

July 2010

## Commissioner's Update



### Thoughts about Change, Recovery and "Woodshedding"

*by Michael F. Hogan, Ph.D., OMH Commissioner*

During these long hot days, it seems that things slow down. We are in the middle of Summer vacations, and awaiting Fall elections. In New York's mental health system, regulations to advance long-planned improvements in outpatient clinic care have been finalized, with implementation set for 2010. The Legislature is--or might be, if they finish the budget--adjourned. Conferences and meetings are few and far between during the Summer. So it seems that much of our attention could be focused on waiting: for others to start acting, for things to happen, for timelines to be reached.

Of course the most important work in the system goes on without reference to these external events: the personal work of recovery, the professional tasks of treatment and rehabilitation, and the challenges that come with health and mental health crises and opportunities. This "real work" goes on according to its own schedules, and has remarkably little to do with the rhythms of government.

Of course, we can note a similar pattern in the relationship between the patterns of formal treatment (scheduled appointments or sessions, program schedules) and the lives of people who rely on or use the system. It might be said that the "real work" of recovery, resiliency and coping with life's challenges goes on in a way that is only semi-connected to the apparatus of treatment...except for those moments of insight, learning and change that happen during treatment.

Yale psychiatrist John Strauss, M.D., who I think of as a "godfather" of what has now become a recovery movement, learned about recovery from his patients. In many conversations and in fact in piecing together the meaning of how people responded to and recovered from illness, Dr. Strauss learned a lesson that still eludes many of us. The process of change is highly individual, but it also has patterns. Change occurs from the inside out as well as from the outside in (as in the old joke: "how many therapists does it take to change a light bulb?"..."One. But the light bulb has to want to change."

In describing some of the patterns of personal change/recovery, Dr. Strauss cited one pattern he termed "woodshedding." (I would provide a citation, but I recall this only from presentations and

conversations years ago.) The pattern involves someone for whom an external view would indicate little change is going on, but for whom, under the surface, a tremendous amount of work is going on ...thinking through problems, adjusting to recent changes, and getting ready perhaps for a spurt of activity. Dr. Strauss used the term "woodshedding" to describe this activity, in a nod to jazz musicians who would play in private--in the shed--until the new repertoire was ready to "go on the road."

Early thinking about recovery was illuminated by ideas like this. Our frame of reference has begun to change from a model of simply dispensing change to an awareness of how we can facilitate it. We need the same change in our thinking about systems and organizations ...less of a focus on top down, and more of an orientation toward how to take advantage of opportunities in the environment; and toward how to solve problems without waiting for direction.

May you have a terrific Summer - with good "woodshedding!"

## **Medical Updates**



### **What's Your Attitude Toward Mental Illness?**

by Lloyd I. Sederer, M.D., OMH Clinical Director

What would you say to a survey that asked two questions:

- 1) Can treatment help people with mental illness lead normal lives?
- 2) Are people generally caring and sympathetic to people with mental illness? And would your answers differ if you suffered from a mental illness?

Those were the questions that the Centers for Disease Control and Prevention (CDC) asked over 200,000 adults in 35 states, the District of Columbia and Puerto Rico. The answers, which are the first state-specific reports of attitudes toward mental illness, appeared in the CDC Weekly Report of May 28, 2010 and were reported in collaboration with The Carter Center and the Federal Substance Abuse Mental Health Services Administration (SAMHSA), as well as other mental health advocates.

Whether you have or don't have significant emotional distress (a proxy for mental illness) this survey indicates that you almost always believe that treatment can help (78 percent of those with emotional distress and 89 percent of those without felt that way). This surprised me, since so many people tend to disparage psychiatric treatments, and even more don't go for care that when effectively delivered can do a lot for a lot of people (not just according to what people think but

according to many studies on the effectiveness of treatments for mental disorders).

But when it comes to whether others are "caring and sympathetic" the report reveals a striking difference that is not reassuring for either group. About 57 percent of those who do not suffer from a mental disorder think that others will be kind but *only 25 percent* -- one in four -- of those who suffer with significant emotional distress think that others are caring and sympathetic. Not only are these individuals ill, they believe that the world around them cares little about them. This is not a good combination. It is hard enough to suffer with a mental disorder but to think that you are disparaged and stigmatized adds to suffering and undermines hope.

In the USA, less than 20 percent of people with a mental disorder get properly diagnosed and effectively treated! This is an alarming statistic in light of the great prevalence of mental disorders (more than 20 percent of adults are affected annually). General medical care clocks in at about 55 percent receiving effective treatment -- not so great, but almost three times better than their psychiatric brethren. The implications are what are so worrisome.

If you think you can be helped but fear how others will react to your problems, you are apt to try to hide and not put yourself in the open and dependent position of seeking help. Or if you do seek help, your engagement and commitment to treatment is precarious because of the powerful urge to run away from a shameful situation or one that puts burden on your loved ones. You may even believe that caregivers are not care giving or sympathetic, mere workers doing their hours to get paid. Avoiding care is all the more painful since the CDC study documents that you are apt to believe that treatment works -- but cannot bear the stigma associated with undergoing it.

The CDC study indicates that attitudes are improving, at least that people are more apt to believe that mental health treatment works. The public education campaigns and celebrity spokespeople may be making a difference, as may the direct to consumer (DTC) ads from pharmaceutical companies that barrage us on television and in print media. Interestingly, in the CDC study those with more education were more hopeful about treatment, perhaps supporting the impact of educational campaigns (at least with this segment of the population). But we still have a lot more work to do.

I loved the [RU-OK media campaign](#) in Australia done last year, its simplicity and caring are wonderful. All you need to do is turn to someone else you think is in distress and ask, "Are you OK?" (Hence, *RU-OK?*)

Not only is that a thoughtful act, it gives all of us a simple script for overcoming our reserve about asking -- our reserve being a contributor to stigma since we tend to distort what we don't know and what we feel little control over. In this country, the Federal mental health agency, [SAMHSA has an internet site](#) to help people understand and respond to mental illness.

The good news is that mental health treatments have been proven to work. And people, whether ill or not, believe that to be true! Imagine how many more lives will be improved if we focused more effort on beating stigma, making mental health systems more accountable, coordinated and collaborative, and making every encounter with a person with mental illness one of respect and consideration for *what they want in life*. When the CDC surveys again it would be good to see how we are doing against all those measures.

*This column originally appeared in the June 21, 2010 Huffington Post.*

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## Planning Quality Services



## Statewide Plan Public Hearing Set for August 24

*from the OMH Office of Planning*

The development of this year's *Statewide Comprehensive Plan*, known as the 5.07 Plan, is under way. The *Plan* will continue to tap into the experiences of individuals and families engaged in treatment and services and serve as a foundation for transforming care. It will do this by providing glimpses of the positive influence that traditional mental health and nontraditional agencies, programs and organizations throughout the State are having on the lives adults, children, and families who are engaged in mental health services and supports. As with last year's stories of individuals who are on the road to recovery, the *Plan* to be published in October seeks to highlight a number of programs and agencies that are passionate about helping others and inspiring positive change.

Along with development of the *Plan*, OMH will also be following the same format for its annual "public hearing" process. For efficiency and to balance local and statewide perspectives, this year's hearing will be hosted by Commissioner Hogan via videoconference. The videoconference will link three regional sessions to be held in New York City, Albany, and Syracuse on Tuesday, August 24, from 1:00 pm to 3:00 pm. The goal is to allow for conversation and dialogue about the challenges and opportunities we face, providing a kind of statewide "town hall meeting" about the needs, strengths and possibilities that exist in New York in these very challenging times. Please read more about the public hearing on the OMH web site.

## Providing Quality Services



[Enlarge](#)

### Therapy Dog a Welcome Addition to Western NY Children's PC *from the Office of Quality Management*

What is soft, warm, and great to cuddle? A body pillow would be a good guess.

But if you asked the children at Western New York Children's Psychiatric Center (WNYCP), they would answer, "Tommy." As part of the federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant to reduce the use of restraints and create a coercion free treatment setting, WNYCPC introduced Tommy, a therapy dog, into the environment. This silky, white poodle with long fluffy ears spends time on all the units where he gets a two thumbs up from both the youngsters and the staff. For some children, one-on-one time with Tommy is part of their treatment.

WNYCPC has provided guidance to staff and the children in the form of an infection control policy that deals with the care and handling of pets. The policy addresses the need to ensure the children do not have allergies to the dog and that they are taught to wash their hands or use hand sanitizer after playing with the dog. The dog must be current with all immunizations, well groomed and kept on a leash. The Joint Commission's article, "When Comfort Has a Cold Nose" published in the December 09 *Environment of Care News* was an aid in allaying any hesitancy in introducing a therapy dog.

Judging from the notes from the youngest children, their enthusiasm was immediate and profuse. [The children's names have been changed to protect confidentiality.]

Tony drew a picture of himself playing with Tommy and wrote: "I like the way Tommy does tricks. I like to cuddle with Tommy. It makes me happy. I have played with Tommy outside. It was fun."

Michael drew a picture of himself walking with Tommy and wrote: "I like to throw the ball to Tommy. I like to run with Tommy. I like to cuddle with Tommy."

Adam wrote simply, "I love Tommy. I like when I take Tommy for a walk. I like to feed Tommy. Tommy is soft."

Erin, an older child, went to the computer to express her thoughts as she wrote, "Tommy is a cool loving dog. He knows how to play. He is a therapy dog that loves people. He is soft and cuddly. He is caring to other people. He is a sweet therapy dog. Thank you for giving us Tommy."

Tommy is teaching the children at WNYCPC a fundamental life lesson: Everyone needs to be cared for and everyone needs to care for the other--all while he quickens their hearts, calms their minds, and leaves them grinning.

**Fiscally Speaking**

**Update on OMH's 2010/11 Preliminary Enacted Budget**

*submitted by the Office of Financial Management*

2010/11 OMH Preliminary Enacted Budget Changes from Executive w/ 21-Day Amendment to Preliminary Enacted			
All Governmental Funds			
	State Operations	Aid to Localities	Capital
Executive Recommendation	\$2,037,688,000	\$1,229,910,000	\$329,464,000
Net Legislative Changes*	+\$1,000,000	(\$5,000,000)	\$0
Enacted	\$2,038,688,000	\$1,224,910,000	\$329,464,000

Note: These highlights do not reflect Financial Plan cash spending adjustments related to the 2010-11 Retirement Incentive Plan.

The Office of Mental Health's (OMH) 2010/11 Budget is in place with the recent passage of the Health/Mental Hygiene appropriation bills and Article VII legislation. While these budget bills represent OMH's spending authority for the 2010/11 Budget, the State's overall budget is considered incomplete until there is action on a final revenue bill which is needed to balance the budget. Furthermore, the Governor is proposing the inclusion of a contingency plan to address the potential budget gap in the event the Federal government fails to extend the enhanced Federal Medical Assistance Percentages (FMAP). The contingency plan would require a uniform reduction in undisbursed State agency appropriations to achieve a maximum savings of approximately \$1 billion. OMH will keep all mental health stakeholders apprised of any budget changes in the event of further reductions.

**State Operations**

The 2010/11 Budget for the OMH's State Operations balances the competing challenges of achieving savings in response to fiscal conditions while ensuring that mental health obligations continue to be met. The year-to-year growth in State Operations funding

supports OMH's network of psychiatric health care settings which are required to meet national accreditation standards set by The Joint Commission and the Centers for Medicare and Medicaid Services. This accreditation is necessary for maintaining about \$1.2 billion in patient revenue streams to the State. These State operated hospitals are the safety net for people with complex and severe psychiatric illnesses who have not been stabilized in other settings. While significant savings have been identified in the budget development process, the net growth in spending is attributed to maintaining quality of care standards for this vulnerable population. Growth supports negotiated salary increases and related general state charges and modest inflation for energy and pharmacy.

## **Legislative Changes**

OMH's State Operations available cash in the 2010/11 Budget reflects an increase of \$1 million from the Executive Recommendation due to the Legislature's rejection of an Article VII proposal which would have enhanced the use of video-conferencing for certain Sex Offender Management and Treatment Act judicial proceedings.

Other Article VII bills that were either accepted or modified by the Legislature include the following:

- Changing the due date of a legislative mandate that the OMH study, evaluate, and report on unmet mental health service needs for traditionally underserved populations to October 1, 2011.
- Clarifying that OMH Facility Directors acting as Representative Payees may continue to use funds for the cost of a resident's care and treatment consistent with federal law and regulations. Furthermore, the Facility Director is authorized to place funds in excess of the appropriate eligibility level into a Qualifying Medicaid Exception Trust.
- Authorizing the reduction of adult inpatient capacity and/or the conversion of inpatient wards to Transitional Placement Programs (TPP), and the extension of the Community Mental Health Support and Workforce Reinvestment Program through March 31, 2013.
- The Legislature also accepted the Executive proposal to repeal the requirements for two annual reports: Capital Plan for the future uses of all state mental health facilities and a long-term plan for state employee utilization.

## **Accepted Executive Proposals**

Furthermore, the 2010/11 Budget accepted the proposals in the Executive Budget as follows:

- Implementing ward efficiencies through the reduction and/or conversion of Adult inpatient beds to the Transitional Placement Program (TPP). (-\$9 million)
- Implementing various initiatives to enhance operating efficiencies. (-\$31.7 million)
- Annualizing prior year initiatives. (+\$18 million)
- Funding for negotiated salary increases, salary increases for State employees not yet at the job rate and other salary-related adjustments. (+\$79.7 million)
- Supporting restored energy, pharmacy and medical expenses. (+\$21.8 million).
- Growth related to fringe benefit and indirect rate adjustments and Civil Service chargeback costs for non-general fund positions. (+\$57.9 million)
- Adjusting recognize Civil Service Chargeback costs for non-general fund positions. (+\$3.9 million).
- Supporting grant awards received by certain NYC-area psychiatric centers participating in New York City's Healthcare Emergency Preparedness Program. (+\$0.3 million)
- Supporting an estimated 16,169 FTE at the end of Fiscal Year 2010/11, reflecting a net budgeted reduction of 128 authorized FTE from March 31, 2010.
- Supporting 3,380 Adult inpatient beds, 538 Children & Youth (C&Y) inpatient beds, 715 Forensic inpatient beds and a projected SOMTA census of 230.

For additional information on these proposals, please see the [2010/11 Executive Budget Recommendation Highlights: State Operations](#).

### **Aid to Localities**

Community mental health services supported by Aid to Localities funding in the 2010/11 Budget are engaged in sweeping changes to reorient programs toward recovery and resiliency, provide sustainable funding models, and make care more consumer and family driven. The Budget accomplishes these changes while dramatically reducing the rate of growth in spending by promoting efficiencies in certain high cost services and by deferring new spending commitments until they are affordable.

Major themes of reform advanced in this budget include:

- Continuing Ambulatory Restructuring to expand access to outpatient clinic treatment, and support implementation of the new Ambulatory Patient Group (APG) rate methodology to rationalize reimbursement and ensure consistency with federal requirements.
- Restructuring existing services for the implementation of the Children's Plan including: redesigning base resources for Clinic Plus services to improve clinical and operational functioning of children's clinic treatment; and redirecting under-utilized resources for residential units to expand community capacity (including Home and Community Based Waiver Services) to serve children and their families at home.
- Continuing commitments to expand capacity for the peer support movement and improve employment opportunities for individuals with disabilities. This budget annualizes funding to support the Peer Recovery, Technical Assistance and Resource Center, as well as includes an additional \$6 million in funding for a second federal grant awarded to New York for continuation of the New York Makes Work Pay program.
- Advancing a multi-year remedial plan in response to a federal court ruling in the Adult Home litigation to begin assessments and expand supported housing capacity for individuals leaving adult homes.

## **Legislative Changes**

OMH's Aid to Localities available cash in the 2010/11 Budget reflects a decrease of \$5 million from the Executive Recommendation for:

- Delays in conversions to the new Personalized Recovery Oriented Services (PROS) program model. This will not impact funding for programs that are already operating. (-\$2 million)
- Delays in the development of new residential beds. (-\$3 million)

Other Article VII bills that were either modified or rejected by the Legislature include the following:

- Two bills (S.5921-A and a Chapter Amendment A.11440) extended the current social worker and mental health professional licensing exemptions for OMH and community mental health providers for three years through July 1, 2013. These bills include specific reporting requirements for State agencies and the State Education Department (SED) including a final report to the Governor and Legislature with recommendations regarding amendments or regulatory

changes

## Accepted Executive Proposals

Furthermore, the 2010/11 Budget accepted the proposals in the Executive Budget as follows:

- Maximize recoveries including State aid close-outs and overpayments for comprehensive outpatient programs. (-\$15 million)
- Recovery of exempt income for residential programs. (-\$4.5 million)
- Carving-out prescription drug reimbursement from the rate methodology for Residential Treatment Facilities (RTF) for Children and Youth to improve access to care and generate savings for Medicaid rebates. (-\$0.4 million)
- Annualization of cost savings measures initiated in the current year and eliminating the enhanced Unified Services funding differential for five counties. (-\$1.5 million)
- Reinvestment to support a proposed multi-year remedial plan to provide additional OMH supported housing for individuals currently in adult homes. (+\$1 million)
- Continue development of high priority residential initiatives including New York / New York III as offset by Legislative reductions for delays. (+\$64.1 million)
- Annualize funding for prior year initiatives. (+\$36 million)
- Expand Personalized Recovery Oriented Services as offset by Legislative reductions for delays. (+\$9 million)
- Annualize funding for program conversions and base level adjustments. (+\$6.9 million)
- Continue to improve employment opportunities through Federal Medicaid Infrastructure Grant (MIG) for the New York Makes Work Pay program. (+\$6 million)

In addition, the Enacted Budget accepted the following Article VII legislation as proposed:

- Eliminate the enhanced funding for mental hygiene services in five Unified Services counties effective July 1, 2010.
- Protect providers from a deflationary Cost-of-Living Adjustment (COLA) for 2010/11 and extend the adjustment for an additional year through March 31, 2014.
- Clarify the OMH's existing authority for recovery of exempt income from residential programs.
- Update the Disproportionate Share Hospital (DSH) base year

- from 2000 to 2008 for payments to community mental health providers. (Submitted as 21 Day Amendment)
- Authorize the transfer of funds from OMH to DOH to increase Medicaid payments for managed care organizations, to provide equivalent 'government' fees consistent with the new Ambulatory Patient Group (APG) methodology. (Submitted as 21 Day Amendment)
  - The Legislature extended the Community Mental Health Support and Workforce Reinvestment Program for three years (expired March 31, 2010) until March 31, 2013.

For additional information on these proposals, please see the [2010/11 Executive Budget Recommendation Highlights: Aid to Localities](#)

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## **Collaborating to Better Meet Needs**

### **OMH and MH Providers Convert Housing to Better Meet Individual Needs**

*by Moira Tashjian, OMH Director of Housing Redesign*

The New York State Office of Mental Health (OMH) believes safe, decent and affordable housing is a cornerstone of recovery from mental illness. Most people want permanent housing that is integrated into the community. Access to affordable housing is a fundamental problem for many people. However, persons with mental illness often face additional barriers to obtaining housing. Socio-economic status, unemployment, the limited supply of very-low-income housing, the rising cost of rental market housing and discrimination make access to housing all that more difficult.

OMH works with counties and providers to enable persons with a serious mental illness access to safe, affordable, integrated housing, and have the ability to utilize flexible supports that are not a condition of housing. Individuals may reside with friends or on their own, with individualized and flexible services available, as needed. It is not necessary for most individuals to use the OMH housing system as a continuum. The intention is that everyone with serious mental illness in NYS has access to safe, decent and affordable housing, most in mainstream housing, with supports and health and mental health care available in the community and not linked to housing but linked to need. A significant minority of individuals require supportive housing with supports brought to them onsite, and still a smaller minority will need staff supported and treatment housing services.

For OMH to transition to a system of care that will fulfill these objectives, we need to address housing affordability and access to sufficient flexible support and treatment services. We also need to

maintain existing supported housing, and both sustain and better utilize staffed housing. Over the course of three years, OMH has been able to work closely with the providers of housing services and stakeholders in NYS to evaluate and discuss the potential conversion of staffed housing programs to integrated mixed housing settings, supported housing and treatment apartments. OMH and its community partners have successfully converted congregate housing to apartment units (treatment, supported, single room occupancy and affordable). To date, 132 congregate units have been converted to apartment treatment and 245 additional units are in the process of converting.

This path of exploration has remained diligent in balancing development goals while moving toward local systems of care that can arrange, provide, and support people in housing that is appropriate to their needs and preferences at any level of recovery. For example, in the past year Occupations, Inc., in Orange County, New York. Occupations, Inc. redesigned 18 of its existing licensed residential congregate units and transitioned them to individual licensed apartments. Occupations reported that its primary goal was to address the rehabilitation needs of people recovering from mental illness to successfully live as they choose; in the community with a flexible service delivery model. This has resulted in Occupations assisting the service system to transition people from higher levels of care to community based programs.

OMH has fostered new and expanded relationships with the State's housing agencies with a renewed emphasis on interagency collaborations. OMH's housing development partners include: Division of Housing and Community Renewal (DHCR), Office of Temporary and Disability Assistance (OTDA), and the Housing Finance Agency (HFA). Interagency collaborations have enabled OMH to participate in the development of mixed-use/integrated housing that it could not accomplish on its own. The OMH continues to assist developers in securing funding to develop integrated housing.

## From the Field



[Photo Gallery](#)

## Over 300 Attend NYC Peer Specialist Conference

*by Celia Brown and Digna Quinones, Regional Recipient Affairs Specialists, New York City Field Office*

Over 300 working peer specialists and program directors from around the Metropolitan New York area and as far away as Elmira, New York attended *Taking The Lead: Cultivating A New Generation Of Peer Leadership*, a peer planned, organized & led conference held June 15, 2010 at New York University's Kimmel Center.

After the registration and continental breakfast, the standing room only crowd heard brief and powerful welcoming remarks from OMH Commissioner Michael F. Hogan, Ph.D.; Adam Karpati, M.D., MPH, Executive Deputy Commissioner for Mental Hygiene, New York City Department of Health and Mental Hygiene (NYCDHMH); Lynn Videka, Ph.D., Dean, NYU School of Social Work; Celia Brown, Regional Advocacy Specialist, Bureau of Recipient Affairs, OMH New York City Field Office; and Jody Silver, Director Office of Consumer Affairs, Division of Mental Hygiene, NYCDHMH. Commissioner Hogan told the audience, as evidenced by this standing room only crowd of peer specialists, that "Change starts from the bottom up, not from the top down as most people believe."

The welcoming remarks were followed by two Keynote Addresses:

- Carlton Whitmore, Assistant Director, Office of Consumer Affairs, Division of Mental Hygiene, NYCDHMH, spoke about "Embracing Our Diversity & the Role of Peer Leadership," and told the group that "Embracing our diversity requires that we not only practice tolerance and acceptance of others but we also become aware of our own cultural influences." Carlton is a consumer and survivor, and recipient of the New York Association of Psychiatric Rehabilitation Services (NYAPRS) 2006 Brendan Nugent Leadership Award. Carlton said in his speech
- The second keynote speaker was Jacki McKinney, MSW, Consultant and nationally known survivor of trauma, addiction, homelessness, and both the psychiatric and criminal justice systems. Jacki's keynote address spoke about "Looking Back, Moving Forward," sharing her own life story and the intergenerational effects of trauma.

Following the keynote addresses, Peer Specialists presented 18 inspiring workshops on such topics as The Role of Peer Specialists, Supervising Peer Counselors in Inpatient and Emergency Room Settings, Trauma: Informed Care and Peer Support, Work Talk: What's Hot and What's Not, Using SSI PASS to Support Peer Job Development, Connecticut Recovery Services – Peers Coaching Peers, and Promoting Employment of Persons in Recovery in the Behavioral Health Workforce. The 18 workshops were followed by a Wrap-Up and End-of-Conference Reception.

Before the afternoon workshops, the conference attendees were treated to a fantastic performance by FACES Theater Network, a program operated out of Maimonides Hospital Medical Center in

Brooklyn. The performance focused on the struggles of trauma in the lives of teens & families. The group was well received and got a rousing standing ovation.

In addition to the workshops, a Resource Room with materials to support the work of Peer Specialists was open all day to participants & presenters. In addition the Empowerment Center of Westchester County launched NYWORKS, an on-line work support website for peer specialists.

There were new ideas, new energy, and conversations with existing and new emerging Peer Specialists. With the sharing of knowledge and experiences of recovery, we think we truly did capture the theme of this conference, cultivating a new generation of peer leadership!!

The conference planning committee did a phenomenal job in organizing the day's events. The committee was comprised of representatives from the OMH NYC Field Office Bureau of Recipient Affairs, Howie T. Harp Advocacy Center, Coalition of Behavioral Health Agencies, Center for Rehabilitation and Recovery, NYCDHMH Office of Consumer Affairs, F.E.G.S Health and Human Services System, The Empowerment Center, NYAPRS, Wellness & Recovery Services, and Kings County Hospital Center Department of Behavioral Health.

A special thanks to the volunteers from Howie T. Harp Peer Specialist Center and The Empowerment Center for helping with registration and workshops. Thanks also to Marty Cohen, the official Conference Photographer whose pictures documented the wonderful day ... well done!!

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