g., neighborhoods, relatives). Activities are designed to establish new relationships (e.g., “open house,” social gatherings, networking days).

Components of peer support networks aimed at building social capital for employment

- **No hierarchies**: All members have a role and opportunity to provide and receive support. Peer facilitators may have additional training and experience (as they are further along the process of employment and economic integration) but no authority. All network members have equal say in group process.

- **Self-determination and self-sustainability**: Training and support can be provided, but decisions ultimately depend on peer network. Sustainability must come from self-motivation of network members.

What can providers do to build social capital?

- **Awareness building**: Conduct seminars, forums, etc. to increase the awareness of people receiving services, providers, families, and advocates about the role of social capital in obtaining and maintaining employment.

- **Develop competencies**: Training providers to develop competencies for facilitating the building of relationships and social capital.

What can providers do to build social capital?

- **Person Centered Employment Planning**: Support a person centered planning process for each individual. Map the relationships and connections that can help each individual achieve their employment goals.

- **Engagement of families**: Engage families to promote their active role in improving the social capital available to individuals.
Social Capital and Peer Support: A Programmatic and Policy Agenda

- Bridging the gap to employment markets: Social capital and peer support can bridge the gap between people with psychiatric disabilities and mainstream employment markets and economy.
- Overcoming the service gap to maintain a job: Social capital and peer support can fill the service gap in employment services to maintain a job; a strong network in place after SEM services stop.
- From Micro to Macro: The Vocational Rehabilitation system must change from 'micro' to 'macro' approaches. Focus on individual's human capital (e.g., skills, competencies) must be complemented with strategies to build the social connections and community networks that can support long-term success.

Bibliography and resources


More information about peer employment support?

Oscar Jimenez, MPH
NTAPRS Director for Community and Economic Integration
518-456-0008, ext. 21
oscarj@ntaprs.org
We Can Go To School: Education, Careers, and Economic Prosperity for Individuals with Mental Illnesses

John S. Sosin, Ph.D.
Associate Professor and Director
University of Pennsylvania Collaborative on Community Integration and Development
Investigator, NIMH Mental Illness Research, Education, and Clinical Center
Philadelphia Veterans Affairs Medical Center

For more information, please visit www.spencer.org or e-mail us at Mark.Schoen@upenn.edu

Current Knowledge about Work
- Growing evidence and culture that persons with psychiatric disabilities —
  - Would work: consumer surveys show that work is a primary objective of 70% of those aged 18 and older
  - Could work: 99% of persons diagnosed with schizophrenia have worked. Research has shown that people can obtain work in the future
  - Should work: studies indicate positive effects of work (self-concept, self-mastery, and life satisfaction as well as on income and lifestyle)

Current Work Experiences
- 75-85% Unemployment
- Long-term financial dependence on entitlements
  - Poverty
- Work often obtained in secondary labor market
  - Low pay, short job tenure, limited benefits, limited career trajectory

What is one big factor that affects everyone’s occupational opportunities?

EDUCATION

Postsecondary Students with Mental Illnesses
- Good news — More students with mental illnesses enrolled in colleges and universities!
  - 1 institution in the Big Ten Conference saw an increase of 30% to 100% in the number of students served with psychiatric disabilities in a one-year period (Dessel, 1998)
- Bad news — 89% of students with mental illnesses withdraw from college prior to completing their degree (Kessler et al., 1995)
  - 42% withdrawal rate for the general student population (Kohn et al., 2006)

Educational Attainment
- Epidemiologic Catchment Area Study (Regier, & Rae, 1991)
  - 57.4% of persons diagnosed with schizophrenia graduated from high school
  - 4.8% went on to college graduation
- Early-onset of a psychiatric disorder has an adverse impact on educational attainment (National Comorbidity Study: Kessler, Foster, Saunders, & Stang, 1995)
- American Community Survey Data from 2007 (Erickson & Lee, 2008)
  - 95% of people with mental illness have a high school diploma vs. US Population average of 88%
  - 3.5% of people with mental illness have a bachelor’s degree or more vs. US Population average of 21%
Factors Affecting Withdrawal (Tinto, 1993)

- Relationship found between engagement and academic outcomes and retention (Kuh et al., 2008)

Campus Engagement and Satisfaction Questions
- College Student Experiences Questionnaire (CSEQ, Chao et al., 2001)
  - Satisfaction with Faculties
  - Academic Faculties (Use of resources to improve study on academic subject)
  - Class and Organization (Rarely or never meeting a campus club, organization, or staff)
  - Early Engagement (Have you attended any student engagement activities?)
  - CSEQ, Student perceptions of effectiveness of student, faculty, and administrative personnel in the institution

National Educational Survey
- 520 Respondents from 357 different institutions
  - 193 current students
  - 327 former students
  - 79% female; 89% White
  - Distress: 58% bipolar, 25% major depression, 10% schizophrenia spectrum
  - 75% taking psychiatric medications while at college

Engagement Results

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean (SD)</th>
<th>Mean (N)</th>
<th>T-value (p-value)</th>
<th>R/S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience with Faculty</td>
<td>71.77 (9.90)</td>
<td>21.55</td>
<td>71 (p&lt;.001)</td>
<td>.43</td>
</tr>
<tr>
<td>Campus Facilities</td>
<td>8.51 (4.00)</td>
<td>8.24</td>
<td>-0.37 (p&gt;.001)</td>
<td>.15</td>
</tr>
<tr>
<td>Clubs and Organizations</td>
<td>8.52 (4.00)</td>
<td>9.24</td>
<td>-0.37 (p&gt;.001)</td>
<td>.15</td>
</tr>
</tbody>
</table>

Satisfaction and Relationship Results

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean (SD)</th>
<th>Mean (N)</th>
<th>T-value (p-value)</th>
<th>R/S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction</td>
<td>5.00 (1.45)</td>
<td>6.11</td>
<td>-4.41 (p&lt;.001)</td>
<td>.29</td>
</tr>
<tr>
<td>Satisfaction with Students</td>
<td>4.13 (1.06)</td>
<td>5.65</td>
<td>-1.35 (p&lt;.001)</td>
<td>.29</td>
</tr>
<tr>
<td>Satisfaction with Administration</td>
<td>4.08 (1.70)</td>
<td>4.77</td>
<td>-0.37 (p&gt;.001)</td>
<td>.29</td>
</tr>
<tr>
<td>Satisfaction with Faculty</td>
<td>4.81 (1.71)</td>
<td>5.29</td>
<td>-0.34 (p&lt;.001)</td>
<td>.29</td>
</tr>
</tbody>
</table>

Perceived Discrimination and Engagement
- 133 out of 477 (28%) reported that they feel other students treat them differently because they have a mental illness
  - Most of the time
  - Some of the time

- 255 (49%) reported sometimes
  - Had much less satisfaction with their college
  - Had poorer relationships with faculty, administration, and especially other students

74
Anecdotal Evidence of Actions That May Further Limit Educational Attainment

- College/University Actions
  - Discouragement
  - Involuntary Withdrawal/Leave of Absence
    - NPR story (12/2/04):errar expelled for violating code of student conduct; was too caught help for suicidal thoughts
    - Coerced “Voluntary” Withdrawal/Leave of absence
    - Making re-enrollment a challenge
  - Ellyn Saks
  - Family member concerns about stress and lack of treatment and campus support

Strategies for Promoting Educational Opportunities

Applying Community Integration Principles to Promotion of Educational Opportunities

- CI Definition: “The opportunity to live in the community, and be valued for our talents and abilities, like everyone else.” (Salzer, 2005)
- Paradigm shift in view of disabilities
  - Individual Model of disability: “Disability is something inherent within an individual
  - Social Model of Disability: “Disability” results from a person-environment interaction that reduces opportunities for people to live life as everyone else
  - Reduce “disability” and increase opportunity by
    - Restricting and eliminating environmental barriers
    - Making individualized supports readily available

Strategies

- Supports
  - Assisting students in accessing accommodations
  - Supported Education
  - Circles of Support
- Addressing Barriers
  - Addressing discrimination on campuses
  - Addressing barriers within agencies

Current Students More Likely to Know and Seek Academic Accommodations

<table>
<thead>
<tr>
<th>Assignment Accommodations</th>
<th>Test that Accom. %</th>
<th>Very or Extremely Helpful %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedules generated in specific circumstances</td>
<td>9.4</td>
<td>75.9</td>
</tr>
<tr>
<td>Administration of assessments</td>
<td>14.3</td>
<td>66.7</td>
</tr>
<tr>
<td>Permission to submit assignments late</td>
<td>5.3</td>
<td>74.1</td>
</tr>
<tr>
<td>Written assignments turned in late, prearranged, or due later</td>
<td>7.1</td>
<td>73.0</td>
</tr>
<tr>
<td>Assignments completed in dynamic format (i.e. field trip)</td>
<td>8.3</td>
<td>61.0</td>
</tr>
<tr>
<td>Assignment instructions during investigation</td>
<td>6.1</td>
<td>61.6</td>
</tr>
<tr>
<td>Extended time to complete assignments</td>
<td>84.3</td>
<td>77.2</td>
</tr>
</tbody>
</table>
Raising Awareness of Rights and Accommodations

Many students do not know about the availability of accommodations and campus supports (30% in my survey).

- Students and faculty should be provided with information on campus resources and accommodations.
- Many students still do not use accommodations (60% in my survey).
- Data suggests that disability office staff are not knowledgeable about the types of support desired by students with psychiatric disabilities.
- Need to ensure that federal requirements are met for students with disabilities.
- Additional training and cooperation for faculty to provide effective supports.

Supported Education as an Essential Practice

1. Regular individual contacts with a supported education specialist.
2. Academic support services: accommodations, education, internships, skill building.
3. On-campus opportunities: research and internships, student government, support for emotional and mental health needs.
4. Additional training and support for faculty to provide effective supports.
5. Note-taking and note-taking aids for students with disabilities.

Supports

- Supported Education Programs
  - Mobile, mental health agency-based
  - Requirements:
    - 1:1-1:2 ratio
    - Approximately 160-200 for a 2 FTE program
    - Development of relationships with local colleges/universities
    - Support staff at local colleges/universities
  - College/University-based (UNC model)
  - Requirements:
    - Internships and support staff
    - Support for students with disabilities

Circles of Support Approach: To what extent was each support valuable in your academic experience?

<table>
<thead>
<tr>
<th>Support</th>
<th>% Very/Extremely Valuable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>36%</td>
</tr>
<tr>
<td>Friends</td>
<td>33%</td>
</tr>
<tr>
<td>Teacher/Professor</td>
<td>33%</td>
</tr>
<tr>
<td>Psychologist/Psychiatrist</td>
<td>38%</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>13%</td>
</tr>
<tr>
<td>On-campus MH services</td>
<td>14%</td>
</tr>
</tbody>
</table>

Notes on the diagram and text:
Addressing Barriers

- Prejudice and discrimination on college campuses
  - About 30% don’t seek accommodations due to this fear and almost 40% report challenges when obtaining them
  - Involuntary withdrawals and other actions may drive students away from seeking supports
  - Students not admitted if they disclose having a mental illness
    - Barlow and Malin’s Education Policy (http://www.barlowmalin.org/pdf/supportingstudents.pdf)
    - Support development of student organizations promoting full inclusion of students with psychiatric disabilities (e.g., Active Minds)
    - Student- and faculty advocacy organizations to address discrimination and change policies

Addressing Barriers

- Colleges weary of doing too much to support students with psychiatric disabilities
  - Fear of the need to water down curriculum
  - Noncompliance
  - Fear of attracting more students with psychiatric disabilities thereby requiring even more support resources
    - Already on campus, in classroom
    - Less costly to adopt a preventive approach that involves a broad range of supports from norms of inclusive practices and campus disruptions
    - Having students with psychiatric disabilities (and other disabilities) is morally and ethically responsible

Addressing Barriers

- Mental health providers lack of encouragement or active discouragement
  - Creating a “Supporting Care for all” environment
  - Use of segregated educational approaches (e.g., closed classrooms)
    - Adapting social inclusion orientation involving engaging persons in mainstream postsecondary settings
  - Education viewed as a hobby/leisure activity
    - Promoting the pursuit of courses that lead to degrees in meaningful, self-determined career areas as an attainable and desirable activity
Growing and Sustaining Recovery Centers

What are Recovery Centers
- Focus on community integration as outcome
- Built on framework of self-help / peer support groups
- Member run

Historical Self-help Services
- Drop-in Centers
- AA / NA / DTR / Substance Abuse groups
- Support for advanced directives, WRAP plans
- Individual advocacy and advocacy training
- Benefits advocacy
- Career club / employment groups
- Clothes Closet

Historical Self-help Services cont.
- Community Meals / kitchen
- Computers / internet access
- Crisis support / warm lines
- Food pantry / nutritional assistance
- Forensic support / jail diversion activities
- Housing and housing assistance
- Laundry

Historical Self-help Services cont.
- Lending library on recovery
- Literacy education support groups
- Mail services
- Newsletters
- Parenting support
- Peer support
- Rep payee services / money management support

Historical Self-help Services cont.
- Speakers Bureau
- Social Recreation Events
- Support groups
- Psycho-education / illness self management education
- Volunteer Referral
Recovery Center Services

- Will be designed with extensive stakeholder / peer advisory process
- Will provide peer supports and role modeling to further recovery / wellness self-management
- Will support individuals to maximize their ability to use existing community supports
- Will focus on community integration

Conceptual Framework

- Recovery centers are businesses
- If recovery centers are to be sustained then they must address not only services people value and want but infrastructure as well

Key Elements of Successful, Sustainable Recovery Centers

- Recovery Centers need to consider:
  - Incorporating an entrepreneurial mindset
  - Policies that ensure that their practices are consistent with their Mission
  - Strengthening internal operations
  - Improving management practices
  - Developing human resources policies and practices
  - Strategies for partnering and leveraging resources
  - Improving internal and external communications and marketing infrastructure

Rationale

- While developing organizational infrastructure is important for peer support programs, helping peers to see that and in that include a sustainable or improve their marketing systems is also essential.
- This not only ensures peer support become a core to their organization, but also to their colleagues in the peer support community and funding sources.
- In addition, peer organizations come in all sizes and with all levels of sophistication.
- This creates a tremendous and valuable resources diversity that exists currently and must be leveraged.
- Although there has been little research on organizing, presenting and disseminating these resources to achieve such change in the policy advocacy, program development and individual right and services levels, these organizations need access to organizing, training and technical assistance programs that will ensure their leadership and volunteers in their organization do better at their jobs.

Support Center Activities: Understand the Organizational and Fiscal Infrastructure of Peer and Family Support Centers

- Assess the current need for management, organizational and fiscal development training and technical assistance across all 300 peer and family support organizations by:
  - Working with peer leaders to gather information about needs and gaps

Activity Two: Develop Training, Technical Assistance and Monitoring Plans that Address the Organizational and Fiscal Infrastructure Needs of Recovery Centers

- Design customized on and off-site training and technical assistance packages.
- Training and TA plans will be developed jointly with Recovery Center Leaders, drawing upon general information obtained through information-gathering and information that is specific to the Centers.
- In each succeeding year the project will engage additional new Recovery Centers in training and TA while providing follow-up support.
Activity Three: Implement Training, Technical Assistance and Monitoring Plans that Address the Organizational and Fiscal Infrastructure Needs of Recovery Centers

- Deploy expert trainers/mentors to conduct on-site group trainings throughout the state with each Recovery Center at regional locations with follow-along support for post-training implementation.
- Conduct webinars and teleconference training and informational sessions to augment on-site work.

Needs and Potential Sources of Expertise

- Developing organizational infrastructure
  - Will manage an extensive portfolio of research, policy guidance, training, and technical assistance projects throughout the United States.
  - Will expand their ability to provide organizational development services and support organizations develop their capacity to bring their missions to market.

- Incorporating an entrepreneurial mindset
  - Will develop a broader range of entrepreneurial training programs and services for organizations.

- Developing marketing, communications and distance learning systems
  - The School of Information Studies at Syracuse University is one of the nation’s leading schools in information science.

Final Points

- Project anticipated to begin June 2009.
- Once underway, we will develop an on-line ‘Updates’ page so Peer and Family Support organizations can track progress.
- Questions???
Peer-run Services: A Model That Works

Joseph A. Rogers, Executive Director
National Mental Health Consumers' Self-Help Clearinghouse
1211 Chestnut St., 11th Floor, Phila., PA 19107
800-653-4529, ext. 370; nymhcs.org
NYAPRS 5th Annual Executive Seminar on Systems Transformation
April 23-24, 2009

Peer-Support Services . . .

- ... provide an opportunity for consumers who have significantly recovered from their illness to assist others in the recovery process . . . by teaching one another the skills necessary to lead meaningful lives in the community . . .
- Peer support services are part of the array of services necessary for a culturally competent, recovery-based mental health and substance abuse system.

Mental Health America Position Statement 17

On Our Own

Judi Chamberlin’s seminal 1973 book about “Parent-Compiled Alternatives to the Mental Health System” galvanized the self-help and advocacy movement.

Peers, run Services: a Component of SAMHSA’s National Consensus Statement on Mental Health Recovery

- “Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and support other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.”

Movement Values

- Control
- Choice
- Self-determination
- Empowerment
- Recovery

“We want as full as possible control over our own lives. Is that too much to ask?”

—Howie the Harp
1953-1996
Paradigm Shift:
Establishment believes in recovery and accepts value of peer support


Models of Peer-run Services (1)

- Drop-in centers: a safe haven for peers to combat isolation and loneliness, meet others and participate in social, educational and vocational activities.
- Crisis diversion: warm, home-like environments, in contrast to the sterile and institutional locked inpatient hospital unit. Peers can learn to manage stress and find compassion and understanding from a trained peer staff, as well as learn new skills to cope and prevent relapse, such as WRAP.

Models of Peer-run Services (2)

- Advocacy services: helps peers become more aware of mental health policies and issues, and encourages them to become more involved in planning and delivering mental health services and developing mental health policy.
- Employment: helps peers obtain and keep jobs.
- Peer Bridge: helps ease the transition from the hospital into community life and to significantly decrease people's need for readmission.
- National Technical Assistance Centers
- Other models . . .

COSP Study

- Consumer-Operated Services Program Multisite Research Initiative: a federally funded four-year study to determine effectiveness of consumer-operated programs as an adjunct to traditional mental health services in improving outcomes of people with serious mental illnesses.
- More than 2,200 racially and ethnically diverse consumers participated.

COSP Sites:

- Pennsylvania site: Friends Connection of MHASP: a mobile psychiatric rehabilitation program that provides one-to-one peer support counseling and "clean and sober" recreation and leisure-time activities for individuals with co-occurring disorders (mental illness and substance abuse).

Innovations 2009

"Uniting Our Movement: For Change"

Hilton Omaha . . . Omaha, Nebraska
October 28, 2009 – November 1, 2009
More information:
We Can Parent!

Katy Kaplan, M.S.Ed., Coordinator
UPENN Collaborative on Community Integration
www.upennnrc.org
kathyknap@mail.med.upenn.edu

Parents with Psychiatric Disabilities can Parent Well

- My Dad's story:
  - Strong support network
  - Appropriate treatment/services
  - Environment that promoted resiliency

Importance of Keeping Families Together

- The world of out of home placement:
  - Trauma of removal for parent and child
  - Family is replaced by staff and other children that often have emotional problems
  - Children on the margin of removal do better with birth parents (Doyle, 2007)

National Statistics on Parenting with a Psychiatric Disorder

Lifetime prevalence of psychiatric disorders

- 46.8% of mothers
- 29.5% of fathers

Lifetime prevalence of affective disorders

- 25.7% of mothers
- 14.7% of fathers

National Statistics on Parenting with a Psychiatric Disorder

Lifetime Prevalence of anxiety disorders

- 32.4% of mothers
- 20.3% of fathers

Lifetime Prevalence of post-traumatic stress disorder

- 11.3% of mothers
- 5.6% of fathers

Psychiatric Disability as Grounds for Termination of Parental Rights

- Only 14 states do not allow a parent's disability to be used as grounds for TPR
- Specific grounds used for TPR by disability:
  - 36 states use a mental illness
  - 32 states use an intellectual/developmental disability
  - 18 states use an emotional disability
  - 8 states use a physical disability

Lightfoot & Lafferty, 2008
New York State
Grounds for terminating parental rights:
1. Abandonment
2. Permanent neglect
3. Severe and repeated abuse
4. The parents are presently and for the foreseeable future unable, by reason of mental illness or mental retardation, to provide proper and adequate care for a child who has been in the care of an authorized agency for a period of one year.

A Mental Health Diagnosis is NOT a Primary Cause of Abuse or Neglect
- 2 leading risk factors:
  - Poverty
  - Unemployment
- Typically considered at risk when multiple factors are in place
- Selection Bias
- Stigma and Discrimination

Outcomes for Children Removed from Birth Parents
- Children on the margin of placement tend to have better outcomes when they remain at home, especially for older children
- Large gains for children placed in foster care are unlikely
- Children removed from parents experienced:
  - An increase in teen birth rates
  - Higher rates of delinquency
  - Lower earnings
  - Higher unemployment

Failure to Address the Specific Needs of Parents with a Mental Illness
- Nicholson et al., 2002 conducted a survey of State Mental Health Program Directors
  - Less than 25% of states formally identify their clients as parents
  - Just over 25% have services/programs designed for adult clients that are parents
  - Only eight percent have written policies or practice guidelines regarding their adult clients who are parents

Parenting Resources
- UPENN Collaborative Resources for Parents
  http://www.upenn.edu/kidsresources/index.php?tool_id=120
- MHANY’s Parents with Psychiatric Disabilities Initiative
  http://www.mhany.org/parentsindex.htm
- Through the Looking Glass
  http://lookingglasse.org/index.php
- Training and Education Center (TEC) at MHASP
  Contact: Edie Mierkow (215) 791-1900 x233 emierkow@mhasp.org
Parenting with Psychiatric Disabilities

Lorraine McNulty
Mental Health Association in New York State, Inc
NYSARS Conference
Ellenville, NY
September 18, 2009

Parents with Psychiatric Disabilities Initiative

- Started in 1993.
- Funded by Office of Mental Health (OMH)
- Raises awareness of parenting strengths & issues
- Resources & referrals to parents, their families, providers, lawyers
- Provides trainings & resource materials
- Identifies service gaps

National Statistics on Parenting with Psychiatric Disorders

- Lifetime prevalence of psychiatric disorders
  - 46.8% of mothers
  - 29.5% of fathers
- Affective Disorders
  - 25.7% of mothers
  - 14.7% of fathers
(Nicholson et al., 2004)

National Statistics on Parenting with Psychiatric Disorders

- Lifetime Prevalence of Anxiety Disorders
  - 32.4% of mothers
  - 20.3% of fathers
- Meet criteria of Post-Traumatic Stress Disorder
  - 11.3% of mothers
  - 5.8% of fathers
(Nicholson et al., 2004)

National Statistics on Loss of Custody

Custody loss rates for parents with mental illness are 70% - 80%.
(Burton, 2002)

New York State

Four grounds for permanently terminating parental rights:
- Abandonment:
- Permanent neglect
- Severe and repeated abuse
- The parents are presently and for the foreseeable future unable, by reason of mental illness or mental retardation, to provide proper and adequate care for a child who has been in the care of an authorized agency for a period of one year.
Termination of Parental Rights
- Termination of parental rights is a drastic, permanent measure, severing forever that parent’s right to be a part of his or her child’s life.
- It is considered the jurisprudential equivalent of capital punishment in the criminal area because it constitutes the legal death of the relationship between that parent and child.

Public Policy
- Statute is destructive because parents are afraid to seek treatment for fear of losing their children & children are removed from families where there is no abuse or neglect.
- Case law has upheld diligent efforts to keep families together and provide services do not need to be provided once a parent is identified with a psychological diagnosis, mental health issue, or mental deficiency.

Outcomes for Children Removed from Families
- Removing cases of obvious neglect and abuse, children on the margin of placement tend to have better outcomes when they remain at home, especially for older children.
- Large gains from foster placement are unlikely for the group of children at the margin of placement.
  (Doyle, 2007)

Supporting Parents with Psychiatric Disabilities
- Newly funded through OPMH based on advocacy of parents & organizations
- Grant written with the input of parents across the state
- Will expand work in terms of knowledge, education, policy, research & direct supports to parents and their families throughout New York State
- MHANYS working with The Institute for Community Research & Training at College of Rose and NYAPRS

Goals of Project
- Identify Best Practices
- Developing model policies
- Identifying technical assistance needs of mental health organizations
- Develop technical assistance addressing needs
- Provide training & support to ensure agencies are providing promising & best practices which promote positive outcomes for parents

Project Structure
- Advisory Panel of parents with psychiatric disabilities
- Working Groups on 13 issues impacting parents and their children
- Self-Advocacy Guide for Parents
- Toolkit on data collection for agencies
- Training curriculums
Project Structure
- Training & support to over 30 consumer-run & agency sponsored organizations to:
  - Support parents & their children
  - Use trauma-informed care
  - Run peer-led Parent Support Groups
  - Provide trauma recovery and empowerment training
  - WRAP training

Resources in New York State
- Parents with Psychiatric Disabilities Initiative
  [www.mhanys.org/pwad]
- Parents with Psychiatric Disabilities Legal Advocacy (PPLA) Project
  [www.cccapd.state.ny.us/Advocacy/advocacy.htm#ppla]

National Resources
- Mental Health America [www.mhala.org]
- UPENN Collaborative Resources for Parents [www.upennnrc.org/resources]
- Through the Looking Glass [www.lookingglass.org/parents]
- Bazelon Center for Mental Health Law [www.bazelon.org/issues/advancedirectives/index.htm]

Basic Support
- Tools that are helpful for parents:
  - Advance Psychiatric Directives [www.bazelon.org/issues/advancedirectives]
  - WRAP [www.mentalhealthrecovery.com]
  - Wellness Self Management Skills [www.omh.state.ny.us/omhweb/wellness]
  - Parent and peer support groups or mentors

Contact Information
Lorraine McMullin
Parents with Psychiatric Disabilities Initiative Director
Building Connections: Sexual Assault and Mental Health Project Co-Director
Mental Health Association in New York State, Inc.
518-434-0439, ext. 211
800-766-6177
[mcmullin@mhanys.org]
[www.mhanys.org]
Service Needs and Desired Supports For Parents with a Psychiatric Disability

NYAPRS 8th Annual Executive Seminar on Systems Transformation
April 23 & 24, 2009
Elizabeth R. Sloan, MA, CASAC-B
NYAPRS Coalition

WE Can Parent!

Rosemary – family adoption

Everyone was against me — I was prepared to agree to the adoption.

Wished for parenting groups & some assistance in taking care of her son so that he could have stayed living with her.

I don’t live with my parents or my son. I had no influence as a parent.

Wished her mother’s siblings would recognize that she is a mother and ask about how her son is.

Today Rosemary has a good relationship with her 26-year-old son, he lives in a CMHC and visits her on weekends.

Don – out of state custody battle

After a hospitalization, my wife wouldn’t pick me up. I couldn’t be released without my parents coming for me and taking me back to NY.

Wished to consult a lawyer from a spouse to help both parents get information about parenting.

After going to court I was able to get visitation rights to see my daughter.

Wished for: connections with people who have been through the system & more support for the rights of fathers.

Don hasn’t seen his daughter in over 2 years. He continues to advocate for parents’ rights.

Latoya – living in the community with supports

I have been working, supporting my family until the birth of my second son.

Wished her mother had been supportive of her parenting and had respected her for attending counseling.

I separated from my abusive husband and moved in with my mother. I had postpartum depression.

After getting Section 8, I was able to move out on my own with my two sons. I’m receiving support from social services.

Wishes for: support groups with moms, former patients, and early intervention services for her son.

Latoya is moving into a new apartment with her 2 sons and is attending a PAKS program. She is appealing the decision on her SSI.
Elizabeth R. Stone, MA, CAS,Ct

Long Island Recovery Facilitation Consultant
NYAPS Collective
Rocky Point
516-729-1936