Tompkins County
COMMUNITY MENTAL HEALTH SERVICES BOARD

Tompkins County Whole Health
201 East Green Street
Ithaca, New York 14850-5421

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Mental Health Subcommittee Meeting
Via Zoom
July 21, 2026 @ 1:00 – 2:30 p.m.
Meeting Minutes

Minutes Approved
9/15/2026

Present: Mary Hutchens, Jessica Conner, Ben Komor, Cindy Freidmutter, and Susan Tabrizi
Excused: Larry Roberts, Tracy Decker, and Aderonke Ilegbusi
Unexcused:
Guests Present: Briggs Seekins, Challenge; Jennie Miller, MHA; and Rick Alvord, TCWH

TCWH Staff Present: Harmony Ayers-Friedlander, DCS; Karan Palazzo, LGU AA; Mary Maruscak, LGU WH Planner; Rich Shaw, Rick Alvord, TCWH

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Mary Hutchens called the meeting to order at 1:02 pm. Introductions were made. Dr. Conner moved to approve the June 2026 minutes, and Susan seconded.

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Privilege of the Floor & **Announcements:** Tracy Decker informed the subcommittee that FLIC is hosting a free screening at Cinemapolis on Sunday, July 26th, at 2:30 pm. to celebrate the 36th anniversary of the Americans with Disabilities Act (ADA). No meeting is scheduled in August.

Discussions:

Overview and Resource Sharing - A System Under Strain: Mary Maruschak, the new LGU Health Planner, presented an overview of the report "The System Under Strain: Why New Yorkers Wait Months for Substance Use Disorder and Mental Health Services." The report, by Unity Alliance, a collaborative of more than 150 community-based organizations and professionals providing substance use and mental health services across New York State, found that 81 mental health and 39 substance use programs are operating in deficit. The report confirms what local providers already know from experience—chronic access barriers and systemic underfunding—but emphasizes that documenting these issues at scale creates powerful leverage for advocacy, grant writing, and upcoming local services planning work.

1. Data Sources & Methodology

- **Qualitative & quantitative methods**:
  - Focus groups
  - Statewide survey of 50 organizations (representing all NYS counties)
    - 26/50 completed the full survey; many results are reported from this subgroup.
  - Analysis of Consolidated Fiscal Reports (CFRs) for 458 organizations:
    - 146 with OASAS (OASAS referred to as “Oasis” in transcript) funding
    - 223 with OMH funding
    - 89 with both

- **Limitations**:
  - Participation was voluntary → missing data and potential bias.
  - Analysis is at an organizational level, not program level, obscuring variation between programs inside the same agency.

2. Core Findings: Financial Strain

- Programs operating at a deficit:
  - 81 mental health programs
  - 39 substance use programs
- **Liquidity risk**:
  - 14 of the 26 fully participating organizations had less than 3 months of cash on hand, meaning they could only operate ~3 months if funding stopped.
  - Mary notes this is "unfortunately pretty standard" in the field.
- **Coverage disruptions**:
  - 23 organizations reported 30–327 Medicaid recipients (range unclear in the transcript; point is large numbers) with coverage disruptions during recertification in the prior year.
- **Chronic underfunding and patchwork financing**:
  - Widespread reliance on cross-subsidization and extra fundraising (e.g., yard sales, grants) to keep underfunded programs—like drop-in centers—open.
  - Reimbursement rates do not cover the true cost of care, particularly for:
    - Complex billing and prior authorizations
    - Regulatory and documentation requirements
    - Administrative overhead needed just to get paid
- **Payment delays and administrative burden**:
  - Across payers, organizations waited an average of ~70 days for payment.
  - 17 organizations reported about 41,000 staff hours spent on prior authorizations and denials.
  - This administrative work is not reimbursed and directly diverts resources from care.

3. System Pathway: How Financial Strain Becomes Wait Lists

Mary highlighted a graphic from the report that essentially shows this chain:

1. Financial strain
   → Underinvestment; rates below actual cost; unstable cash flow.
2. Operational impact
   → Staffing challenges, reduced capacity, program cuts, increased admin time, delayed contract execution.
3. Access delays
   → Longer wait lists, limited service availability, fewer options for consumers.
4. Outcomes
   → People go without services or wait so long that the originally needed services are no longer appropriate.

This is framed as the **core explanation** for why New Yorkers wait months for MH and SUD services.

4. Key Recommendations and Levers - Results and Recommendations

- Payment that covers the cost of care
  - Acknowledge that current rates are insufficient.
  - Identify financially unsustainable programs early and create strategies to preserve access, not just let programs quietly fail.
  - Focus on value and impact of services, not just volume.
- **Reliable, timely payments**
  - Evaluate how insurance and grant payment delays affect:
    - Timely access to care
    - Availability of services
    - Organizational stability
- **Workforce and administrative burden**
  - Reassess workforce requirements given the time and complexity of:
    - Prior authorizations
    - Documentation
    - Contracting and regulatory compliance

- **Coverage stability**
    - Identify and address Medicaid coverage disruption points (e.g., recertification cliffs).
    - Develop models to mitigate coverage gaps, so clients don't cycle in and out of eligibility and services.

Mary's own reflection: a large portion of the drivers are outside local control, so the critical question for planning and advocacy is: *What do we actually have control over? What can we truly advocate for and change based on this information?*

5. Relevance to Tompkins County & Next Steps

- Strong alignment with current Local Services Plan themes and likely direction for the next planning cycle.
- The report and companion documents (including "Closing the coverage gap" and the reentry outcomes report) are **rich sources for:
    - Local Services Plan problem statements
    - Justification for rate advocacy and contract reform
    - Grant narratives on workforce and access barriers
- Suggestions:
    - Inviting In Unity Alliance to present in more depth (with more granular data, if possible).
    - Integrating this work with existing Human Services Coalition efforts on Medicaid reimbursement and cross-agency funding strategies.

Recommendations focus on several levers for change, even in a largely state- and payer-driven environment. The report calls for payment that truly covers the cost of care, early identification of financially unsustainable programs to preserve access, closer evaluation of how payment delays from insurance and grants affect timely access, reassessment of workforce and administrative requirements, and the development of models to reduce Medicaid coverage disruptions. Mary underscored that many structural drivers are outside local control, raising critical planning questions about where local systems can realistically act and what they can effectively advocate for.

Finally, Mary linked the report to local planning and advocacy efforts. She noted that the findings closely align with issues raised by Tompkins County subcommittees and with ongoing conversations about rate adequacy, workforce strain, and access to care. Suggestions from participants included exploring a presentation from In Unity Alliance to dig deeper into the data and tying these findings to community-level initiatives, such as the Human Services Coalition's work on Medicaid reimbursement. Mary positioned the report and its companion documents as valuable conversation starters and sources of evidence for the next Local Services Plan cycle, strategy development, and cross-agency advocacy to stabilize and strengthen the local mental health and substance use service system.

The Science Behind Childhood Trauma in Adulthood – Mental Health Subcommittee Member, Ben Komar begins by explaining the difference between trauma and PTSD, noting that trauma is an experience, while PTSD is a condition resulting from repeated trauma.

Ben distinguished trauma (a threatening experience) from PTSD (a resulting condition) and framed both within an ecological model in which genetics and environment interact over time. He described how trauma affects three key brain regions—the amygdala, hippocampus, and prefrontal cortex—altering volume, activity, and connectivity, thereby driving hypervigilance, intrusive memories, and emotional dysregulation. Ben explained dysregulation of the HPA axis and cortisol, chronic low-grade inflammation, and effects on the vagus nerve and the gut–brain axis, linking trauma to long-term physical health problems. He reviewed trauma-related changes in serotonin, GABA, and dopamine, along with cellular effects (oxidative stress, altered cell death and neurotransmitter release), which together shape mood, anxiety, reward, and arousal.

His presentation highlighted **transgenerational and attachment effects**, including epigenetic changes and disrupted caregiver–child relationships that can pass trauma vulnerability across generations. He emphasized that the brain is **plastic**, with recovery depending on building new neural connections, supported by **BDNF** and treatments such as **cognitive processing therapy, EMDR, narrative and prolonged exposure**, and attachment-focused approaches.

Members discussed the link of this science to **housing and service models**, underscoring that stabilizing basic needs (e.g., housing first, transitional supports) is often necessary before intensive trauma work can be effective.

- **Conceptual framing:** Ben distinguished **trauma (an experience involving threat to safety)** from **PTSD (a resulting condition)** and located both within an ecological framework (Bronfenbrenner-style), where genetic vulnerability and multiple environmental systems interact over time. He noted five broad PTSD groupings (normal stress response, acute stress disorder, uncomplicated PTSD, complex PTSD, and comorbid PTSD) and highlighted common symptoms such as chronic anxiety, hypervigilance, racing thoughts, and physical tension.
- **Key brain regions affected:** The presentation focused on three main regions: the **amygdala** (threat detection and fear), **hippocampus** (memory consolidation, contextual processing, and stress regulation), and **prefrontal cortex** (executive function, emotional regulation, impulse control). Early trauma can alter the **volume, activity, and connectivity** of these regions, with "critical windows" where the region most rapidly developing is the most vulnerable. Childhood trauma is associated with **reduced hippocampal and prefrontal volume**, heightened amygdala reactivity, and weaker prefrontal–amygdala connections, contributing to hypervigilance, intrusive memories, and emotional dysregulation.
- **Stress systems, inflammation, and the body:** Ben described dysregulation of the HPA axis (hypothalamus–pituitary–adrenal) in people with significant trauma, leading to abnormal cortisol levels, immune suppression, and chronic low-grade inflammation associated with cardiovascular disease, diabetes, and autoimmune conditions. He also discussed the vagus nerve and "shutdown" responses (emotional numbness, dissociation, fatigue) when the system is overwhelmed, as well as the gut–brain axis, where trauma-related changes in the gut microbiome may contribute to gastrointestinal and systemic health problems.
- **Neurotransmitters and cellular changes:** The talk highlighted alterations in serotonin, GABA, dopamine, and other hormones and neurotransmitters in PTSD, which affect mood, sleep, anxiety, reward, and arousal. Reduced GABA (the major inhibitory neurotransmitter) and altered serotonin and dopamine signaling contribute to anxiety, hyperarousal, and anhedonia. Ben also noted cellular-level effects, including changes in apoptosis (programmed cell death), oxidative stress, and vesicle formation (which affects neurotransmitter release).
- **Transgenerational and attachment impacts**: Ben described epigenetic mechanisms by which trauma can influence gene expression and stress hormone patterns in offspring, as well as how caregivers' unresolved trauma can disrupt attachment relationships. This combination—biological changes and relational patterns—can transmit vulnerability and dysregulated stress responses across generations, further embedding trauma in families and communities.
- **Recovery, neuroplasticity, and treatment:** A central theme was that the nervous system is plastic, and recovery hinges on building new neural connections and modulating automatic survival responses. Ben emphasized brain-derived neurotrophic factor (BDNF) as a key supporter of neural health and adaptive connectivity, especially in the hippocampus, amygdala, and prefrontal cortex. He described multi-phase recovery models (stabilization, integration, reorganization, optimization), the attachment rewiring process (targeting implicit memory and autonomic dysregulation, safety detection, and secure-base formation), and evidence-based therapies such as cognitive processing therapy, EMDR, narrative exposure, and prolonged exposure. He briefly mentioned experimental/medical approaches (e.g., prazosin; neurosurgical ideas) but framed psychotherapy and relational, attachment-informed work.

Following Ben's presentation, members discussed how the neuroscience of trauma and PTSD underscores the importance of housing stability as a prerequisite for effective trauma treatment, noting that individuals living in ongoing crisis (e.g., homelessness) are often not ready for intensive trauma work. The value of Housing First and transitional housing with embedded supports was highlighted, emphasizing phased, trauma-informed models that integrate housing, mental health, and supportive services to prevent destabilization when trauma symptoms surface after basic needs are met.

The meeting adjourned at 2:30 pm

The Next Meeting is Tuesday, September 15, 2026 @ 1 pm