MENTAL HEALTH NEWS™

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SPRING 2007 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 9 NO. 2

Who Will Serve ? The Challenge of The Mental Health Workforce

By John A. Javis
Director of Special Projects
Mental Health Association
of Nassau County

A few months ago, while my son and I were in a fast food restaurant, he gave me a big hug and said, "Daddy, when I grow up I want your job." When I asked my son, if he understood what I did for a living, he replied, "You work for an agency that helps people have better lives."

As a parent, I was certainly proud of my son in his desire to help others. Service to others, and leadership, are values that I seek to instill in my children.

However, what will the mental health workforce look like in another ten to fifteen years, when my son is ready to begin working? Will I want my son to follow in my footsteps? Will he be able to support himself (and a family) by working in the non-profit mental health field?

The current mental health workforce is in a state of terrible crisis. Employee turnover is high, staffing vacancies are lengthy, and staff salary and benefit packages are generally inadequate. Staff absenteeism, lateness, inability to grasp key concepts, and poor work behavior, are issues that vex many program supervisors.

It seems that they don't make many mental health workers in the mold of Dr. Larry Brody anymore. Dr. Larry Brody was one of my employees at the Mental Health Association of Nassau County. For over 60 years, he worked as an educator, a speaker, and a mental health advocate. He worked for us until he was in his late eighties, and came to work the day before he died.

The Mental Health Workforce Crisis Is Well Documented

The 2003 White House "New Freedom Commission" on Mental Health, chaired by the new NYS Office of Mental Health Commissioner Dr. Michael F. Hogan, acknowledged that, "serious workforce problems exist." The Commission went on to say that it "heard constant testimony from consumers, families, advocates and public and private providers about the 'workforce crisis' in mental health care." The Commission recommended that "the mental health field needs a comprehensive strategic plan to improve workforce recruitment, retention, diversity and skills training."

In New York State, a piece of legislation entitled the "Quality Workforce Act" (A4280 / S657) states that, "Current difficulties in assuring adequate direct services recruitment, retention and competence are widely reported as the single largest barrier to the growth and sustainability for quality community services for persons with developmental disabilities, mental illness and substance abuse."

In 2006, the Campaign for Behavioral Health Transformation In New York State document, "Transforming New York's Behavioral Health Care System: A Call to Action," recommended that "staff is adequately compensated to reduce turnover and vacancies."

The 2005 Report by the Mental Hygiene Task Force to NYS Assemblyman Peter Rivera, "An Evaluation of the Delivery of Mental Hygiene Services in New York State" recommended the establishment of "workforce enhancement initiatives,"

see The Challenge on page 36

Historic Agreement on Timothy's Law New York Adopts Mental Health Parity Legislation

By Shelly Nortz
Deputy Executive Director for Policy
Coalition for the Homeless

Two decades worth of effort have finally paid off with the adoption of Timothy's Law in New York State. Over the years, various coalitions of family members, consumers, mental health professionals, and other advocates have pushed for a comprehensive mental health parity law - only to be met with seemingly insurmountable opposition from health plans and small business interests.

But tireless advocacy coupled with the compelling story of Timothy O'Clair for whom the law is named, along with the efforts of thousands of grass roots supporters and expert lobbying finally won the day. Following a week of candlelight vigils outside the Governor's office, and thousands of calls and emails from across the state, the O'Clair family received the word they had been waiting to hear through four long years: Now that the legislation had won unanimous approval in both the Senate and Assembly, and notwithstanding continued opposition from some parties, the Governor had decided to sign the bill.

On December 22, 2006 then-Governor George Pataki signed Timothy's Law and shared a few moments with Timothy's family placing a snowflake ornament bearing Timothy's school picture on the Christmas Tree in the Red Room of the Executive Chamber in Albany. Supporters, including parents of other children lost to mental illness and chemical dependency, shared with the O'Clairs that they thought that Timothy must be smiling at the news.

Timothy's Law took effect January 1, 2007 and applies to most insurance policies in New York on the day they are issued, renewed, or modified - for most policies, the law is presently in effect.

Before the law was passed, health plans were permitted to discriminate against those with mental health needs by charging much higher co-payments and deductibles compared with the fees they charge consumers for regular medical office visits.

Top health plans had in recent years begun to restrict coverage to "acute" mental health conditions susceptible to short-term treatment; excluded coverage for chronic mental illnesses; charged a $50 per visit co-pay for the 4th through 20th outpatient mental health visits; and imposed 60-day (30 days per year) lifetime limits on inpatient psychiatric care.

Timothy's Law seeks to remedy these barriers to care. It is named in memory of a 12 year-old boy from Rotterdam who hanged himself five years ago after being denied coverage for care he needed to deal with his mental illnesses. His family even relinquished custody of Timothy, and paid child support to the state, so that they could obtain Medicaid to cover his treatment costs. He would have celebrated

see Timothy's Law on page 43

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From The Publisher

The Mental Health Workforce: Saving Those Who Save Us

By Ira H. Minot, LMSW, Founder and Publisher, Mental Health News

An ambulance pulled up to an apartment building located on Eastchester Road in New Rochelle, New York. This would not be that unusual except for the fact that the paramedics who rushed into the building with a stretcher, were not called to apartment 1E by the man who lived there alone. They were responding to an emergency call placed by a quick-thinking psychotherapist from a prominent mental health agency in New Rochelle.

The man in the apartment was the therapists' client, who had been absent from his daily attendance at the agency's day treatment program. Due to his client's absence, the psychotherapist telephoned his client (who had a history of depression) to see if he was all right. The man's speech was quite slurred, weak and disoriented, and the psychotherapist determined that he had taken a dangerous overdose of his medications.

When the paramedics entered the man's apartment they found him lying on the bed—incoherent and semi-conscious. They took his vitals, put him on the stretcher, and rushed him over to the nearby hospital emergency room. Once medically stabilized, he was discharged to a leading local psychiatric hospital, for inpatient care.

This was to be a turning-point in the man's devastating ten-year battle with depression. Having had two prior life-threatening incidents such as this, the doctors recommended that he remain in inpatient care and undergo electro-convulsive therapy (ECT) in a last attempt to break the bonds of his long-term depression.

After a full course of ECT and inpatient care, the man was finally discharged back to his apartment and outpatient program he had attended back in New Rochelle. The dark curtain of his relentless depression slowly began to lift after a few weeks, and the man seemed to be on the road to recovery.

This is a true story. Fortunately, for the man, it has a happy ending.

He continued in treatment and taking medication—now realizing he might have to do so for the rest of his life. He found a new avocation, which would have more significance and meaning to his own life and mental health.

He set out to make a difference in the lives of people with mental illness who would travel the same difficult road that he had. He went on to meet and work with the people who he felt were saving the lives of people with mental illness, each and every day in communities across the county, state and nation. He desperately wanted to tell *their* story and to tell what he called, "the good news about our mental health community."

I can say *this is* a true story, because the man in the story is a personal friend of mine. The happy ending to the story is that he went on to become the founder and publisher of *Mental Health News*.

Ira H. Minot, LMSW

This issue of *Mental Health News* explores the challenge of the mental health workforce. This workforce includes professional and para-professional staff who provide direct services to people with mental illness and their families. "Professionals are individuals who have a master's level or higher degree in psychology, social work, counseling, psychiatric nursing, or who are psychologists, psychiatrists or related professionals. Para-professionals are people who have a bachelor's degree or less or who are not human service professionals. They have strong intuitive skills about people or relate well to others, possess good judgment, common sense, are good listeners and most often are indigenous to the community." (CMHS, 2000)

If you are a recipient of mental health services, you are almost always in direct contact with psychiatrists, therapists, nurses and program coordinators. However, there are many others who work behind the scenes who are also vital to the workings of the mental health community. They are the agency directors, program supervisors and others that work in an administrative capacity to manage the operations of mental health agencies.

While struggling with a mental illness, so many of us owe our lives to people we meet along the way. The doctors, therapists, and nurses, play an enormous part. However, there are others in the workforce who help in different ways that are not involved with prescribing medications or psychotherapy. For example, case-workers play a vital role in monitoring issues related to health coverage, discharge planning and follow-up care. During a long mental illness, you get to meet quite a few. Other members of the mental health workforce who play vital roles in helping people with mental illness are from agencies outside of the "clinical arena," yet are important nonetheless.

During a difficult or prolonged mental illness, people quite often can loose many of the things they had going for them during their pre-illness life. Things like a job or career, savings, a home, a family and extended relationships. When these things begin to slip away, it is very damaging to one's self esteem, and can feed the fire of even deeper despair and hopelessness. It is at these times that agencies involved in areas such as housing, employment, family support, peer counseling and consumer advocacy can play a vital role.

Housing agencies provide supported apartments (Section 8, and Shelter Plus) in many communities. However, in many states, there are long waiting lists and too few units available to house those in need. Some areas do not have these agencies at all. This is a very unfortunate situation. There is nothing more important to a person's recovery than for them to be able to live in a community in safety and with dignity. The workforce in the housing agency sector provide a life-line for people with mental illness. They help to monitor how people are doing on a week to week basis. Consumer's are usually required to participate in treatment or be in a vocational program while living in the agency's housing units. Housing agency workers wear many hats including counseling, advocacy and referrals to other services in the community.

Once you are able to leave the hospital, you are usually placed (or continue) in an outpatient treatment program. However, most programs only occupy a part of your day. Many communities are fortunate to have "clubhouses" and (or) "drop-in centers." In my community, there were both. Many of these are peer-run or peer-supported. This means that they are staffed by people with mental illness who have received some training or have gained experience as para-professional counselors, advocates, and benefit entitlement experts. There are even new programs that offer extensive training certificates in these areas and case-management skills, for consumers to move into higher levels of employment in mental health agencies. Drop-in centers and clubhouses provide a lot of caring, acceptance and encouragement to people with mental illness, in a *non-clinical setting*. To many consumers, this can be a welcome break from their daily clinical treatment program. Some of the more structured peer-centers offer courses in computers and other activities such as storefront consumer-run businesses, that can help consumers get back into meaningful employment. They are a place to go, to find meaningful friendships, camaraderie, and a renewed sense of self—a vital component to the recovery process.

This issue of Mental Health News is devoted to bringing some of the challenges facing the mental health workforce into focus. Through the many articles presented in this issue, it is clear that steps need to be taken to fortify and support the workforce. Funding is critical to providing competitive salaries, benefits, and cost of living adjustments which serve to attract and maintain this vital workforce. Many agencies are loosing good people because they are attracted to higher salaries and a faster career track in other professions. Funding shortfalls also put in-service training programs, which keep staff up to date on the latest methods and guidelines, in jeopardy.

We want to hold all agencies and their staff to the highest ideals of practice and accountability. However, this becomes increasingly more difficult when federal and state funding sources provide bare-bones budgets for agencies to implement patient services. Something has to give, and patient care ends up suffering. We must not let this continue, and must invest in the future of our workforce. We must strive to "save those who save us."

We have a wonderful mental health community that stands ready to help you. I hope you continue to find inspiration within the pages of this publication. □

Good luck in your own recovery
and NEVER give up trying .
Wishing You a Wonderful Spring !!

Mental Health News
Upcoming Themes and Deadline Dates

Summer 2007 Issue
"Child and Adolescent Mental Health"
Deadline: May 1, 2007

Fall 2007 Issue
"Understanding and Treating Bipolar Disorder"
Deadline: August 1, 2007

Winter 2008 Issue
"Understanding Family Mental Health Services"
Deadline: November 1, 2007

Spring 2008 Issue
"Housing for People With Mental Illness"
Deadline: February 1, 2008

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Mental Health News Education, Inc., is the publisher of Mental Health News and Salud Mental.

We are an award-winning, nonprofit organization with a vital mission: to provide essential mental health information, education, advocacy and resources to people with mental illness, their families and the broader mental health community.

Our mission also includes providing bilingual (Spanish) and culturally sensitive mental health education, advocacy and resources to the Hispanic community.

We wish to thank our many contributors listed above, whose support enables us to continue to strengthen our mission and broaden our geographic reach. We also want to thank our readers for their continued feedback, guidance and encouragement.

MENTAL HEALTH NEWSDESK

Hispanic Mental Health Professionals Present Advocacy Awards To Friedman and Carrasco

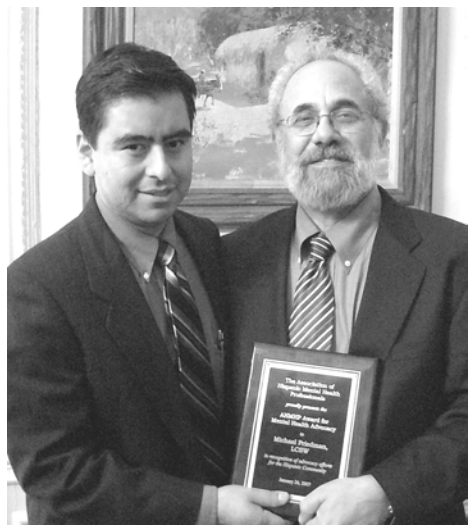
By The Mental Health Association of Westchester

The Association of Hispanic Mental Heath Professionals (AHMHP) presented the Advocacy Award to White Plains Resident Michael Friedman, LMSW, Director of the Center for Policy and Advocacy of the Mental Health Associations of Westchester and New York City.

In presenting the award, Israel Garcia, MSSW, an AHMHP Board member and a staff member of the New York City Department for the Aging, said, "Mr. Friedman has been extremely active in the community over the years, working with numerous advisory and advocacy groups at the local, state, and federal levels. He is the author of the Geriatric Mental Health Act, which was signed into law this past summer of 2006 by former Governor Pataki. Mr. Friedman was also named to Governor Spitzer transition team's health policy committee."

"Michael Friedman has been a tireless advocate for expansion and improvement of mental health services for all populations, including the most underserved," said Carolyn Hedlund, Executive Director of the Mental Health Association of Westchester, "I applaud Michael's accomplishments and the passion and commitment he brings to this work."

The awards ceremony was a part of the 2007 annual meeting of the (AHMHP), held at the Consulate General of Argentina. The annual meeting is an opportunity for fellow members, community leaders, health care providers, and other people committed with the mental health and well-being of the Latino community to meet, discuss and share their opinions and experiences.



Israel Garcia & Michael Friedman

The AHMHP's 2007 Awards were presented to five other mental health leaders who are fighting to shape the mental health system to better serve New York's significant Latino population. Ms. Majose Carrasco was also presented with the Mental Health Advocacy Award, along with Mr. Friedman.

The mission of Mental Health Association (MHA) of Westchester is to promote mental health in Westchester County through advocacy, community

see Awards on page 42

Dr. Michael F. Hogan Nominated Commissioner of the New York State Office of Mental Health

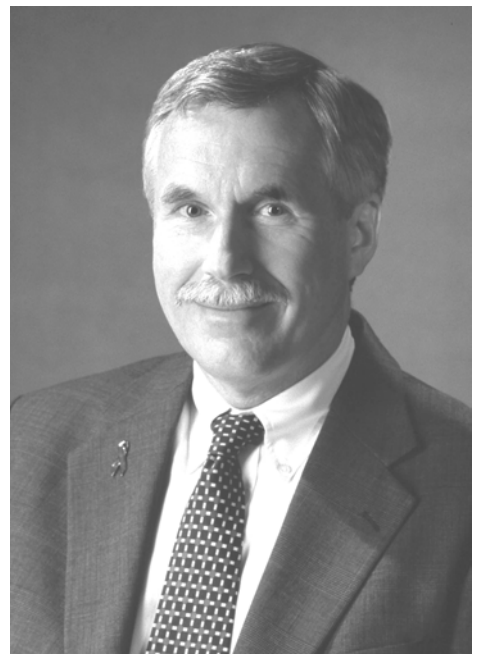
Staff Writer
Mental Health News

New York State Governor Eliot Spitzer has nominated Michael F. Hogan, PhD, to be Commissioner of the New York State Office of Mental Health. Dr. Hogan comes to New York from Ohio, where he has served as Director of the Ohio Department of Mental Health since March 1991. He previously was director of the Connecticut Department of Mental Health from 1987-1991.

Dr. Hogan chaired the President's New Freedom Commission on Mental Health in 2002-2003. He also served from 1994-1998 on the National Advisory Mental Health Council, and as President of the National Association of State Mental Health Program Directors from 2003-2005. He has co-authored a book and several national reports, and written over 50 journal articles or book chapters.

In 2002, Dr. Hogan received the Distinguished Service to State Government Award from the National Governors' Association and the Distinguished Service Award from The National Alliance for the Mentally Ill. In 2006, he was received a Special Leadership Award at the first national meeting of the Campaign for Mental Health Reform, and the SPAN USA Allies for Action Award from the Suicide Prevention Action Network.

A graduate of Cornell University, Dr. Hogan has also received an M.S. from the State University College at Brockport, and a Ph.D. from Syracuse University.



Michael F. Hogan, PhD

Dr. Peter C. Campanelli, President and CEO of the Institute for Community Living, and Chairman of the Board of *Mental Health News*, said, "We are delighted to welcome Dr. Hogan to New York State. As one of the nation's most respected and innovative mental health professionals, Dr. Hogan's position as the head of the New York State Office of Mental Health, will certainly elevate our mental health community to the highest levels of service and national prominence. We look forward to following the progress of Commissioner Hogan in many future issues of *Mental Health News*." □

Major Report on Behavioral Health Workforce Nears Release

By John A. Morris, and Ann McManis
The Annapolis Coalition

The Annapolis Coalition on the Behavioral Health Workforce has been engaged in a multi-year effort to improve training, education, recruitment, and retention in the mental health and substance use disorders fields. That work is about to reach a watershed with the impending release of An Action Plan for Behavioral Health Workforce Development – A Framework for Discussion. The report, prepared over the past two years by the Annapolis Coalition under a contract with the Substance Abuse and Mental Health Services Administration (SAMHSA), will be simultaneously posted on the SAMHSA (www.samhsa.gov) and Coalition (www.annapoliscoalition.org) websites in the coming weeks. The report addresses issues of workforce development from a very broad perspective, including issues of recruitment and retention, pre-employment preparation, and continuing education across the spectrum of prevention and intervention in mental and/or substance use conditions.

The Coalition is not a newcomer to this issue, having been active in efforts to strengthen the workforce formally since 2001. To put the report in context, following is a brief summary of the work that led to the Action Plan.

Building Momentum. The Coalition's formal work began when 65 individuals came together in Annapolis, Maryland, on September 10 and 11, 2001, to focus on growing concerns that the behavioral health workforce was in a state of crisis. Those gathered included providers, educators, persons in recovery, and family advocates with expertise in both mental health care and substance use disorders treatment. These participants adopted a very broad definition of workforce that encompassed persons in recovery, family members, professionals, direct care staff without professional training, and other health and human services providers, such as teachers, emergency room personnel, and primary care providers. This broad and inclusive definition of workforce has remained a hallmark of the Coalition's work, and is reflected in the action plan.

The initial meeting in Annapolis was funded by the federal Agency for Healthcare Research and Quality, along with the Center for Mental Health Services, and was organized by representatives from two organizations: the Academic Behavioral Health Consortium (ABHC) and the American College of Mental Health Administration (ACMHA). With the support and encouragement from these latter two organizations, The Annapolis Coalition on the Behavioral Health Workforce was formed as a separate, not-for-profit entity.

see Report on page 44

MENTAL HEALTH NEWSDESK

NIH Director Welcomes Seven New Members to Advisory Committee

By The National Institutes of Health (NIH)

The National Institutes of Health (NIH) has selected seven individuals to serve as members of the Advisory Committee to the Director (ACD). Since 1966, the ACD has advised the NIH Director on policy and planning issues.

"These seven outstanding new members to the NIH Advisory Committee to the Director join a dedicated team of esteemed advisors," said NIH Director Elias A. Zerhouni, M.D. "The NIH relies on the willingness of these great minds and the efforts of other scientists and public members who participate on advisory councils and peer-review committees."

The ACD advises the NIH Director on policy matters important to the NIH mission of conducting and supporting biomedical and behavioral research, research training, and translating research results for the public.

The new members, who join 13 current members of the council, are Catherine D. DeAngelis, M.D., MPH, of Chicago, Illinois; Karen A. Holbrook, Ph.D., of Columbus, Ohio; Ralph I. Horwitz, M.D., of Stanford, California; Mary-Claire King, Ph.D., of Seattle, Washington; Alan, I. Leshner, Ph.D., of Washington, District of Columbia; John C. Nelson, M.D., MPH, FACOG, FACPM, of Chicago, Illinois; and Barbara L. Wolfe, Ph.D., of Seattle, Washington.

Elias A. Zerhouni, MD

CATHERINE D. DEANGELIS, M.D., MPH, is editor-in-chief of "JAMA", the Journal of the American Medical Association; editor-in-chief of Scientific Publications and Multimedia Applications; and Professor of Pediatrics at the Johns Hopkins University School of Medicine. She received her M.D. from the University of Pittsburgh's School of Medicine; her MPH from the Harvard Graduate School of Public Health (Health Services Administration); and her pediatric specialty training at the Johns Hopkins Hospital. Dr. DeAngelis oversees "JAMA" as well as nine "Archives" publications and "JAMA" related Web site content. Dr. DeAngelis is a past council member of the National Academy of Science, Institute of Medicine, a Fellow of the American Association for the Advancement of Science, and has served as an officer of numerous national academic societies, including former chairman of the American Board of Pediatrics and chair of the Pediatric Accreditation Council for the Residency Review Committee of the American Council on Graduate Medical Education.

KAREN A. HOLBROOK, PH.D., is president of The Ohio State University, and professor of Physiology and Cell Biology and Medicine (Dermatology) in the College of Medicine. Dr. Holbrook earned B.S. and M.S. degrees in zoology at the University of Wisconsin-Madison and a Ph.D. in biological structure from the University of Washington School of Medicine. She came to Ohio State from the University of Georgia, where she served as senior vice president for academic affairs and provost, as well as professor of cell biology and adjunct professor of anatomy and cell biology and medicine at the Medical College of Georgia. Prior to these roles, she served at the University of Florida at Gainesville as vice president for research and dean of the Graduate School, as well as professor of anatomy and cell biology and medicine (dermatology). She spent the majority of her academic career as a professor of biological structure and medicine at the University of Washington School of Medicine, where her research focused on human fetal skin development and genetic skin disease.

RALPH I. HORWITZ, M.D., is the Arthur Bloomfield Professor and chair of the Department of Medicine at Stanford University. Dr. Horwitz received his M.D. from the Pennsylvania State University College of Medicine; trained in internal medicine at McGill University and the Massachusetts General Hospital; and was a research fellow in the Robert Wood Johnson Clinical Scholars Program at Yale. He is internationally known for his pioneering research that helped to establish the field of clinical investigation and outcomes research; for his innovative programs in the education of physicians and the training of physician scientists; and his visionary renewal of the social contract linking the practice of medicine to the civic responsibility of the profession of medicine. He is an elected member of the American Society of Clinical Investigation, the Institute of Medicine of the National Academy of Sciences, and the Association of American Physicians (AAP). He recently completed a term as president of the American Board of Internal

see NIH Director on page 42

Benefits to Employers Outweigh Enhanced Depression-Care Costs

By The National Institute of Mental Health (NIMH)

It may be in society's and employers' best interests to offer programs that actively seek out and treat depression in the workforce, suggests an analysis funded by the National Institutes of Health's (NIH) National Institute of Mental Health (NIMH). A simulation based on dozens of studies revealed that providing a minimal level of enhanced care for employees' depression* would result in a cumulative savings to employers of $2,898 per 1,000 workers over 5 years. Even though the intervention would initially increase use of mental health services, it ultimately would save employers money, by reducing absenteeism and employee turnover costs, according to Drs. Philip Wang and Ronald Kessler, of Harvard University, and colleagues, who report on their findings in the December 2006 "Archives of General Psychiatry."

"Depression exacts economic costs totaling tens of billions of dollars annually in the United States, mostly from lost work productivity," noted Wang. "Yet we're not making the most of available services and treatments. Our study calculates what employers' return on their investment would be if they purchased enhanced depression treatment programs for their workers."

The analysis simulated an enhanced intervention in which master's-level health professionals managed the care of a hypothetical group of 40-year-old depressed workers diagnosed with depression. In this scenario, after assessments had detected the workers' depression, the care managers did further assessments and, when necessary, referred the workers for treatment in this scenario. The researchers gauged the cost-effectiveness for society and cost-benefit to employers, using data from existing trials and epidemiological studies, including the National Comorbidity Survey Replication, a nationally representative household survey of 9,282 U.S. adults, conducted in 2001-2003.

The hypothetical workers were assigned to either the enhanced care or "usual care" -- care-seeking and treatment patterns that would normally occur in the absence of care management. For both groups, treatment was defined in terms of visits to either a primary care physician or a psychiatrist who prescribed an antidepressant. Every three months, the hypothetical workers' illness status could change, based on depression prevalence, remission and ongoing treatment rates, and the probabilities of various outcomes, including increased risk of death by suicide.

Using results of recent primary care effectiveness trials, the researchers estimated how successful care managers might be in helping workers seek out and adhere to adequate treatment regimens. While the cost-benefit analysis from employers' perspectives weighed only monetary factors, quality of life figured into the cost-effectiveness to society calculation.

Savings from reduced absenteeism and employee turnover and other benefits of the intervention began to exceed the costs of the program by the second year, yielding a net savings of $4,633 per 1,000 workers. These savings were somewhat reduced in years 3 through 5, based on conservative assumptions that benefits wane after care management ceases, while increased use of treatments continues. The intervention became more expensive than usual care (no workplace depression management) when there was greater use of psychiatrists (instead of primary care doctors) or brand-name (instead of generic) drugs. It also ceased to be cost-saving if employees spent more than 4 hours of work time in treatment per 3-month cycle. Enhanced care had the most benefit in cases of higher-level employees who influenced the productivity of co-workers.

The intervention yielded gains when the simulated costs for care were consistent with those charged in the real world, suggesting that providing such programs for workers "appears to be a good investment of society's resources," say the researchers. It will be important to see if the findings are replicated in effectiveness trials that directly assess the intervention's impact on work outcomes, they added.

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Scientists Find New Genetic Clue to Alzheimer's Disease

By The National Institute on Aging (NIA)

Variations in a gene known as SORL1 may be a factor in the development of late onset Alzheimer's disease, an international team of researchers has discovered. The genetic clue, which could lead to a better understanding of one cause of Alzheimer's, was reported in "Nature Genetics," and was supported in part by the National Institutes of Health (NIH).

The researchers suggest that faulty versions of the SORL1 gene contribute to formation of amyloid plaques, a hallmark sign of Alzheimer's in the brains of people with the disease. They identified 29 variants that mark relatively short segments of DNA where disease-causing changes could lie. The study did not, however, identify specific genetic changes that result in Alzheimer's.

Richard Mayeux, M.D., of Columbia University, Lindsay Farrer, Ph.D., of Boston University, and Peter St. George-Hyslop, M.D., of the University of Toronto, led the study, which involved 14 collaborating institutions in North America, Europe and Asia, and 6,000 individuals who donated blood for genetic typing. The work was funded by NIH's National Institute on Aging (NIA) and National Human Genome Research Institute (NHGRI), as well as by 18 other international public and private organizations.

"We do not fully understand what causes Alzheimer's disease, but we know that genetic factors can play a role," says NIA director Richard J. Hodes. M.D. "Scientists have previously identified three genes, variants of which can cause early onset Alzheimer's, and one that increases risk for the late onset form. This discovery provides a completely new genetic clue about the late onset forms of this very complex disease. We are eager to investigate the role of this gene further."

Scientists think that in Alzheimer's disease, amyloid precursor protein, or APP, is processed into amyloid beta protein fragments that make up plaques in the brain. The researchers began their search for genetic influences amid a group of proteins that transport APP within cells, looking for small changes, or "misspellings," in seven genes involved in moving APP within cells.

To start, the scientists combed two large data sets of genetic information from families in which more than one person has Alzheimer's disease. They were soon able to see that many of the families with Alzheimer's had variations in the SORL1 gene but not consistently in any of the other six genes.

They then expanded their search to genetic data sets from families of Northern European, Caribbean Hispanic, Caucasian, African American, and Israeli Arab heritage for changes in the SORL1 gene. Again, they found same association between SORL1 variations and Alzheimer's disease. Searching additional data sets provided by Steven Younkin, M.D., Ph.D., of the Mayo Clinic further confirmed the association of SORL1 variations and Alzheimer's.

"We are seeing the gene implicated in multiple data sets, across ethnic and racial groups," says Farrer. He adds that the group was "encouraged and excited" by cell biology experiments that demonstrate SORL1's role in production of beta amyloid fragments.

Examining blood cells from people with and without Alzheimer's, the researchers found less than half the level of SORL1 protein in people with Alzheimer's compared to people without the disease. In laboratory experiments, they found that altering the levels of SORL1 changed the way APP was moved around in cells, with low levels of SORL1 resulting in increased production of amyloid beta fragments while high levels decreased production. However, the researchers note, other genetic and non-genetic factors are likely to affect SORL1 production in people, and more research is needed to determine the how different versions of the SORL1 gene influence production of the harmful protein fragments.

NIA and NHGRI support a number of studies looking at genetic factors that may be involved in Alzheimer's disease. For information on the NIA Alzheimer's Disease Genetics Study, which is currently recruiting volunteers from families with two or more siblings affected by late onset Alzheimer's disease, visit the study web site, www.ncrad.org, call 1-800-526-2839, or email alzstudy@iupui.edu. □

Consumers Trained to Enter Mental Health Workforce In Award Winning Program of The Mental Health Association of New Jersey

Staff Writer
Mental Health News

Consumer Connections, a program of the Mental Health Association in New Jersey, has been awarded the 2006 Consumer Innovation Programming Award by The Annapolis Coalition on the Behavioral Health Workforce, a not-for-profit organization committed to improving the quality and relevance of workforce training and education in behavioral health and the effectiveness of recruitment and retention. As a result of being recognized, Consumer Connections will be added to the Coalition's Registry of Innovative Practices in Workforce Development, identifying it as a national best practice.

The Annapolis Coalition initiative spans the treatment and prevention of mental health problems, substance use disorders, and co-occurring mental and addictive disorders. Winners of their Innovation Awards were evaluated on the degree to which the program successfully addresses an important element of behavioral health workforce education, training, recruitment or retention, novelty of approach, transferability and effectiveness of the program.

Consumer Connections demonstrates that mental health consumers, with proper training, education and support, are able to work within the mental health system beyond "peer" specified roles, up to and including case-management. Since 1997, over 1,000 consumers have participated in the program with a remarkable 65% of participants becoming employed within NJ's mental health system. Consumer Connections developed a 90 hour curriculum, combined with a 2000 hour practicum, to create the Community Mental Health Associate certification (CMHA), which was specifically designed for mental health consumers. The CMHA is awarded by the Certification Board, a state recognized certification organization to recognize consumers with skills and knowledge equivalent to work at a paraprofessional case management level and expand options for employers to use consumers in the mental health workforce.

Consumer Connections is designed to meet the individual needs of consumers by providing internship programs and ongoing workshops to continually increase skills beyond the initial training level. Monthly Work and Wellness Forums provide mutual support for consumers transitioning from the role of consumers to the role of consumer providers. It also provides technical assistance and consultation to mental health providers to deal with workplace issues and stigma surrounding consumer providers becoming part of the workforce.

In addition to receiving the Annapolis Coalition Consumer Programming Innovation Award, Consumer Connections has also previously been recognized by the National Mental Health Association as its Innovative Program of the Year, by Eli Lilly as an Advocacy Employment Reintegration Program, the National Association of County Behavioral Health Directors, the US Department of Labor, and most recently the Commonwealth Fund.

The Mental Health Association in New Jersey is a private non-profit organization serving NJ since 1948. MHANJ strives for mental health for children and adults through advocacy, education, training and services. For further information about MHANJ or the Consumer Connections program, call (973) 571-4100 or visit www.mhanj.org. □

Who Will Care for the Mentally Ill? How One Hospital is Addressing the Nursing Shortage

By Carolyn Castelli, APRN, BC
Nurse Retention Specialist and
Linda Espinosa, MS, RN,
Vice President of Patient Care Services
Payne Whitney Westchester (PPW)

At a recent nursing symposium entitled Who Will Care for Me? one of the most compelling statistics noted was that by 2020, the U.S. will face a shortage of one million registered nurses1.

How is NewYork-Presbyterian Hospital's Westchester Division, a behavioral health facility in suburban White Plains, NY, caring for mentally ill patients and their families in the face of this impending crisis?

Nursing leaders are responding to this dire issue by pursuing creative nurse recruitment and retention strategies, seeking to improve the environment in which care is provided, and establishing a patient/ family-centric approach to treatment.

Carolyn Castelli, APRN, BC and Linda Espinosa, MS, RN

About NewYork-Presbyterian, Westchester Division: Payne Whitney Westchester

The Westchester Division is one of five facilities comprising NewYork-Presbyterian Hospital (NYPH). While behavioral health care is provided at the other sites, the Westchester Division's program, known as Payne Whitney Westchester (PWW), is one of the country's oldest, largest and most renowned center for psychiatric care. Since 1894, the Hospital has been committed to serving children, adolescents, adults and the elderly with psychiatric, behavioral and emotional issues.

Located in an idyllic setting on 214-acres, PWW offers comprehensive outpatient, day treatment, partial hospitalization and specialized inpatient programs. In 2006, there were 4,100 admissions to the inpatient unit (which has a total of 260 beds) and 45,600 out-patient visits.

The nursing staff includes 140 full-time and part-time registered nurses (RNs) as well as 36 "per diem" RNs.

With increased attention in the media on such nursing specialties as critical and emergency care, behavioral health care is sometimes overlooked. As such, NYPH management has made it a priority to be responsive to nurses who choose this field, as well as support efforts in developing recruitment and retention strategies focused on lowering nurse vacancy and turnover rates. The initiatives discussed in this article are designed and implemented by our nurses who are committed to working with the hospital in addressing this critical issue.

Recruitment Strategies

PWW is facing the challenge of the nursing shortage head-on with recruitment strategies that begin with competitive salaries and benefits, including a $10,000 per year tuition reimbursement for staff matriculated in nursing programs at any level. Many recipients choose to work here as nurses when they graduate, although they are not obligated to do so through the tuition reimbursement program.

Senior-year nursing students can receive scholarships in return for a two-year commitment to work at the hospital. A summer extern program for nursing students provides an intensive 12-week experience in behavioral health with the hope that students will select this specialty as their area of practice.

PWW offers a loan repayment program for qualified new graduate nurses as well as a nurse-refresher program for those interested in re-entering the profession. In addition, most recently, NYPH began international recruitment of nurses from a country that does not have a nursing shortage.

The Nursing Recruitment and Retention Council sends nurses to local Middle and High Schools to speak to students about choosing nursing as a career. Since Westchester County has a growing Latino population, this provides an opportunity to address the under-representation of Hispanic and other minorities in the profession.

PWW provides a clinical setting for nursing students from many local colleges and schools to come and learn. Working with deans and college faculty, PWW nurses evaluate and enhance the experience with the goal of recruiting these students to work in behavioral health immediately upon graduation.

Flexible scheduling is another offering by the hospital as it adds nurse positions to the budget. One-half of our units have 12-hour shifts, and other units are utilizing combinations of 8- and 12-hour shifts depending on needs. Increased staffing leads to improved scheduling, improved nurse-patient ratios, and greater job satisfaction.

Enhancing Environment for Patients and Staff

Enhancing the environment (also referred to as the "milieu") in which patients receive care has been a major focus for PWW nurses. Patients, their advocates, and regulators want to see restraint and seclusion free settings. With input from clients, staff at PWW have embarked on a milieu improvement project that seeks to transform care models to reduce, if not eliminate, these practices. Staff listens and responds to patients via interviews and satisfaction surveys. Behavioral programs provide effective structure and modeling. Cognitive behavior therapy programs give patients skills to change dysfunctional thoughts and destructive behaviors. The Retreat (for addiction recovery) and The Haven (for adults with various diagnoses) provide patients with added amenities, such as meals prepared by a gourmet chef. However, all units are continually striving to improve their treatment environments.

Nurses today want a work environment where they can share leadership and have a voice in all aspects of practice. NYPH instituted a shared-governance-model approach to decision-making that was quickly implemented by nurses at PWW. The Nursing Research and Publications Council is sponsoring a nursing research study to determine if the scent of lavender can help people sleep during addiction recovery. Insomnia is a nearly universal problem for people in recovery, so a non-addicting, non-pharmacological intervention that works to improve sleep would be an important advance. This is one example of how evidence-based practice is improving patient care.

Research has proved that collaboration of physicians and nurses improves patient outcomes and job satisfaction. A nursing-sponsored Physician of the Year Awards gives high profile to healthy professional relationships. This is an opportunity for our nurses to nominate and recognize those physicians who excel in collegiality, collaboration, and contributions to nursing practice.

Patient-Family Focus

"Putting Patients First" is the core of NYPH's mission. As 2007 began, PWW entered the fourth year of a very active and productive affiliation with the Planetree organization. Planetree is a model of patient- centered care that focuses on healing and nurturing the body, mind and spirit, and providing for the patient's and family's needs. Through organizational transformation, PWW used this model to create healing environments in which patients are active participants in their care. PWW nurses have embraced this model in their treatment of patients and families, and this has clearly contributed to a steady increase in both patient and employee satisfaction.

As nurses educate patients and families, treatment outcomes improve. Nurses teach patients and their families based on evidenced-based information and research. A patient, Joseph, recently shared that nurses who teach the weekly patient education seminars help him learn how to cope with his symptoms and remain stable with out-patient treatment services.

Retention Efforts

From the moment of hire, PWW seeks to provide nurses with the support and skills they need to be successful. In conjunction with classroom and clinical orientation, the Nurse Preceptor Program pairs each new nurse with a more experienced Nurse Preceptor.

New graduates have a monthly support group to assist them during the first year of transition, since this is a vulnerable time of adjustment to the profession. The Division of Nursing is committed to creating opportunities to be mentored and to mentor throughout the career of a nurse. While teaching and mentoring add to the workload, nurses report satisfaction in facilitating the professional growth of new nurses, and helping students and externs learn about treating those with mental illness.

The Nurse Retention Specialist also assists in facilitating various retention initiatives, including the Career Pathway Program. This program allows for nurses to remain in direct patient care while enjoying increased job responsibility, promotional opportunity, and increased compensation. One of the Career Pathway nurses has been involved in lobbying efforts to urge the NYS legislature to allocate more funds for healthcare education.
Our Health Education staff provides continuing education opportunities to assist nurses in their growing and changing roles. Nurses are encouraged to seek advanced nursing degrees and become nationally certified as psychiatric-mental health nurses. Many belong to national and international nursing organizations, publish articles, and seek to advocate for change in legislation to promote nursing as a profession and improve treatment for those with mental illness.

The Vice President of Patient Care Services meets with new nurses in focus groups several months after hire to hear their beginning work-related experiences. In addition, she provides regularly scheduled open-door sessions throughout the

see Nursing Shortage on page 46

NewYork-Presbyterian Psychiatry

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Columbia Psychiatry

NewYork-Presbyterian Hospital/ Columbia University Medical Center
622 West 168th Street
New York, NY 10032
212-305-6001

NewYork-Presbyterian Hospital/ The Allen Pavilion
5141 Broadway
New York, NY 10034
212-305-6001

New York State Psychiatric Institute
1051 Riverside Drive
New York, NY 10032
212-543-5000

Weill Cornell Psychiatry

NewYork-Presbyterian Hospital/ Weill Cornell Medical Center
Payne Whitney Manhattan
525 East 68th Street
New York, NY 10021
888-694-5700

NewYork-Presbyterian Hospital/ The Westchester Division
Payne Whitney Westchester
21 Bloomingdale Road
White Plains, NY 10605
888-694-5700

The NYSPA Report

SVP Legislation and the Misuse of Psychiatry

By Barry B. Perlman, MD
Legislative Chair and
Immediate Past President
New York State Psychiatric Association

In the NYSPA Report in the Summer, 2006 issue of Mental Health News, Dr. Perlman articulated NYSPA's opposition to the proposed civil confinement of "sexually violent predators" in state mental hospitals subsequent to their term of imprisonment. In this article he places that concern in the broader context of the political misuse of psychiatry.

Barry B. Perlman, MD

It was disappointing to hear Governor Spitzer call for the enactment of a civil confinement statute for sexually violent felons in his first State of the State Address, just as Governor Pataki had done before him. When governments resort to the use of their mental health systems to solve what otherwise appear to be insoluble political or criminal problems, persons with mental illness and the professionals who serve them are damaged. Psychiatrists recall with dismay the abuses of psychiatry which have occurred worldwide in recent decades. Most familiar to us have been the misuse of the mental health systems by the Soviet Union and China. Last year the government of Afghanistan made use of psychiatry to solve the dicey situation of a capital sentence of a Muslim convert to Christianity. Ultimately, the apostate was spared but forced from his country. This result was realized only by his being declared mentally ill. Likewise, the United States has looked to its mental health system to dodge awkward political situations. On the basis of a 5 to 4 Supreme Court decision, *Kansas v. Hendricks* (1997), 17 states passed laws which direct the civil confinement of persons convicted of having committed a sexually violent offense at the conclusion of their prison term. New York State, our state, now wishes to pass a similar law.

Professional psychiatric organizations, such as the American Psychiatric Association and NYSPA, view such legal "hijacking" of the mental health system as an assault on the integrity and scientific basis of their profession. Looking through the dark lens of the Cold War it was easier for Americans to be critical of the Soviet Union's corruption of its psychiatric system to suppress political dissent than it for us today to self-critically note the misuse of the system in our country where those being effected are societal pariahs. The 1977 book, "Psychiatric Terror: How Soviet Psychiatry Is Used to Suppress Dissent", describes how the lack of strict medical criteria for the diagnosis of mental illness enabled the state to create alternate diagnostic schemes for the purpose justifying the commitment of political dissidents to special "hospitals" such as the infamous Serbsky Institute for Forensic Psychiatry. During that period *samizdat* (underground) publications were the vehicle by which the abuses were made known. In one such publication the anonymous author says, "…the blame for these outrages lies not in the science but those who have seized power in science". In another the psychiatrist Dr. Semyon Gluzman reminds the reader that, "Psychiatry is a branch of medicine and not of the penal law." Each of these statements is relevant to our concerns about the abusive use of civil confinement. The approach justified by the majority decision in *Hendricks* disingenuously asserts that the scheme is not meant as punishment and that there is no requirement that the legislature use the term "mental illness" as "…we have traditionally left to legislators the task of defining terms of a medical nature that have legal significance." Thus in existing laws dealing with sexually violent predators and in the proposed NYS bills the non scientific term "mental abnormality", a legal construct, becomes the basis for commitment. The question then is whether by generating such terminology the legislature is defining a pseudo diagnostic scheme about which psychiatrists can claim no special expertise.

A NY Times article on 3/17/06 reported the suppression of political dissidents in China by incarcerating them in "Ankang", a special network of forensic psychiatric hospitals, often without trial. The referenced case was of a prominent dissident who spent 13 years in such an institution for his "delusions of grandeur, litigation mania, and conspicuously enhanced pathological will." Human rights groups reported that 2 Dutch experts who examined the internee found that he did not have mental problems justifying his commitment. "Dangerous Minds: Political Psychiatry in China Today and Its Origin in the Mao Era", published in 2002, details the misuse of psychiatry for purposes of political repression throughout modern Chinese history and, since mid-1999, the forcible confinement of Falun Gong members in mental hospitals. They document official inclusion in Chinese psychiatric literature of the notion of 'political dangerousness' and how it was incorporated into official diagnoses and made part of the concept of psychiatric dangerousness.

In the United States a renowned example of the expedient political use of psychiatry was the commitment of the poet Ezra Pound to Saint Elizabeth's Hospital. Pound had been indicted for treason, a potential capital offense, for his broadcasts from Italy during World War II. For constitutional reasons a conviction seemed unlikely and for that reason prosecutors did not challenge Pound's attorney's assertion that he was not mentally fit to stand trial. He was remanded to a psychiatric hospital. Thus did Pound avoid conviction and the government embarrassment. In similar vein, Attorney General Robert F. Kennedy attempted to make political use of psychiatry when he encouraged the civil commitment of General Edwin Walker, a WWII military hero and right wing segregationist, who was arrested for resisting and impeding federal marshals sent to assure the integration of the University of Mississippi by James Meredith in 1962.

While our country and state should not be facilely compared to other nations, many totalitarian, which have misused their psychiatric systems to silence political dissidents, we are in danger addressing the criminal problem of sexually violent predators, which has become a political flashpoint, by wrongly resorting to a psychiatric solution. While some, such as Justice Scalia assert that the purposes of medicine are not for the profession to decide but are rather "a matter for 'public morality,' the province of elected officials." We dissent and assert that beyond the legal boundaries which define our practices lie important ethical and historic traditions which serve to inform our work. Those latter elements lead us to decry misuses of our profession, psychiatry, because it diminishes us and those for whom we care. Those defining elements are what differentiate a profession from a trade. □

NAMI Corner

Providing support to families and friends of individuals with mental illness and working to improve the quality of life for individuals with mental illness. Helpline: 1 800-950-3228 (NY Only) - www.naminys.org - Families Helping Families

NAMI-NYS 2007 Action Agenda

By J. David Seay, Esquire
Executive Director
NAMI-New York State

The 2007 Legislative season has begun in Albany and what a new day it is! The Spitzer administration has come into office with lightening speed pushing a reform agenda and an aggressive list of policy aspirations. Health care is both a big issue and a big target.

However in his first Executive Budget released on January 31st, mental health advocates were very pleased with the direction he is taking in our field. Funding for 2,000 new beds of mental health housing, more money for research, increased funding for treatment of prisoners with mental illness as an alternative to the Special Housing Units (SHUs), also known as "the hole" and "the box" – the 23-hour solitary confinement cells. He also put $100 million in the Department of Insurance budget to fully implement the first year of Timothy's Law for mental health parity in health insurance and health plans. He even funded a $2.7 reduction in the Federal block grant for mental health services.

And he hired Dr. Michael F. Hogan as Commissioner of the New York State Office of Mental Health. Dr. Hogan, formerly commissioner in Connecticut, Massachusetts and Ohio, and former Chairman of the President's New Freedom Commission on Mental Illness, is widely recognized as about the best mental health commissioner in the country. He has a good and solid reputation as a transformational change agent and worked very closely with our colleagues in NAMI Ohio, including Gloria Walker, Terry Russell and Jim Mauro. NAMI-NYS anticipates that kind of relationship with Dr. Hogan and we look forward to working with him as we continue to pursue our mission of improving the lives of all New Yorkers affected by the brain disorders known as mental illness.

All in all, things seem off to a very good start in Albany regarding the issues and concerns of NAMI-NYS and our colleague mental health advocates.

As is my custom at this time of year, I will share in my NAMI Corner column the NAMI-NYS 2007 Agenda for Action. These are out top legislative and budgetary priorities for the year which we showcase at our annual NAMI-NYS Legislative Conference and Lobby Day in February and use throughout the legislative session in our advocacy efforts. The theme of our agenda this year flows from remarks made by Governor Spitzer in his inaugural address about there being a fresh start in Albany and in New York government. Our theme is **"A Fresh Start – A Fair Deal"** and it applies with equal force to our four legislative priorities and our five budget priorities.

J. David Seay, Esquire

Keep the Sexual Predators Out

Legislative proposals call for using the state psychiatric system for civil confinement or "holding pens" for violent sexual predators coming out of prison. Hospitals are for treatment and recovery, not confinement and warehousing. The safety of New Yorkers with mental illness and those who care for them is at stake. Precious dollars would be drained from the mental health system and beds would be taken from the ill New Yorkers who need them. And the stigma of mental illness, already bad enough, would be exponentially exacerbated. NAMI-NYS says "Keep the Sexual Predators Out!"

Legislators must not create an artificial mental disorder – "mental abnormality" -- to allow psychiatric hospitals to become holding pens for violent sexual predators. This would cause irreparable harm to mental health care in New York, would be prohibitively expensive and would not make New Yorkers any safer. Legislators should listen to the experts and create an effective, cost-effective and comprehensive way to protect our communities from violent sexual predators.

NAMI-NYS calls for legislation that would place sexual predators in secure facilities away from patients with serious mental illnesses. Sexual predators are not patients. Fewer than 5% have a valid mental illness diagnosis. Persons with serious mental illness are already 20 times more likely than the general population to be a victim of sexual assault.

The law must guarantee that both dollars and beds be segregated. Every dollar spent to house a sexual predator in the state psychiatric system is a dollar drained out of the OMH budget for persons with serious mental illness. Every bed filled with a sexual predator is a bed closed to a New Yorker with a serious mental illness in need of treatment.

The law must avoid guilt by association. Longstanding efforts to reduce the stigma associated with mental illness will be turned back decades by equating sexual predators with those who have a serious brain illness.

The American Psychiatric Association and the National Association of State Mental Health Program Directors oppose this use of the mental health system.

Boot the SHU

A "Special Housing Unit" (SHU) is the punitive 23-hour solitary lock-down cell in prisons, also known as the "box." It is used to punish "bad behavior," even behavior caused by an inmate's mental illness. It is a barbaric practice that should not be tolerated by any civilized society. NAMI-NYS says "Boot the SHU."

Approximately 8,000 New York inmates -- 12% of the prison population -- suffer from serious and persistent mental illness and yet at any given time 25% of persons in SHUs suffer from serious mental illness. NAMI-NYS believes that the rate of inmates with mental illness in SHUs is 3 times that of the general prison population.

Inmates in SHUs spend months -- and often many years -- in solitary confinement. The psychological damage caused by this is well documented. Inmates suffering from psychiatric deterioration while in the box often become so ill that they engage in more "misconduct," leading to further SHU confinement. And studies show that these persons engage in acts of self-mutilation and commit suicide three times as often as other inmates.

The American Psychiatric Association and the American Association of Community Psychiatrists caution against the use of isolation cells for such inmates and say that isolation and enforced idleness leads to further deterioration and illness. Persons with a serious mental illness in the state prison system need treatment, not punishment.

NAMI-NYS calls for passage of legislation – once again -- which would effectively boot the SHUs and require the Department of Correctional Services and OMH to develop effective alternatives to solitary confinement. Both houses of the Legislature passed the bill last year and Governor Pataki vetoed it; NAMI-NYS urges Governor Spitzer to sign it. We were encouraged when Governor Spitzer put money in his budget that would expand mental health treatment services for prisoners with mental illness as an alternative to the SHU. Perhaps he will be able to achieve the same goals as the SHU bill even without legislation.

Housing Waiting List

NAMI-NYS supports passage – once again – of the community mental health housing waiting list bill. In the absence of needs-based planning for mental health services, no one really knows how many units of housing (with support services) are needed in which communities. By requiring the state to maintain waiting lists for such housing community by community, a better understanding of the need for such housing can be obtained.

The law would require the NYS Office of Mental Health (OMH) to keep accurate and timely local waiting lists of people with serious mental illness who need housing and services.

No one will ever know the full extent of the need for community mental health housing (with services) without a waiting list or needs-based planning.

The NYS Office of Mental Retardation and Developmental Disabilities routinely maintains waiting lists for housing and services for people who need them and it works just fine. New Yorkers with mental illness deserve no less.

Last year the Senate and the Assembly passed a waiting list bill with bi-partisan support. Governor Pataki vetoed this bill.

This year, NAMI-NYS urges both houses of the Legislature to again pass the waiting list bill for community mental health housing with support services and for Governor Spitzer to sign it into law.

Timothy's Law

Now that it has been enacted, Timothy's Law must be fully implemented in a timely manner. The law must also be expanded to provide full parity for everyone, including the employees of companies with fewer than 50 people. Parity must also be expanded to include the full range of services, including chemical dependency services, and all mental illness diagnoses. 91% of New Yorkers want to see an end to discrimination in health insurance.

Timothy's Law is a profound first step towards full parity and the ending of this discrimination.

But the HMOs and insurance companies are trying to stall implementation of the law and the law needs to be expanded and improved.

The law mandates parity only for large employers (with more than 50 employees) and then only for a short list of diagnoses. And for New Yorkers who work for small employers, the law only requires what most people already had – 30 days of inpatient coverage and 20 outpatient visits per year.

And the law omitted chemical dependency coverage – a glaring omission given that as many as 50% of persons with a mental illness also have a co-occurring substance abuse or chemical dependency diagnosis as well.

HMOs and insurance companies can be given time to adjust their policies and practices, but the coverage must be effective

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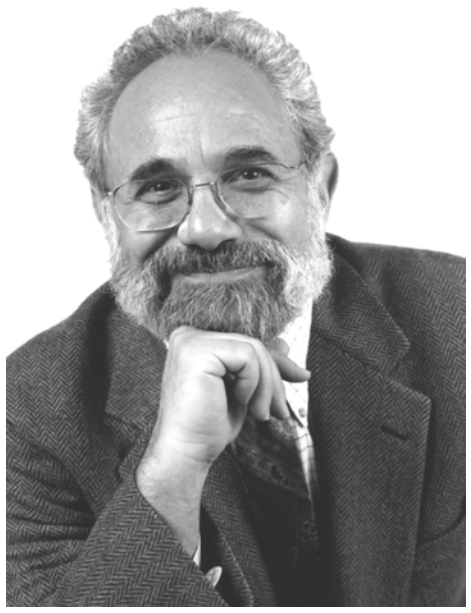
POINT OF VIEW

Save Money, Saves Lives

By Michael B. Friedman, LMSW



Michael B. Friedman, LMSW

In his first State of the State Message, Governor Spitzer said, "We will … invest in better management of high-cost [Medicaid] cases involving patients with multiple chronic [physical and mental] illnesses—a relatively small number of cases that make up a disproportionately high cost to the system. … [This] will not just save money for patients and the state, but will lead to better overall care."

I think, and hope, that this statement means that New York State is on the verge of a major change in mental health and health policy—that mental health will become a priority of the health system and that health will become a priority of the mental health system. Perhaps, after many years of talk about integration of services, steps will be taken to end the current fragmentation of mental health and health services.

Two discoveries made in the past few years are driving this change.

(1) Several studies make it clear that the nation's health care expenditures are for disproportionately a small percentage of people. E.g. in NYS it appears that about 70% of Medicaid spending is for about 10% of the state's Medicaid recipients. Who are the 10%? A great many of them are people with serious and persistent mental illness and/or substance abuse disorders in addition to chronic health conditions.[1]

(2) A recent research study indicates that people with serious mental illnesses die—on average—25 years younger than the general population.[2] (Earlier studies put it at 10 years. Horrible enough at that rate.)

Bottom line: people with mental and substance abuse disorders often have very high health care costs and people with serious mental illness are dying young because of poor health and poor health care. Meaningful integration of health and mental health services is the only way to address these problems.

Those of us who work in health and mental health policy should not have been surprised by the recent discoveries. It has been known for a very long time that depression, for example, complicates cardiac disease and drives up the costs of its treatment. And all of us who have worked with, had family, or been people with serious mental illness have known from terrible experiences that getting good health care is terribly difficult for this population. In fact, in the mid-1970s when I was working in a psychiatric rehabilitation program, I briefly considered organizing a medical practice that specialized in serving people with serious mental illness. I never followed up on the idea and instead did what almost all of us in the provider community did – i.e. focused on the development of very important services – such as housing, outpatient treatment, psychiatric rehabilitation, case management, family and peer support, etc.—that were being increasingly funded via the Community Support Program and Medicaid. We built some remarkable service programs in the community – great programs, needed programs; but all along our clients, our family members, and our friends were dying virtually without notice.

Alarms were sounded along the way. For example in the late 80s and early 90s, Russell Massaro – then the Medical Director of OMH – talked frequently about research findings that indicated that 50% of the people with serious mental illness had serious, chronic health conditions, that only half of them had been diagnosed, and that fewer than half of the diagnosed cases got appropriate medical follow-up. And it wasn't just Dr. Massaro who pointed to problems of physical health. The report of the study that suggests life expectancy of people with serious mental illness is 25 years lower than the general population cites research going back to 1969.

I look back now with a sense of embarrassment that health has not been high on the mental health advocacy agenda. Objectively I understand that we were all doing and advocating for important other services and that it often takes a shock like the report that people with serious mental illness have a dramatically low life expectancy to rouse our awareness of what should have been obvious. I still feel we should have known.

But we're on it now.
What should NYS do?

1. Make health a priority for the mental health system and make mental health—and people with serious mental illness and/or substance abuse disorders—a priority for the health system.

2. Make sure that people with serious mental illness have "a medical home" providing good primary care. And make sure that people receiving primary, specialty, home health, or emergency care get good mental health services when they need them.

3. Support the development of health maintenance, self-management, and peer support initiatives in programs serving high-risk populations.

4. Identity those with co-occurring severe, chronic physical, mental, and/or substance abuse disorders by name (using Medicaid claims data) and organize outreach programs to aggressively offer help.

5. Using these outreach programs, provide a person to work with these high-risk individuals one-on-one and face-to-face to develop an individualized services plan and to facilitate access to needed services, including housing and community supports as well as clinical care.

6. Institute a financing structure to support individualized services.

Suggestions 5-6 above are often called "managed care." I think this is a mistake, not only because the expression "managed care" complicates the politics of change, but also because managed care as practiced has evolved into a limited set of techniques. We probably need to think outside that box. In addition, the concept of managed care implicitly puts the responsibility for integrating health and mental health services outside the service providers. In fact, it is the mental health and health professionals, working in partnership with service recipients, who need to do the integrating. This will require them to think differently about their roles and responsibilities and to modify their practice accordingly.

Clearly, a great many details need to be worked through. But Governor Spitzer's attention to co-occurring disorders gives reason to hope that New York State will act now to address the mental health needs of people with serious, chronic health conditions and to address the health needs of people with serious mental illness and/or substance abuse disorders. The only alternative is continued, preventable high mental health/health care costs and an awful lot of unnecessary deaths.

Michael B. Friedman is the Director of the Center for Policy and Advocacy of The Mental Health Associations of NYC and Westchester. The opinions expressed in this column are his own and do not necessarily reflect the positions of the MHAs. Mr. Friedman can be reached at center@mhaofnyc.org. □

Footnotes:

(1) Wagner School of Public Service Center for Health and Public Service Research. "High Cost Medicaid Patients: An Analysis of New York City Medicaid High Cost Patients." United Hospital Fund. 2004.

(2) Colton and Manderscheid. "Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States," Preventing Chronic Disease: Public Health Research, Practice, and Policy, April 2006.

The Economics of Recovery:
How to Understand & Access Government Entitlements

By Donald M. Fitch, MS
Executive Director
Center for Career Freedom

The purpose of this column is to assist providers and consumers to be more effective when negotiating with local government agencies for income, health care, housing, food, transportation, job training, employment and other social services.

The focus is on single adults (18-64 years) with a mental and/or physical disability, substance abuse issues and the homeless. The information is gleaned from government websites and local, state and federal government offices.

Tips for accessing benefits are based on assisting over nine hundred persons at the Center. Our experience is supplemented by regular mystery shopper, provider and consumer surveys.

Q. What are Mystery Shopper Surveys?

A. The Mystery Shopper interviewing technique has been used for years by business' to monitor the effectiveness of their sales staff. At the Center, consumers often interview their local government workers on benefit and back-to-work issues. We have found the technique is useful in identifying the gap between local workers' knowledge and their agencies' website. In the process, we sometimes uncover opportunities for system reform.

• For example, while researching why Department of Social Service (DSS) workers in New York award different amounts of Food Stamps to persons with identical eligibility criteria. We learned that they often skip the twenty-six step application form and ball-park the amount of the award).

Donald M. Fitch, MS

• Mystery Shopper questions about wait times for Section8/Shelter Plus housing is 6 months to 5 years; Cost: $1,100 for a one bedroom apt. We found that local shelters' charge the government $3,500/Mo and up per person, placing many people in the same room.

• When researching access to health care, several Medicaid recipients volunteered they regularly call an ambulance to take them to the ER, even if it is not an emergency (at about $2K per event).

Q. Several of my patients on disability are work ready. How much would they have to earn to replace the value of their income, health, housing, food, etc. benefits?

A. The average cost to replace these benefits is about $1,700/Mo or about $20,000/Yr. The economics of recovery for single persons living alone receiving Social Security Disability Income (SSDI) and or Social Security Income (SSI) are that they will require sufficient marketable skills to earn at least $14/hr and the endurance to work thirty-five hours/week.

Q. One way to cut Medicaid costs is to help recipients return to competitive employment. What are the savings to taxpayers for every consumer that returns to self-sustaining work?

A. The Social Security Administration (SSA) estimates if one half of one percent of the SSI/SSDI recipients returned to work, the contribution to the Trust Fund would be thirty billion dollars. For every individual that returns to work, taxpayers save about $20,000 in government benefits. With a salary of 25K/Yr, their total contribution to the economy would be about $45,000/Yr or about $675,000 over their lifetime (15 years).

Q. How much can I earn before I'm cut off Welfare? My Case Worker does not know.

A. According to the NYS Office for Temporary Disability (OTDA) the overseer for all DSS Offices, there is no fixed income cap as there is for SSI/SSDI recipients. The maximum earned income cap is equal to the amount you receive from DSS (not including Food Stamps), plus a $90.00 income disregard.

For example, in Westchester County, the maximum Temporary Assistance (TA) grant is $408/Mo ($137.10/Mo for Basic, Home Energy Allowance (HEA), and $271/Mo for shelter). Therefore, the maximum amount one can earn must be less than $498/Mo or, your benefits will be discontinued. (Freedom of Information law; 18 NYCRR 352.31 (a) (2) not available on the website)

Q. How much can a recipient on SSDI earn before their cutoff from SSAs' income benefit? (Generally, SSDI recipients must have more than ten years paid employment)

A. SSAs' maximum earned income cut off point for 2007 is $900/Mo. Some deductions apply. (SSAs' Redbook).

This means a recipient could earn up to $900/Mo. and still keep their SSA benefits. For example, if a recipient returned to work part-time and earned $10/hr. and worked 10 hrs/week, they would have an income of about $400/Mo. In addition, if they received the average SSDI benefit of $943/Mo. in NYS, their total income, earned and unearned, would be $1443/Mo.

Q. And, how much can a recipient on SSI earn? (Generally SSI recipients have much less than ten years paid employment)

A. SSAs' maximum earned income cut off point for 2007 is $1463/Mo. for recipients of SSI. However, SSA deducts half of their gross income, after $85., so the recipient gets to keep half of what they make, ($774) before employment related expenses; taxes, transportation, meals, work clothing, and Section 8/Shelter Plus housing.

We have found unless the SSI recipient is receiving free room and board, they cannot work their way off SSI – even with the Medicaid buy-in, Pass Plan, 1619b, etc. (ssa.gov) SSA does not dispute the Economics of Recovery. Legislation is required.

Please send your questions to donfitch@freecenter.org. If your questions are used in the column you will receive a complimentary copy of Form-Link CD, a compilation of over seven-hundred pages of Government Benefit application forms. □

Strengthening the Mental Health Workforce: A Provider Commitment and A Systemic Need

By Marc D. Kutner, MSW, MPA
The Coalition
of Behavioral Health Agencies

Any stakeholder within our mental health system, whether consumer, provider or policy maker would be hard-pressed to counter that the public-private collaborative that comprises "the system" exists in a state of perpetual change. Many critical variables define the nature of the changes we are now encountering. Shifting policy priorities, regulatory flux, the decreasing purchasing power of the mental health care dollar, and differing viewpoints on how dollars are best utilized programmatically are but a few. Yet, through it all, direct-service staff employed by community-based providers continue to represent a large proportion of the workforce tasked with delivering services. Irrespective of the challenges, provider organizations remain committed to keeping pace with systemic change and often do so through continuous staff training and education.

To do what we need to do well, staff must be equipped with the relevant competencies-knowledge, skills and attitudes - informed by the latest evidence-based practices. Although most direct-service staff possess formal academic training and various credentials appropriate to their roles, is that really sufficient? Too often, academic training is fixed in time. Post-graduation education and training also enjoys but a limited shelf-life in today's system. In order to maintain currency, educational and training entities must maintain consistent relationships with providers to assure staff possess the skills necessary to remain effective. A. Kathryn Power, Director of SAMHSA's Center for Mental Health Services has recognized this need and states in reference to the mental health workforce, "Human capital is our most valuable resource, and as such, we must invest in it wisely."

New York State and City government alongside New York City's community-based providers have chosen to invest

Marc D. Kutner, MSW, MPA

wisely as evidenced by their continued support for The Coalition of Behavioral Health Agencies. Through both our Center for Rehabilitation and Recovery and Professional Learning Center, the Coalition is responsive to the expressed staff development needs of member and non-member behavioral health providers alike. Both Coalition programs provide year-round trainings, seminars and technical assistance addressing salient clinical, regulatory and policy issues.

The Coalition's Center for Rehabilitation and Recovery, largely funded by the New York State Office of Mental Health (OMH) promotes rehabilitation and recovery opportunities for mental health recipients throughout the five boroughs. The Center's staff training efforts are currently focused on a number of key areas: increasing knowledge of benefits and entitlements, clinician use of the psychiatric rehabilitation approach, and developing core competencies including an understanding of rehabilitation and recovery concepts and how to apply them toward helping clients attain self-directed goals.

Additionally, the Center's special projects provide both training and technical assistance. While training often represents the cornerstone of staff development, the degree to which learning translates into practice can vary. To that end, as part of our special projects we provide the ongoing consultation needed for staff to successfully implement key learning principles and service delivery approaches. Included among the Center's current special projects are our Youth Initiative and the Peer Recovery Pilot, a collaboration with the New York City Department of Health and Mental Hygiene (DOHMH) and the Howie T. Harp Peer Advocacy Center.

The Center's Youth Initiative is a response to providers calling for evidence-based practices designed to prepare and support youth with Serious Emotional Disturbances (SED) in their movement into living situations, community life functioning, educational opportunities, and employment. Through trainings on the Transition to Independence Process (TIP) system developed by Dr. Hewitt Clark, University of South Florida/Tampa, the New York City youth provider community is now equipped with an evidence-based model that has been demonstrated to improve outcomes for young people in these four domains; selected organizations choosing to implement this model are receiving on-site technical assistance.

Also a part of our Youth Initiative and consistent with our focus on employment as a critical component of rehabilitation and recovery, the Center is providing training to agency staff on developing employability skills for SED youth. Developing Employment Solutions for Seriously Emotionally Disturbed Adolescents and Young Adults addresses job readiness, job development and the use of motivational strategies when working with this population.

Essential to the development of higher quality programs that better serve consumers is the increased use of peer staff in clinical settings. The Peer Recovery Pilot is intended to demonstrate the importance and feasibility of using peer staff to deliver and promote recovery-enhanced services. There are three goals of this year-long pilot project: to demonstrate the benefits of using trained peer staff to assist consumers and clinicians in developing and delivering recovery-oriented continuing day treatment program (CDTP) services; to assess whether peer-facilitated individual recovery planning and delivery of services creates a more recovery-oriented program, and to create sustainable conditions for peer recovery facilitators to be used in CDTPs. The project partners believe this pilot will promote recovery-oriented practices such as the utilization of recovery-oriented treatment plans. Further, this pilot will help to diminish illness-related stigma, strengthen awareness of the possibility of recovery among consumers and staff, and incorporate consumers in their wider communities in meaningful ways.

In addition to the Center for Rehabilitation and Recovery's work, the Coalition's Professional Learning Center typically provides training and technical assistance opportunities to the Coalition's member organizations. With an emphasis on assisting staff prepare for policy and regulatory changes with crucial implications for funding and client services, the Professional Learning Center currently offers training on issues including the Medicare Part D benefit, and an exciting four-part training series on Integrated Dual Disorder Treatment (IDDT). Past training topics include legal issues in behavioral healthcare, cultural competency, corporate compliance, HIPAA (Health Insurance Portability and Accountability Act) requirements, training for new and mid-level managers and Medicaid billing, coding and documentation.

Judging by the range and reach of the Coalition's training and technical assistance work, provider staff must navigate an intricate network of systems, regulation, policies and service delivery methods each and every day. Through ongoing reinvestment in staff, we can help assure that the mental health workforce will remain committed to delivering the kind of services recipients deserve and providers can be proud of.

For more information about the Coalition of Behavioral Agencies, Please visit our website, www.coalitionny.org □

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The Mental Health News
Nassau County Section

"Hope" Works in Nassau County

By Barbara Tedesco, MS, CRC
Director of Consumer Link
Mental Health Association
of Nassau County

"Operation Hope" Conference Leadership: See List on Page 42

This past December, over 160 Nassau County Health and Human Service workers, mental health providers, mental health consumers, family members, law enforcement, media, and elected officials attended "Operation Hope: Tools, Techniques, and Transformation for Recovery in Mental Health," an informational and inspirational conference co-sponsored by Nassau County Executive Tom Suozzi, the Nassau County Department of Mental Health, Chemical Dependency, and Developmental Disabilities Services, the New York Association of Psychiatric Rehabilitation Services (NYAPRS), and the Mental Health Association (MHA) of Nassau County.

The entire day centered on the juxtaposition of the mental health system of the last century, that focused on an uncompromising negative view of individuals with mental illness as infirm, unable, and increasingly impaired over time, and the promise of a recovery-oriented mental health system focused on personhood, human potential and strengths.

The day began with John Javis, co-chair of the conference, giving an explanation of the symbolism of the Mental Health Association's Bell as a reminder of our history and our commitment to a better future for individuals diagnosed with mental illnesses. Fifty years ago, MHA issued a call to institutions across the country for their discarded chains and shackles. On April 13, 1956, the McShane Bell Foundry in Baltimore, MD, melted down these bindings and recast them into a 300 pound bell as a symbol of hope for the future. This Bell is also, however, a powerful reminder that there remain invisible chains of misunderstanding and discrimination that continue to bind people with mental illnesses.

Mr. Javis brought the analogy closer to home by reminding the audience that it was not that long ago that people were locked in institutions, like Pilgrim Psychiatric Center, for 40 or 50 years of their lives (or more). Today self-determination, community integration and recovery are supported by local, state and federal decree (including, but not limited to, the President's New Freedom Commission on Mental Health, the Veterans' Administration Action Agenda, the Surgeon General's Report on Mental Health, the National Council on Disability Report and the New York State Office of Mental Health).

The conference itself offered three keynote addresses by national-acclaimed speakers, and six thematic workshops dealing with issues such as:

- An overview of mental illness and recovery principles
- The mental health needs of children, young adults, and seniors
- Combating the stigma of mental illness
- An overview of the Nassau County Mental Health System
- Mental health in a multi-cultural context
- Community living and employment opportunities for those with psychiatric illnesses.

In addition, there was a unique plenary session designed to answer specific audience questions about how to respond to difficult situations within programs or health and human services in a respectful and recovery-oriented way.

Each keynote address brought it's own distinct information and inspiration. Dan Fisher, M.D., board certified psychiatrist, Executive Director of the National Empowerment Center, and 1 of the 22 members of President Bush's New Freedom Commission on Mental Health, spoke of his personal experiences of dealing with schizophrenia, the treatment he experienced, his ultimate recovery and subsequent commitment to the belief that "recovery" can actually be the common ground uniting providers, families and consumers. His detailed journey and career affirms the belief that true human contact (professional, peer, friend, and family) and belief in recovery has the power to reach the person inside the illness.

Harvey Rosenthal, Executive Director of the New York Association for Psychiatric Rehabilitation Services (NYAPRS), a coalition of mental health consumers and providers, based in Albany returned to his Long Island roots to share his experiences of a depression so severe and encompassing that it resulted in hospitalization at age 19. He continued to share how he turned his ensuing journey of recovery and life experiences, first, toward a career as a mental health provider and, ultimately, to serve at the helm of NYAPRS, an advocacy organization truly dedicated to improving services and social conditions for people with psychiatric disabilities/diagnoses by supporting the fundamental belief in the capacity for recovery, healing, and independence for all individuals.

At lunch, Nassau County Legislators Jeffrey Toback and David Denenberg not only "broke bread" with conference participants and presenters, but also expressed strong support for the best of innovative and recovery-oriented mental health services in Nassau County and shared the welcomed news that Nassau County will again allocate $1.3 million in local funds to enhance mental health services for 2007.

There was probably no moment throughout the day that HOPE was more palpable than in the final keynote presentation of the day by Jacki McKinney, co-founder of the National People of Color Consumer/Survivor Network. The audience seemed mesmerized by her story, first brought to tears and then to their feet when she told her story of triumph over trauma, abuse, addiction, homelessness, and the psychiatric system. Again, the critical need of human acceptance was emphasized as the very foundation of recovery. Ms. McKinney recounted that on the very day that she believed that her death was imminent, the simple, humanistic act of an individual reaching out to her and her acceptance that someone could believe in her (in all her "raging and ravaged glory") slowly led to her ultimately believing in herself and turning her life around. Her life is now dedicated to sharing her powerful story of "hopelessness" turned into resilience with the potent formula of kindness, caring, compassion, and persistence.

There was a time, probably not so long ago, that this conference could not have taken place in Nassau County. It is only due to the combined effort of mental health and other service providers, government officials, consumers, and family members, that made this conference possible. Above and beyond a mental health system that was based on perceived deficits, low expectations, control, and coercion, mental health and other social services were the target of deadly budget cuts.

see Hope Works on page 36

Dear Friends of The Long Island Mental Health Community. Please Join With Us to Help Bring Life Saving Mental Health Education To Individuals and Families Whose Lives Are Affected by Mental Illness. We Now Have our Own Nassau County Section in Mental Health News And Urge You to Please Call the Publisher at (570) 629-5960 or E-mail at mhnmail@aol.com, To Discuss How Your Organization's Vital Programs and Services Can Become Part of This Exciting and Necessary Mental Health Education Project

Preparing Today's Workforce for Being Good Cross System Partners

By Andrew Malekoff, LCSW, CASAC
Executive Director & CEO
North Shore Child & Family Guidance Center, Roslyn Heights, New York

Today's children's mental health workforce requires certain universal capabilities that are essential for competent and principled practice. These longstanding fundamentals include respecting diversity, practicing ethically, challenging inequality, addressing the causes and consequences of stigma, providing consumer centered care, identifying people's needs and strengths and maintaining a commitment to personal development and learning.

A competency that should stand on the top of the list in this era of shrinking government support (the growing gap between costs and revenues and the need for joint ventures among service providers and stakeholders), is *promoting and supporting a culture of healthy partnership and collaboration among systems*. This necessitates recruiting, cultivating, and supporting a workforce that has the flexibility to be both fluid and grounded. We need children's mental health professionals who understand that they must be much more than therapists. They must also be educators, counselors, advocates and especially mediators that help children and the systems (family, community, school) that they often become alienated from to rediscover their stake in one another.

Psychiatrist Robert Lifton's concept of the "protean self," characterized by fluidity and many-sidedness, is one that seems ideally suited for today's children's mental health workforce. At North Shore Child and Family Guidance Center, work with children and youth is always provided in the context of the family and the community. We do not accept children being deposited and picked up for "tune-up" or repair, as an automobile might be dropped off at a service station. Our staff members are often active participants in joint ventures with various systems, including education, juvenile justice, youth development, and child care. They are advised early on, that a joint venture is the programmatic equivalent of intermarriage.

Andrew Malekoff, LCSW, CASAC

When we join with other systems we understand that each partner has their own unique culture, worldview, values, policies, regulations and ways of doing things. It is critical for today's workforce to have this knowledge and to develop the skill to work effectively across systems and across disciplines.

Children and adolescents suffering from serious emotional disturbances may be accustomed to experiencing unhealthy interaction. Therefore, it is the duty of today's workforce to have the knowledge and practice skill to model healthy communication across systems, to discover common ground with family and community partners, and to avoid "splitting" behavior that pits one partner or system against another. A good knowledge and skill base in evidence-based protocols to address discrete diagnostic categories, will do us little good if we are not attentive to and skillful in optimizing healthy communication and collaboration across systems. In other words, our workforce must be prepared to tend to the *context*, not just the label or diagnosis, and be vigilant about not contributing to the replication of dysfunctional patterns of communication among helping partners.

How do we help today's workforce promote and support a culture of healthy partnership and collaboration among systems? By forming carefully composed and purposeful interdisciplinary teams, we can prevent systemic dysfunction and optimize collaborative potential. Among our many joint ventures at North Shore Child and Family Guidance Center is a school-based mental health partnership with Nassau B.O.C.E.S. Department of Special Education. The program is known as the Intensive Support Program (ISP); providing service to all 56 school districts in Nassau County. The program, now in its eleventh year, provides on-site services for close to 150 students ages 5 to 22 that are identified as having serious emotional disturbances. Psychiatric social workers, psychiatrists and vocational rehabilitation workers work collaboratively with educators, pupil personnel staff and administrators. The development of interdisciplinary teams has been critical to the success of the program. The following, is an example of how the purpose of one such team has been conceptualized to maximize partnership and collaboration. A team purpose is essential and provides the working group with a sense of direction and mission to guide the important work ahead.

ISP Middle School
Interdisciplinary Team Purpose

Achieve and maintain open communication among all program staff. This aim includes modeling healthy communication for ISP students, preventing the team from developing dysfunctional communication patterns (such as griping, splitting and scapegoating), and demonstrating that differences can be addressed in a productive way.

Enhance team problem-solving related to students and their environments. This aim includes a thoughtful process of identifying problems, exploring them in depth, considering alternative solutions and obstacles, deciding on solutions, implementing decisions and evaluating results. The key is to avoid jumping from problem identification to problem solution.

Increase staff sensitivity to the meaning of transitions for ISP students and develop program features to address students' needs and increase predictability. This aim includes considering the impact of transitions on students with serious emotional disturbances. The transitions include those that occur at the beginning and end of each day, when students move from activity to activity, and those before and after holiday and summer breaks. Staff members develop procedures, practices and program elements to ease transitions and build a more predictable environment.

Build and maintain healthy working alliances with parents of ISP students, caregivers and relevant others. This aim serves as a constant reminder that multiple stakeholders must be part of the service user team.

A team's purpose can always be modified as the work of the team proceeds and new needs emerge and are articulated. Both standing and ad hoc teams need to have clear purposes in order to establish common ground regarding aims and to optimize collaboration.

We must be sure that the people who use mental health services are viewed as partners in care rather than as passive recipients. It is up to us to develop a workforce that has the ability to communicate effectively with all the stakeholders involved in a child's mental health care. We need workers that are flexible and have a good understanding of their role and the role of others within a multidisciplinary setting. Our workforce must effectively communicate across disciplinary, professional and organizational boundaries. Flexibility is a key to adjusting sensitively to the changing tides in building and maintaining productive working relationships with all partners that have a stake in kids – consumers, family members and colleagues from various systems and disciplines.

The North Shore Child and Family Guidance Center is located at 480 Old Westbury Road, Roslyn Heights, NY 11577. Andrew Malekoff, LCSW, CASAC is editor of the quarterly professional journal, Social Work with Groups: A Journal of Community and Clinical Practice (The Haworth Press), since 1990. □

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Our firm regularly contributes to a number of publications concerned with Mental Health and related Health Care issues and participates in seminars and presentations to professional organizations and community groups.

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What Are They Thinking?
Identifying, Understanding, and Responding to High Risk Adolescent Behaviors

By Jennifer A. Powell-Lunder, PsyD
Program Director, Child Partial Hospitalization Program
Four Winds Hospital

We live in a society in which thrill seeking behaviors are glorified. The inconceivable is portrayed on reality TV as not only plausible, but desirable. Why has the world become such a complicated place? What can we do to find the balance between protecting our children and allowing them to live and learn about the world around them?

One high-risk behavior that has received much media attention over the past few years-the choking game has actually been "played" by children of all ages for generations. Because it has seemingly reached epidemic proportions-and has been attributed to so many "accidental" deaths of children primarily aged between 9-16, it has become a "hot topic."

The "Choking Game," is also known by a host of other names including: "Hawaiian High," "Passout Game," "Space Monkey," "Black Out," "Flatliner," "Funky Chicken," "Suffocation Roulette," and "Tingling," among many others. Common signs include: bloodshot eyes, frequent, severe headaches, inexplicable marks on the neck, locked doors, belts, ropes, and leashes in unusual places with knots, marks on bedposts, closets, and/or shower rods, etc, and disorientation after spending time alone. Of course not all of these signs may be present (Stop The Choking Game Association, Inc., 2006).

The Choking Game should not be confused with another dangerous phenomenon predominately associated with adolescent males: auto-erotic asphyxia or AeA. This is the practice of inducing cerebral anoxia in order to heighten sexual satisfaction usually during masturbation. It is surmised that a portion of adolescent male suicides by asphyxiation (e.g. hanging) are probably cases of accidental death due to AeA. Death is probably caused because the practitioner becomes so weak and disoriented that he can not pull out the knot or stand up and therefore, passes out and dies. (Deadly Games Children Play, 2006).

Does www equal danger? While recent research seems to indicate that there are certainly many new risks present to children with the evolution of the information highway, there is also research which clearly supports that by instituting some minor preventative steps, it doesn't have to be.

A 2006 study conducted by Cox Communication in partnership with the National Center for Missing & Exploited Children® (John Walsh of *America's Most Wanted's* organization) surveyed 1160 adolescents ages 13-17. Some highlights of the study include the following: 14% of teens surveyed reported face-to-face meetings with a person they had known through the internet, 45% had been asked personal information by someone they did not know, 1 in 5 teens surveyed believed it was safe to share personal information on a live journal or networking site and 37% reported they were "not very concerned" or "not at all concerned" about someone using their posted personal information in ways they wouldn't want.

Perhaps the most important finding to come out of the study also offers a solution. Teens of parents and guardians who had talked to them "a lot" about online safety, were less likely to have an instant messaging (IM) name or pictures on the internet, in comparison to kids who reported they had not discussed internet safety with parents or guardians. Additionally, these teens were more likely to ignore messages from unfamiliar people, refuse to reply or chat, block unknown senders, and report these situations to trusted adults.

In addition to the internet dangers discussed above, other internet threats include cyber bullies (who may or may not be known to the victim), the consequences of downloading viruses and the threats posed by hackers, financial and legal consequences associated with making internet purchases of both legal and illegal goods and services (e.g. drugs, gambling), and legal consequences associated with accessing inappropriate or illegal websites routinely monitored by the authorities. In addition, teens are often unaware of consequences resulting from inappropriate internet conduct such as sending threatening e-mails.

A discussion of high-risk adolescent behaviors would not be complete without addressing the issue of substance abuse. There has been a recent seemingly new focus on the "natural" or "organic" substances. Of particular note is the rise in Salvia use. Known as "Magic Mint", "Ska Maria Pastoria," or "Sally D," it is classified as a powerful hallucinogen which researchers claim is probably the most "potent naturally occurring" drug of its kind. While it can be smoked or chewed, more often it is brewed into a tea (Navy Personnel Command Drug Detection and Deterrence Branch, 2004). Because it is considered an herb there is concern that teens have the false sense that it can not be harmful. Although no research currently links Salvia directly to overdose, there is a burgeoning body of testimony suggesting that because the effects of the drug promote a feeling of detachment from the environment, as opposed to the euphoria typically associated with opiates, it can encourage suicide (Dorell, 2006).

PCP laced marijuana is a danger that also merits mention. The reaction of affected adolescents is often one of incredulousness (once some clarity has been achieved days, sometimes weeks later) along with an admission that, although there was intentional marijuana use, there was no knowledge that it was laced with PCP.

When we talk about high-risk behaviors, our first goal is prevention. This can be accomplished by educating children and adolescents about the risks their behaviors may pose. Study after study confirms that perceived risk is a strong deterrent. Parents and guardians are cautioned to know with whom their adolescents are with, the places they are going, and the things they are doing. Parents and guardians should inform their children that they will be checking up on them on a random basis. Boundaries and rules must be discussed and instituted. Parents and guardians should be encouraged to develop a safety plan with their adolescents in the event that the adolescent finds him/herself in an unwanted high-risk situation.

When preventative measures have been unsuccessful, intervention becomes necessary. Some general rules for intervention include the following: parents and guardians are cautioned to ask questions when their child is in a good space (e.g. sober). They should remain calm when addressing the issues. Parents and guardians should ask assuming questions not questions which could elicit simple "yes" or "no" responses. For example: "so where did you first meet face to face," instead of "Did you meet face to face." Parents and guardians are cautioned to

see High Risk on page 26

FOUR WINDS HOSPITAL • SPRING 2007

APRIL 2007

GRAND ROUNDS

Friday, April 13th • 9:30 - 11:00 am

Resilience and Coping Strategies for Older Adults

The Werner & Elaine Dannheisser Memorial Lecture Series

David Drassner, Ph.D.

Psychologist in Independent Practice, Rockland County, NY; President, Rockland Resiliency Institute; Adjunct Associate Professor, Long Island University Graduate Program in School and Mental Health Counseling

This seminar will provide an overview of counseling and therapeutic strategies for professionals to utilize when working with older adults. In addition, participants will enhance their knowledge regarding age-related psychosocial stressors, "compassion fatigue" and caregiver stress. A major focus of this presentation will be on the identification and amplification of resiliency factors within older adults, caregivers, families and communities and implications for intervening and coping with life transitions and traumatic events.

At the conclusion of this program, participants shall:

- Enhance their knowledge of incremental, proactive, goal-directed, solution-focused counseling strategies and their application to older adults.
- Become more knowledgeable about reflective counseling strategies such as journaling, reminiscence, and life review as sources of self-esteem and self-efficacy in older adults.
- Identify sources of interpersonal and community "connectedness" for older adults.

Fee: $20.^{00}$ payable to the Four Winds Foundation, a not-for-profit organization

1.5 CME Credits Available

THIS LECTURE IS MADE POSSIBLE BY A GRANT FROM THE WERNER & ELAINE DANNHEISSER TESTAMENTARY TRUST FUND.

SAVE THE DATE!

Nursing Career Day

Tuesday, April 17th • 4:00 - 7:00 pm

Experience Four Winds firsthand during this informal event.

JOIN A TEAM THAT USES A MULTI-DISCIPLINARY APPROACH TO TREATMENT.

Your Voice Will Make a Difference!

Refreshments, Tours, an Opportunity to Meet with Nursing Leadership

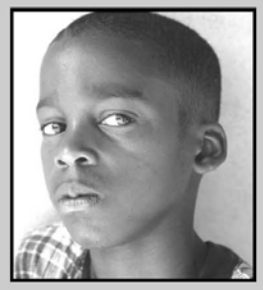
Competitive Salaries/Benefits

RSVP by April 10th at 1-800-546-1754 ext. 2413

APRIL 2007

SPECIAL TRAINING

Thursday, April 26 • 9:30 am - 12:00 pm



Child Abuse Identification and Reporting

Valerie Saltz, L.C.S.W.

Four Winds Hospital

New York State recognizes certain professionals to be specially equipped to hold the important role of mandated reporter of child abuse or maltreatment. These include Mental Health Counselors, Marriage and Family Therapists, Creative Arts Therapists, Psychoanalysts, Licensed Social Workers, Physicians, Dentists, Dental Hygienists, Chiropractors, Psychologists, RN's, School Administrators, Teachers, etc. A State Education Department Certificate of Completion will be given at the end of the class.

Fee: $45.^{00}$ payable to the Four Winds Foundation, a not-for-profit organization

MAY 2007

MAY IS MENTAL HEALTH MONTH

GRAND ROUNDS

Friday, May 4th • 9:30 - 11:00 am

Turning Bullies into Buddies: How to Turn Your Enemies into Friends

Israel C. (Izzy) Kalman, MS,

Nationally Certified School Psychologist; Author

This presentation, appropriate for educators, mental health practitioners and parents, will describe an innovative approach to bullying with simple yet highly effective methods to dramatically reduce the bully problem at school. A key ingredient in this approach is empowering children and teens alike to solve their problems without anyone's help and without getting into trouble.

This program will enable participants to:

- Recognize the hidden dynamics of teasing and bullying.
- Demonstrate ways to respond to insults, name-calling, rumors, racial slurs and physical threats.
- Empower students to victim-proof themselves.

Fee: $15.^{00}$ payable to Four Winds Hospital

1.5 CME Credits Available

Book Sale Following Lecture

Community and Professional Education Programs

MAY 2007

GRAND ROUNDS

Friday, May 18th • 9:30 - 11:00 am

Dialectical Behavior Therapy: Treating Trauma Safely

Patricia Trainor, Ph.D.
Private Practice, Mt. Kisco, NY

Dialectical Behavior Therapy was developed by Dr. Marsha Linehan, a psychologist at Seattle's University of Washington. DBT blends standard cognitive-behavioral approaches with Eastern philosophy and mindfulness practice. This staged treatment balances the need for validation of the client and achieving necessary behavioral change with an emphasis on maintaining safety and increasing skillfulness of managing emotions, thoughts and actions.

Clinicians are familiar with the emotional and behavioral dysregulation that clients may experience during trauma work. This presentation will provide an overview of the modes of Dialectical Behavior Therapy as well as the frame of treatment stages. Emphasis will be placed on assessing client readiness for specific trauma treatment. Participants will learn and practice several strategies for providing temporary relief of intense emotion prior to the initiation of actual trauma treatment. The need for specific clinician training will be explored in relation to client safety during exposure work.

This presentation will facilitate participants' ability to:

- Describe how working within the framework of Dialectical Behavioral Therapy assists clients to achieve behavioral control in the present and move toward the goal of experiencing traumatic memories safely.
- Demonstrate three strategies to reduce intensity of emotional pain prior to trauma work.
- Identify criteria for assessing client readiness for trauma work.

Fee: $15.00 payable to Four Winds Hospital

1.5 CME Credits Available

Albert Einstein College of Medicine designates each continuing medical education activity for a maximum of 2.0 category 1 credits towards the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity.

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Albert Einstein College of Medicine and Four Winds Hospital. Albert Einstein College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

These programs will be of interest to: physicians, physician's assistants, psychologists, nurse practitioners, social workers, mental health providers, EAP's, education professionals, school counselors, RN's and consumers.

All of the Grand Rounds, Special Trainings and Special Events will be held at the Four Winds Hospital Conference Center unless otherwise noted.

Registration is Required for All Programs.

Please Call 1-800-546-1754 ext. 2413.

JUNE 2007

GRAND ROUNDS

Friday, June 1st • 9:30 – 11:00 am

Asperger's Disorder and Autism: An Update on Understanding and Interventions

Katherine D. Tsatsanis, Ph.D.,
Clinical Neuropsychologist, Associate Research Scientist,
Yale Autism Program, Yale Child Study Center, New Haven, CT

The diagnostic category of pervasive developmental disorders (PDD) refers to a group of disorders characterized by delays in the development of socialization and communication skills. Autism (a developmental brain disorder characterized by impaired social interaction and communication skills, and a limited range of activities and interests) is the most characteristic and best studied PDD. Dr. Tsatsanis will provide an overview of Asperger's Disorder, Autism and related conditions, discuss assessment and implications for treatment, and will describe behavioral approaches to interventions.

This program will enable participants to:

- Gain an understanding of the clinical features, epidemiology, genetics and medical aspects of PDD and Autism.
- Become aware of issues in assessment, including the selection and use of assessment instruments.
- Examine various treatment strategies and interventions utilized in treatment of PDD and Autism.

Fee: $25.00 payable to the Four Winds Foundation

1.5 CME Credits Available

Save the Dates!

10th Annual Chamber Music Series to Support
The Counseling Center

February 18, 2007

Works by Bach, Mozart, Tansman, Tchaikovsky
arranged for cello quartet

• Peter Wiley, Cello • Rafael Figueroa, Cello
• Jeremy Turner, Cello • Edward Arron, Cello

March 18, 2007

(This performance is dedicated in memory of John B. Segal)

Strauss - Andante for Horn and Piano
Dvorak - Quartet for Piano, Violin, Viola and Cello, Opus 87
Brahms - Trio for Piano, Violin and Horn, Opus 40

• Julie Landsman, French Horn • David Chan, Violin
• Ronald Arron, Viola • Edward Arron, Cello • Jeewon Park, Piano

April 15, 2007

Playel - String Trio Opus 10 No. 2 for Violin, Viola and Cello
Songs for Soprano, Violin, Viola, Cello and Piano by Rachmaninoff, Strauss, Beethoven, Goddard, Vaughn-Williams and more
Brahms - Quartet for Piano, Violin, Viola and Cello, Opus 25

• Rachel Luxen, Soprano • Abraham Appleman, Violin
• Ronald Arron, Viola • Edward Arron, Cello • Jeewon Park, Piano

All performances held at Christ Church
17 Sagamore Rd., Bronxville, NY
Ticket Price: $25.00
For complete details call: The Counseling Center, Bronxville, NY
914-793-3388

An Inspiring Program on Mental Illness Takes Place at Four Winds

By Eve Marx

Mike grew up one of 13 children in an environment that only 35 years later did he recognize as "chaotic." "I grew up thinking that I was the only one in my family who was bothered by the confusion and the noise," he said, smiling sweetly at an audience of physicians, psychotherapists and clinical social workers assembled in the conference center at the hospital, Four Winds. "At a family reunion my brother told me that our household had always been frenetic and that he had been bothered by it as well. It was the first time I understood that the chaos wasn't just in my head."

During a program entitled, "In Our Own Voice: Living with Mental Illness," Mike, along with a woman named Nancy, spoke of their personal experiences with mental illness, or as Nancy called it, her "mental challenge." The program, made possible by NAMI Westchester, a self-help, support and advocacy organization dedicated to improving the lives of people living with brain disorders known as mental illness, was offered through the Grand Rounds series at Four Winds.

The program differed drastically from other programs usually given at Four Winds in that it was led not by a clinician or a psychiatrist, but by two late middle aged individuals who have had a lifetime dealing with mental illness. Because of their candid stories describing their experiences, the program was enlightening and profoundly moving. The purpose of the program is to enlighten consumers, family members, health providers, law enforcement officials and civic and faith communities to understand mental illness, and the stigma of living with it from the very people who have been there.

The presentation covered issues frequently faced by those who live with the illness. There was a short film that focused on dark days, acceptance, treatment, coping strategies and successes as well as hopes and dreams. It is said that 5.4% of American adults have a serious mental illness, and that 9 to 13% of children aged 9-17 suffer as well. Every person, no matter their age, ethnicity, education or social status, is at risk.

Mike, a soft spoken, earnest man in his early 50's described his darkest days as the ones when he first was hospitalized, an event which occurred during his college sophomore year. "In high school I knew something was wrong," he said, "But that was in the 70's and there were a lot of substances for me to abuse to cover up my feelings." When he realized that he had begun to deeply dissociate, he went home and broke down to his father, who took him to a hospital and left him. "I felt abandoned," Mike said. He regretted that the old electroshock therapy once used resulted in memory loss, but said he held no grudge against the institutions or the doctors who once treated him because, "The tools and drugs they had at the time were crude and clumsy." His face briefly clouded over at his recollection of Thorazine. Mike was able to return to college where he received his degree in philosophy. College, he said, was good for him, in part because nobody knew of his illness, and that the hard work itself helped. "Having to produce all those papers took my mind off myself."

Mike spoke in a positive manner about living in a half way house, and praised the concept of community residences. Living with others who shared his disease gave him hope, as well as the realization that all he had to do to succeed was, "See the doctor, take my medications and show up for work." Acceptance – by others as well as his acceptance about himself, he said is the key ingredient to getting well. "I'm not okay and it's okay," he riffed.

Nancy, a vibrant 60 year old who looked closer to 40, said she became aware something was very wrong in her early 30's when she was living in the city and having her first success as a singer. She vividly described the feelings of anxiety, fear and paranoia that overtook her, eventually leading her to remove all her clothes and walk stark naked into a hospital. But she called her breakdown a "breakthrough," because it was the first step to getting better.

Nancy, who holds several academic degrees and teaches yoga said health care providers have called her "treatment resistant," because she asks a lot of questions. She said it took many years to find a doctor who would work with her and not control her. At present she is on a small amount of medication. "If there is a stigma about mental illness,," she said, "the instability itself is not the stigma. It's the stigma about the way mentally ill patients are treated."

Nancy told the audience about her strategies and coping mechanisms which include eating well, exercising, meditating and making music. She tries to have fun, and said that, "Advocating for your own care is important."

Mike said, "I'm dealing with life pretty well and trying to stay happy." For him, balance is achieved by "being in a 12 step program, opening myself up to art, learning the tools of life, getting out of the house, keeping busy and showing up. And keeping an open mind." Both Mike and Nancy agreed that participating in programs like "In Our Own Voices," has been beneficial and that they enjoy knowing they are educating people.

"I don't have big dreams," Nancy said. "I live a simple life." Mental illness, Mike said, "Is not a death sentence. We're people, not monsters." "We have good days, we have bad days," Nancy said. "Just like everybody else."

For more information about NAMI, contact Executive Director Gloria Hernandez or Program Administrator Milly Murphy at 914 592-5458. Or visit their website at www.namiwestchester.org Four Winds Hospital is located at 800 Cross River Road, Katonah, N.Y. The phone is 914 763-8151. This article originally ran in the Record Review, on November 24, 2006. □

High Risk from page 23

offer support without being judgmental. They should acknowledge the situation as high risk and one which has to be addressed appropriately. Parents and guardians need to develop a plan with the adolescent which affords him/her the opportunity to slowly and safely win back trust. Rules and consequences should be formulated with the adolescent. It is empowering for adolescents to be part of the decision making process. Such participation encourages acceptance of the rules and consequences instead of rejection. Finally, parents and guardians need to be able to offer a "clean slate with history." This means that high-risk situations are not necessarily forgotten, but a reminder is not offered on a regular basis, giving the adolescent the sense that they can never "live it down."

It is important for parents and guardians to be aware that there are support services available through community resources such as the local office of mental health and through the juvenile justice system when necessary.

Adolescence is an exciting, confusing and sometimes ambiguous time. Technologic innovations continue to make the world both a simpler yet more complicated environment to negotiate. Through education, support and guidance we can ensure that today's youth make a smooth transition into adulthood.

Helpful Websites:

www.stop-the-choking-game.com
www.deadlygameschildrenplay.com
www.netsmartz.org
www.internetchildsafety.net
www.safekids.com
www.samhsa.gov
www.teendrugabuse.us
www.strugglingteens.com
www.nami.org

Websites & software designed to monitor internet use:

www.chatchecker.com
www.cybersitter.com

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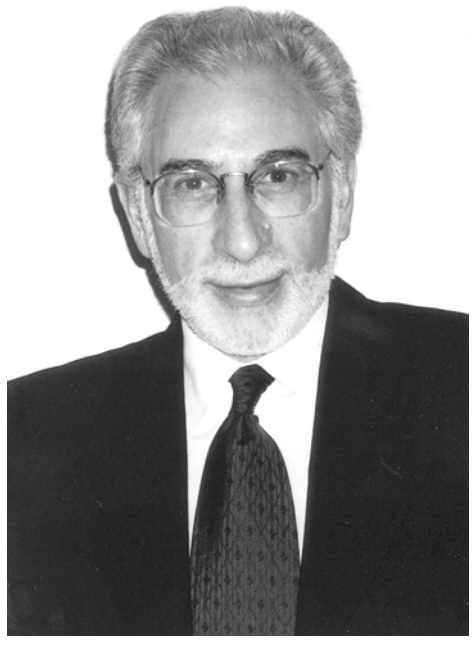
The Mental Health News
New York City Section

Meeting New York's Mental Health Workforce Needs

By Lloyd I. Sederer, MD
Executive Deputy Commissioner
for Mental Hygiene
New York City Department
of Health and Mental Hygiene

New York State's mental health workforce is one of the largest and most diverse in the world, with thousands of well-trained people working to help the hundreds of thousands of New Yorkers with psychiatric disabilities live fuller lives. But this remarkable group of women and men face a variety of challenges: consumers with multiple and complex disorders, salaries that often do not keep pace with inflation, and varied insurance payment rules and government regulations that limit their ability to provide services. These challenges are especially acute in New York City, both because of the sheer size of its population and because of the needs generated by the most multicultural metropolis in the country.

The most pressing needs occur at the ends of the age spectrum, where specialization is most necessary.



Lloyd I. Sederer, MD

One in every five people aged 55 or older experiences a mental disorder such as depression, anxiety, schizophrenia or dementia, but seniors are among the least likely to seek help for mental health issues. With the number of Americans over 65 expected to double by 2030, the unique needs of older adults with mental illness will need to be met by a large workforce trained in the specifics of geriatrics and with the cultural competence needed for this City.

Likewise, at the other end of the age spectrum, there are not enough mental health workers to meet the needs of our children. Recent studies suggest that about 20% of U.S. children need mental health care, yet more than 80% of those in need care go untreated. Bills under discussion in Congress would offer student loan forgiveness for mental health professionals who agree to work with children; unfortunately, those bills have not progressed very far.

In New York City, DOHMH is working to solve these problems.

Since 1990, the Department has operated a Mental Hygiene Training Program/ One Year Residence. The program offers a master's degree in social work at Hunter College to employees of community-based agencies who are in contract with DOHMH. Participants must be committed to working with underserved populations, including minorities as well as older adults and children. They must be New York State residents and must have a bachelor's degree and two years of experience in social work. Those accepted into the program attend seminars and receive intensive advising and mentoring, supported by scholarships. In return, they commit to working at least two years in their home agencies after receiving their degrees. So far, 352 people have received their MSWs through this program.

New York City DOHMH is also a member of New York State's Conference of Local Mental Hygiene Directors. Through its Solutions to End Psychiatric Shortages (STEPS) program, the conference works to raise awareness about the shortage of child psychiatrists, identify and reduce regulatory barriers, explore the utilization of mental health specialties beyond child psychiatrists (e.g., nurse practitioners, behavioral pediatricians), establish and expand financial incentives for child psychiatrists, and disseminate best-practices findings.

We have made a good start, but there is much more to be done. New York City's diverse population deserves the nation's best mental health care, provided by the nation's best trained mental health workers. □

Baltic Street AEH
A Model for Peer Employment into the Mental Health Workforce

By Rick Sostchen
Executive Director
Baltic Street AEH

The shortage of adequately trained personnel to provide services for substance abuse and mental health programs that serve the community has become a serious problem. This issue has become a crisis of major concern within the field. Many local, state, and federal agencies are striving to create strategies to solve the urgent problem.

The Answer Right In Front of Us

If America's history has a single constant, it is this: the desire and need her people have to seek useful, productive work. No group has been exempt from this yearning, no matter what obstacles have stood in their way. Witness the civil rights movement of the 60's. Witness the effort by today's men and women coping with mental illness to find employment in a society replete with nay-sayers, negative statistics, and non believers: an effort that Baltic Street AEH (advocacy, employment, and housing) determined to aid and support by every means possible.

Baltic Street is not only one of the largest peer agencies in New York State but also the nation. Its 100 plus personnel provide a range of services from empowerment/advocacy to housing, self-help, and supported employment. A close look at this agency begins to answer the question: who will serve? Staffed by well-trained peer personnel—who have fought back against negative images and barriers to employment for people with mental illness, homelessness, substance abuse and forensic issues—Baltic Street offer a direction for the future.

Baltic Street provides Advocacy, Bridger, Housing and Employment Services, which totaled 19,500 service visits in 2006. Since its inception, the Agency has grown from one program in Brooklyn to 11 programs in four Boroughs and from one staff member to 88 current staff members and 15 trainees. The Advocacy, Bridger, Geriatric Advocacy, Self Help, Assisted Competitive Employment, Affirmative Business and Supported Housing programs totaled 2316 new admissions this year. The Agency has been dedicated to expanding the skill set and maximizing the management skills of staff without sacrificing the high quality and quantity of service delivered by the staff.

Rick Sostchen

The past decades have brought new advances and understandings to the field of mental health. New medications, evidence based practices and the beginning of acceptance that recovery for those diagnosed with mental illness is possible—and does happen everyday—are among those culture changing advances.

The recovery movement has begun to shape not only the kinds of services that are offered to those diagnosed with a mental illness, but also has begun to shape the means by which those services are delivered. Peer services are available in many states but are often limited to what would be considered ancillary services, with peers having a secondary role, at best, in providing those services. Baltic Street however provides a vision of how much more is possible.

Baltic Street employs peers, men and women who are themselves users of mental health services, to provide the range of services noted above. Beyond that, Baltic Street's mission is to ensure that peers can work successfully in a range of human-service

see Peer Employment on page 34

the mental health association of new york city, inc.

Dedication Derived from Personal Experience Keeps the Mental Health Field Thriving

By Giselle Stolper
Executive Director
The Mental Health Association of New York City

When Brian Lombrowski was 13 he was lost in a world of his own. Feeling isolated from friends and his parents, he set a series of trash fires at his middle school. He was subsequently hospitalized for nearly a year and then placed in day treatment for another six months, diagnosed with an array of mental illnesses. For several months he was considered "high risk" and was not allowed to leave the building where he lived and went to treatment. In time, Brian recovered and came home to live with his family. Though he returned to high school as a sophomore and nearly picked up where he left off, it was those 18 months that defined the course his life would take.

Today, Brian manages a growing caseload of families as a care coordinator in Staten Island for the Mental Health Association of New York City's Coordinated Children's Services Initiative (CCSI), a program that works with the families of children with severe emotional disorders. CCSI employs the Family Network model of care coordination to bring together all of a child's service providers in the areas of mental health, child welfare, juvenile justice and education, to design and implement a comprehensive, individualized plan for the child that promotes consistent care across services.

With a master's degree in public policy from the University of Chicago, after work Brian provides pro bono policy advice to the Alliance for the Safe, Therapeutic and Appropriate Use of Residential Treatment, an advocacy group for children. He also serves as an advisor to the Out-of-State Placement Committee, an inter-agency group under the auspices of the Council on Children and Families, which helps manage the logistics of bringing home children who have mental illness or developmental disabilities, and who have been placed in facilities outside New York.

Giselle Stolper

As Brian explains, "The experience of being hospitalized left me with a sense of emptiness. I realized I could only resolve it by finding others who had been in similar circumstances, or who still were in those circumstances. When I was in college I joined every mental health-related group I could find. I needed something, *anything*, that gave me a sense of belonging. My experience had become a part of my identity and I was afraid to share it with others because of the stigma. I took a summer job as a peer advocate at the hospital where I had stayed, and worked with kids who had been in my position. By my senior year of college I knew I wanted to advocate for the rights of youth with mental illness."

So many of us are drawn to the mental health field as a result of a first-hand experience with mental illness. We struggled with illness ourselves, or our lives were changed or shaped by a loved one who lived with its challenges and who coped, recovered, or succumbed. For children and families, advocates who have been down the road themselves or with their children are a source of comfort, information and support when a child is newly diagnosed with an emotional disorder.

Parent Advocates Help Families Follow in Their Footsteps

Lorraine Jacobs, supervisor of the MHA of NYC Parent Resource Center in Elmhurst, Queens, raised five children of her own. Then she and her husband assumed responsibility for his sister's five children, who had originally been turned over to foster care due to his sister's overwhelming drug addiction. The younger two, a boy and girl, were born addicted to crack. When the youngest daughter turned 18 months old, her unexplained tantrums made it impossible for her to stay in daycare. Lorraine's challenges were compounded when her husband died a year later. When her daughter turned 4 years old she was diagnosed with attention deficit hyperactivity disorder. That is when Lorraine learned how pervasive and insidious both an emotional disorder, and its accompanying stigma, can be.

"The doctors saw a sweet, smiling child when I took her for evaluations," explains Lorraine. "They didn't believe there was anything wrong with her, even when I told them about her outbursts and difficult behavior. They thought I was the problem. And our family members told me I spoiled her, that she was just a bad kid. In a way the stigma got even worse after she was finally diagnosed. Then she became 'the girl down the street with the mental illness.'"

Lorraine had gained experience in social services over the years. After many years on welfare, she took a job as a receptionist at a vocational foundation. After her husband's death, when her older children were in their teens and the young ones were still at home, she returned to school to earn a bachelor's degree in human services and then worked as a counselor for young mothers. As her daughter grew older and was ultimately diagnosed with bipolar disorder, Lorraine believed it was her job to build her daughter's self-esteem. Now that her daughter has reached her teens and the worst is behind them, Lorraine realized she could be a positive force for other parents.

The MHA of NYC Parent Resource Centers, located in Manhattan, the Bronx and Queens, equip parents with the tools, knowledge and support to become their children's best advocate and case manager. The Centers are staffed by parents who have children with emotional disorders and are trained to help others in the same situation.

Now, as a parent advocate, Lorraine talks about her role. "Sometimes it's teaching parents how to talk with clinicians so they can ask the right questions. Sometimes it's just explaining all the forms they make you sign for the evaluations and treatment." The most rewarding part for Lorraine is how she recognizes herself in the families who rely on her. "When I tell our clients what I've been through with my child, I can see the relief in their eyes. They know I understand, and they trust me to help them do what's best for their own children."

Certainly the mental health field always has a need for trained professionals to diagnose, treat and help enhance the quality of life for those who have a mental illness. Yet the field thrives thanks to the dedication of families and individuals who have chosen to share with others the wisdom and knowledge that they acquired in their personal journeys from illness to better emotional health.

As Brian concluded, "When people ask me now why I do this kind of work, I tell them it's because of what happened to me when I was young."

MHA of NYC services can strengthen families while giving children the help and support they need. For more information about the Coordinated Children's Services Initiative, call 212-964-5253, x769. For more information about the MHA of NYC Parent Resource Centers, call our offices in Manhattan (212-964-5253), the Bronx (718-220-0456) or Queens (718-264-4599). If you have questions about your child, or would like to learn more about available services for children and families citywide, contact LifeNet, the 24/7 confidential multilingual mental health hotline operated by the MHA of NYC. For English, call 1-800-LIFENET; for Spanish, 1-877-AYUDESE; and for Chinese, call 1-877-990-8585. □

Concerns and Cures For Compassion Fatigue

Ellen Stoller, ATR-BC, LCAT
Assistant VP Community Services, Training and Consumer Affairs
F.E.G.S. Health & Human Services System

One of the rewards for doing our jobs well is that we are invisible. We help people who have serious and persistent mental illness live their lives outside of hospitals, outside of jails and prison and out of the news. Of course some still end up there. But no one reads about the vast number of people with mental illness who work, who live in supported housing in the community, who go to clinics, clubhouses, psychiatric rehabilitation services, and supported employment programs and in fact do much, much more.

What is the price we pay for being invisible? "Compassion fatigue", the nicer, more professional term for burnout, is an occupational hazard for mental health professionals who work in the aforementioned environments. Yes, our jobs are "rewarding." We feel good about what we do. But how are we viewed by society? How are we treated in the larger "workplace"? How do we withstand the stories we hear from our clients?

Like sponges we soak up the traumatic, often horrific, sad and complicated stories of the clients we serve. We provide treatment, hope, choices, and training. How well do our workplaces take care of us? How well do we take care of ourselves?

I am no stranger to compassion fatigue. After Sept 11, 2001 I found myself managing an ever changing and growing disaster relief effort for New Yorkers who were affected emotionally, financially, and spiritually by the attack. My worries included grant writing, contract compliance, quality program development and the training and care of a staff of almost 50 people who counseled, case managed, and otherwise saw to the well being of thousands of New Yorkers. I know compassion fatigue well. I saw it in my staff and I diagnosed it in myself. It has been curious to me that in disaster work compassion fatigue is a well-recognized and documented phenomena. Why isn't it equally recognized or talked about in the less dramatic, less sexy work of providing for thousands and thousands of people with mental illness?

Compassion fatigue is when you are unable to care anymore. You may find yourself unusually irritable. One client's story begins to sound like every other client's story. You can become angry with yourself, your co-workers, and your family. You may eat too much, drink too much. You tell people you are "stressed out." We get burnout when the rewards we get from our job, intellectual, social, emotional, spiritual or financial no longer balance the effort. What do we who serve in administrative, advising or consulting positions do to help combat staff burnout? We have meetings (with food makes it "team building"), trainings, discussions, and official "team building" activities. What else can we do?

We Are Who We Serve

Those of us in this field can suffer the stigma of mental illness along with our clients. Historically, psychiatric hospitals were built on the edge of town, out of sight, out of mind. Our clients now live in communities, but out of sight and out of mind is still the message.

When teachers and nurses raised their collective voices to ask for more respect in the form of higher pay, society was pressed by the public to ante up. The same will not necessarily be so for mental health professionals. Many feel you are whom you serve. Nurses serve all of us. Teachers serve our children. People with mental illness, in this society, are served by an invisible workforce, better when not seen and not heard.

I truly believe that this is one of the challenges of the mental health workforce now and in years to come. We ask more and more of mental health professionals. We need to be paid more, too. We are in the shadows along with our clients. Part of combating compassion fatigue is taking care of yourself. You can't take care of others unless you are cared for. In stress reduction workshops we talk about eating better, sleeping better and exercising. Those things are necessary but we need to consider advocating for ourselves too.

September 11, 2001 had a "leveling" effect in mental health. Suddenly there was recognition from all over that many people were suffering and many could be helped with brief mental health interventions. If people had an acute stress reaction, or even PTSD, treatment could be made available, and was, for thousands of people. But it should not take disaster to make people value mental health services and the people who are trained to provide them.

I offer three proposals. First, community mental health organizations become better equipped to provide their staff with regular sessions that address compassion fatigue and "care for care-givers."

Second, the stigma associated with serving the mentally ill should be acknowledged and confronted along with the battle to remove the stigma of mental illness, itself.

Finally, the community-based workforce needs to be supported in competitive wages, comparable to those provided to hospital workers and other healthcare specialties.

By paying attention to these workforce issues we can strengthen our professional community, continue to attract committed and qualified people to the field and improve recovery outcomes for the mental health consumers we serve. □

The Training Magnet: Attracting Staff for Mental Health Services

By Lisa V. Blitz, PhD, LCSW, Director Genesis Domestic Violence Shelter and Rick Greenberg, PhD, LCSW, Director Martha K. Selig Educational Institute JBFCS

Training. We hear the word every day—on-the-job training, weight training, fitness training, you name it and you probably can find a training program to match. At JBFCS, it's a word we take seriously, and it's at the core of the work we do to serve our clients. Since the 1940's a training department has been part of JBFCS. In 1973, our training program was chartered by the New York State Board of Regents, and in 1978 it was renamed the Martha K. Selig Educational Institute to honor the woman who championed the cause of training. The Institute combines the latest theories in mental health care and human services intervention with hands-on experience to train hundreds of JBFCS employees each year.

The educational aspect of JBFCS is key to helping attract mental health practitioners who offer a broad range of services to our clients. These include staff involved in direct care, case management, and counseling. Since its start, the Institute has offered courses to social work staff with undergraduate or graduate degrees. In 1999, a training program began for JBFCS child care workers in residential and day treatment programs. Staff members in these programs typically have a high school education, associates degree or a few years of college. This training helped enhance and support child care staff.

Lisa V. Blitz, PhD, LCSW

Rick Greenberg, PhD, LCSW

Adult Milieu Services
Training Program

Our work with child care workers inspired us to expand to other direct care staff. In 2003, the Adult Milieu Services Training Program was launched. This training was designed for direct care workers in programs for adults with serious mental illness and clients in domestic violence shelters. These workers also have high school diplomas or a few years of college. We designed the training to provide continuing education for staff who often worked some of the toughest shifts, such as overnights, weekends, and holidays, when access to the support and insights of the regular team of staff was more limited.

The training is a two-year program that staff attend 10 weeks per year. Each weekly class is three hours long. Though staff are paid for training time, because of their shifts they may have to work overtime to attend the sessions or otherwise adjust their schedules. There are three training modules, with the first year focusing on team work, conflict resolution, and mental health issues. The second year offers four modules that address cultural competency and social justice, collaboration and partnership, and effective communication. The second year also offers a wide range of elective classes that focus on some of the unique issues staff face in their work. Elective classes include:

- mentally ill and clinically addicted (MICA) clients
- clients who were in prison
- safety in off-site visits
- supporting clients' parenting skills
- leadership skills
- spirituality in assessment and treatment
- self care
- professional development

Classes are taught by senior staff at JBFCS, which has the additional benefit of introducing direct care staff to senior people throughout the agency and encouraging mentoring relationships.

One aspect that makes this training program unique is that it builds the conceptual framework for the clinical and case management services provided by the agency. The direct care worker is encouraged to understand his or her role in the larger picture as part of the clinical team. In the past, courses focused on skills development, which though very important, did not provide the philosophy or context behind a technique. The Adult Services Training program integrates skills development with theory.

Attending the training program is now an expected part of the job. All direct care workers in programs for adults with mental illness or with clients in domestic violence shelters who have worked with our agency for the past two years have completed the program. We have received excellent reviews from staff who say they like the program and have learned a lot from the training. The training also helps us send the message that we value the work that they are doing and view them as professionals.

Another important part of the training program, which also reflects an ongoing initiative throughout JBFCS, is advancing the agency's anti-racism work. This work is part of a new book, Racism and Racial Identity: Reflections on Urban Practice in Mental Health and Social Services, published by Haworth Press and co-edited by Lisa Blitz and Mary Pender Greene, JBFCS Chief of Social Work, with contributions from JBFCS staff. The traditional internal training programs were designed for employees with degrees responsible for clinical services who historically were white, while the direct care workers were mostly people of color. Our Adult Milieu Services Training Program helped address this racial divide.

JBFCS has had a diversity task force since the early 1990's with a focus on multiculturalism, cultural competence and a concern for fairness and equality. In 2003, as part of our visiting scholars program in the Martha K. Selig Educational Institute, Anderson J. Franklin, PhD, and Nancy Boyd-Franklin, PhD, became our Saul Z. Cohen Chairs in Child and Family Mental Health and remained as Chairs until 2005. They began to move our anti-racism work forward by helping us look at institutionalized racism, and to understand power and access to resources as well as our own racial and cultural identity. Their focus was also combined with the agency's own work with the People's Institute of Survival and Beyond. Currently, we are fortunate to have Kenneth V. Hardy, PhD, as the Cohen Chair and David Billings, DMin, of the People's Institute, as the Pauline Falk Chair in Community Education and Research, who are helping us to continue our anti-racism efforts.

The anti-racism work is integrated into the curriculum of all Martha K. Selig Educational Institute courses including the Adult Milieu Services Training Program. In the teamwork courses that Lisa has taught in the Adult Milieu Services Program, we have found that race comes up frequently. Race is discussed in every class whether it's five minutes or an hour-and-a-half. When we talk about teamwork, milieu issues, and roles and boundaries, if we're not talking about race then we are not having an effective conversation.

Another example of how race is incorporated into the training is in the mental health issues module. We focus on understanding how cultural differences may show up through symptoms, as well as how people think about mental health services, their cultural assumptions and what they are familiar with.

Ultimately, because racism is so pervasive throughout our society, doing good work with clients means understanding racism and its impact and working to change it. The training we offer works toward that. But it is not only a focus on clients, which is crucial, but also a focus on relationships between staff members and system structures within our organization. We are committed to being an agency that attracts skilled and effective mental health practitioners to the field, offering the tools needed to serve our clients, and creating a workplace that values all of its employees. □

Peer Employment from page 27

industries. Training in all things pertinent to this task is provided, including management, clinical, and educational, often by national experts in the field. Staff members have moved on to work in integrated (non-peer) settings and a variety of human service settings.

Who better to provide the nurturing dedication coupled with administrative attention to detail required of service providers than someone who has experienced the anxiety and rigors of the system first-hand? The bond established between a peer provider and a mental health client is mutually beneficial. Both are empowered while working toward a common goal. Peers are willing, able and successful at providing services and many can answer the questions that if posed to a government agency worker might meet with a question mark. The cumulative experiences of those who have previously traveled the road to recovery provide a rich knowledge base and nurturing haven. Mental health recipients realize that there is hope for their future and they don't have to feel stigmatized or isolated in the bureaucratic, and often impersonal, mental health world.

Baltic Street's employment programs provide preparation, placement and continued job coaching for men and women coping with a diagnosis of mental illness who then feel prepared to enter the work force. Baltic Street's *netWorkplus I* and *II* provide employment support for as long as the client needs it, with peer employment specialists providing vocational counseling and goal setting, skills assessment, computer skills training, volunteer opportunities, paid internships and on the job training. *Baltic Bazaar Thrift*, an affirmative business provides training and competitive work experience. Employment specialists establish links with a wide variety of community businesses, non-profit organizations and public agencies.

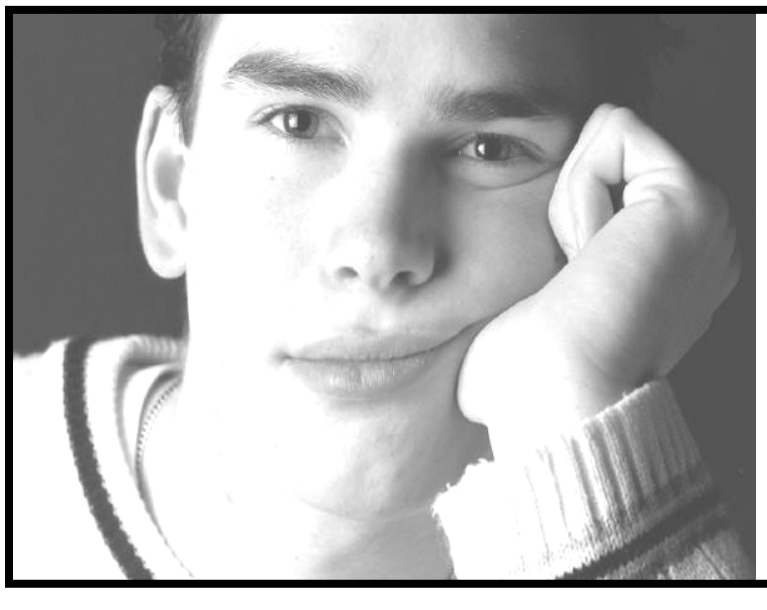
The employment programs of Baltic Street have already demonstrated the effectiveness of a collaborative process - one that includes peer support. They exemplify the need to continue promoting, encouraging, and providing opportunities for "more peers to work as paid employees and mentors in the system." The combination of professional and peer support has proven to be the best strategy for helping our clients become part of the workforce.

We need to continue developing support teams that incorporate the expertise of several disciplines including: clinical, rehabilitation, employment and peer. The recovery movement has begun to shape the kinds of services that are offered to those diagnosed with a mental illness, as well as shaping the kinds of people who are needed to deliver those services.

Baltic Street understands that the fundamental components and core values of recovery speak to the need for more effective individualized service planning. In this regard, it becomes clear that the call to serve is best answered by people who have an innate understanding and empathy for men and women diagnosed with a mental illness. Who better to serve than those who have repeatedly demonstrated an inordinate amount of resourcefulness, borne out of experience and necessity? And who better to be utilized than a group of individuals who seek and receive ongoing experiences, education and training that leads to an increased understanding of the people they serve, as well as a broadened understanding of themselves?

For the past ten years, Baltic Street has demonstrated that service provision dedicated to a person's recovery is possible and that anything short of this is unacceptable. This is not a theoretical model but one that has been implemented and is bearing fruit. It is a program that provides a template enjoining us to continue to mine the vast richness of training, education, and experience in this nation, embodied by those who have "been there, done that" and found it good.

If we are to continue to support the use of supported employment services as a primary strategy for community integration we will have to expand and build upon collaborative employment strategies that include peer support in its formula. Nothing succeeds like success and this is a formula that has proven itself very successful indeed. □



The Challenge from page 1

as well as funding for "consumer / peer counselor training programs."

The Mental Health Workforce
In The 1990's

My anecdotal experience confirms the above. In 1994, I began working in the mental health field as a Job Coach in a clubhouse program. I was paid about $21,000 a year. Shortly thereafter, I became the Clubhouse Coordinator. My staff was entirely comprised of those who had recently obtained their college degrees. Many of the staff were also going to school in the evening to pursue Masters Degrees in Social Work or Rehab Counseling.

They all had a basic knowledge of psychology, and so they easily absorbed new information on mental health and recovery, that they may not have learned from their textbooks. They could write well, and they performed goal planning and charting responsibilities to standard. They were willing, and able, to do "hands on" work alongside clubhouse members, like mopping the floor or job coaching at a beach front food stand, in one-hundred degree heat.

The staff would stay about 3 – 4 years, and then move on to a higher position within the human services field. When I ran help wanted ads for a replacement, I would easily get over 100 resumes.

At the same time, there was a great excitement in community mental health. With the downsizing of the state hospital system, and the start of Community Reinvestment, hundreds of new jobs in mental health were created. In New York City alone, a dozen new clubhouse programs were funded. New and innovative programs were developed in order to meet the needs of the consumers being discharged into the community.

The Mental Health Workforce
In the 2000's

A decade later, many entry level mental health positions still pay in the low twenty thousand dollar range. Because of low salaries, programs struggle to recruit, and retain staff. I once had a job applicant tell me that he could make more money by being a janitor in his local church, than he could by working in the mental health field.

Two years ago my Transitional Employment Staff experienced a 100% turnover. One employee left to accept a comparable position with the state, but one that offered a higher salary and better benefit package. Another employee, a mental health peer counselor, left for a higher paying job outside of the mental health field. A third employee left, citing the stress, and difficulty of the work.

Additionally, many mental health professionals need to work additional hours for their agency, or take second jobs outside of the mental health field, in order to pay their bills. Working extra hours takes away from the time that the employee would normally spend with their family.

While many in the current mental health workforce are well intentioned, they are often not as qualified, when compared to a decade ago. Many entry level workers today do not have a Bachelor's degree; they instead may have an Associate's Degree, or a high school diploma.

Some apply for work in mental health, after leaving other careers, and so they come without even a basic knowledge of mental health. They require a tremendous amount of training. Compounding the problem, is the fact that training monies in program budgets tends to be very limited, or even non-existent.

At the same time, the work of mental health has become more complicated. New issues like Assisted Outpatient Treatment, Medicare Part D, the Medicaid Buy-In, and the Ticket to Work have developed. We are also seeing consumers with increasingly complex needs such as: co-morbid health conditions, forensics, dual-diagnoses, geriatric issues, as well as linguistic and cultural needs.

Rehab and recovery programs are not the only programs that are challenged to hire and retain qualified workers. Residential services – a cornerstone for stability – are woefully underpaid and inadequately staffed by a funding model designed over 20 years ago and never updated.

Negative Impact on Mental Health
Consumers Receiving Services

The mental health workforce crisis has a deleterious impact on the delivery of quality services. A vital component of mental health rehabilitation and recovery is a healthy relationship between the consumer, and his / her staff worker. Clubhouse programs foster this relationship while members and staff perform tasks side by side on behalf of the clubhouse community, or at a job site.

When mental health programs have vacant positions, staff members take on larger caseloads. This results in the consumer receiving less individual time and attention.

The high turnover in mental health programs is also problematic. Some consumers report having three different therapists, or case managers, in one year; this disrupts the development of a trusting relationship. Consumers are also discouraged by having to constantly re-tell difficult life stories, "all over again" every time they get a new worker. Some report that this constant repeating of painful events brings about a "re-traumatization".

Staff shortages are also a barrier to accessing services. Some individuals seeking to access clinical services may have to wait several months, before being seen for an initial appointment.

The Increasing Role of Consumers
In the Mental Health Workforce

The increasing use of consumers in the mental health workforce has been a welcome change. A decade ago, I did not have any consumers on my staff; today they comprise 70% of my staff members.

The consumer-staff handle much of the hands-on responsibilities in the clubhouse in regards to basic vocational and educational skills. They also serve as inspirational role models, by sharing their recovery stories and techniques with the members. Their presence has allowed staff time to be used much more efficiently.

Solutions to the Workforce Crisis

Last year, mental health advocates came to Albany to request a "10% Rate Adjustment" for state funded mental health programs such as Clubhouses, Supported Employment, and Peer Support. They made the case that most of these programs have been in existence for a decade or more, and had not had any kind of a rate increase. In that same period of time, the cost of items like fuel, utilities, food, gasoline, and program supplies increased over 30%.

Programs reported that they have been forced to: cut hours and services, and eliminate staff positions in order to remain solvent.

In 2006, a three year, CPI rate adjusted COLA, for a broad array of community services, was approved. While we are grateful for any kind of funding increase, the mental health field still needs additional funds to improve its workforce.

The following are ways of addressing the mental health workforce crisis:

(1) Make the CPI-rate adjusted COLA permanent.

(2) New York State should pass the "Quality Workforce Act" (A04280, S657) This legislation allocates additional funds for staff education, training, and benefits enhancements for workers in the not-for-profit mental health, developmental disabilities, and substance abuse agencies.

Mental health agencies could utilize training funds in the following areas:

- Psychiatric Rehabilitation
- Multi-Cultural / Diversity
- Healthcare Education (Understanding the impact of co-morbid chronic health conditions such as diabetes and hypertension on mental health consumers.)
- Geriatric mental health issues
- Goal planning and documentation
- To facilitate the training of mental health peers in the workforce

(3) Mental health workers should have health insurance parity with workers in the OMRDD system. Employees of developmental disabilities agencies receive a reimbursement for their out of pocket healthcare expenses under a new initiative called "Healthcare Enhancement II". The reimbursement totals a few hundred dollars each year per employee.

(4) To examine scholarship opportunities / loan forgiveness programs to encourage new workers to enter the mental health field.

We were pleased to see that the new NYS Office of Mental Health Commissioner Michael Hogan, in the state mental health plan he developed for Ohio (November 2006), entitled, "A New Day, Wellness for All," highlighted workforce issues. Goal 5 -12 stated a need to, "Develop strategies to address the serious workforce issues that affect the ability to attract and retain skilled professionals (both clinical and administrative). This includes an aging workforce, competitive pay, regulations, training, and higher education programs." As I have outlined, the workforce issues that exist in Ohio, also exist today in New York.

If we come up with sensible strategies to attract good workers to the mental health field, to pay them adequately, and provide them with proper benefits, then my son's desire to follow in his father's footsteps, and help people have better lives, can become a happy reality. □

Hope Works from page 19

Providers and consumers had to protest to fight for funds that were necessary and rightfully theirs.

Today, things are different in Nassau County. In 2006, Nassau County Executive Thomas Suozzi and the Nassau County Legislature allocated an additional $1.3 million of county funds to restore cuts and INCREASE mental health services. Although some of that $1.3 million was supposed to be "one-time only" funds, today, these monies were restored for 2007 to support HOPE and the vision of recovery. Today, people needing human services can access them through a model program called "No Wrong Door," where all the agencies are under one roof. The building and services are designed to treat people with respect and people's needs can be met in an efficient manner (and one that also yields a savings for taxpayers). And finally, today, we have Commissioner Arlene Sanchez, who is showing vision and leadership in her commitment to educate mental health and other social service providers, not from a "sickness" and "patient" perspective, but by using a strength-based, recovery-oriented model that brings HOPE and the opportunity of recovery to every individual in all mental health services throughout the county.

The day ended with the dissemination of framed HOPE plaques (courtesy of Steve Miccio, Executive Director of PEOPLe, Inc.) to all participating programs in Nassau

see Hope Works on page 42

LMHCs: Qualified to Serve in the Mental Health Workforce

By Kristen Fortuna, MC, LHMC
Outreach Coordinator
The Hudson Valley Interest Group

According to the New York State Department of Labor, employment in community and social service occupations throughout the state will increase 14% by 2014. It is projected that within the next 7 years, the annual number of job openings expected in the related occupations due to growth (2,350) plus replacement need (3,230) will equal 5,580. Who will meet the challenge of the growing mental health workforce? The ensuing will discuss the relatively new establishment of mental health counseling as a profession in New York State and explain why mental health counselors make qualified professionals to serve in the mental health workforce.

Mental Health Counseling is a distinct profession with national standards for education, training and clinical practice. Currently, forty-eight states, as well the District of Columbia and Guam license or certify mental health counselors for practice. It was not until December 2002 that New York signed a law that established the profession of Mental Health Counseling throughout the state. Article 163 of the Education Law posted by the NY State Department of Education Office of the Professions defines the practice of the profession of mental health counseling as:

- the evaluation, assessment, amelioration, treatment, modification, or adjustment to a disability, problem, or disorder of behavior, character, development, emotion, personality or relationships by the use of verbal or behavioral methods with individuals, couples, families or groups in private practice, group, or organized settings; and
- the use of assessment instruments and mental health counseling and psychotherapy to identify, evaluate and treat dysfunctions and disorders for purposes of providing appropriate mental health counseling services.

Kristen Fortuna, MC, LHMC

As of today, approximately 3,640 mental health counselors have been licensed to practice in NY. Licensure requirements for mental health counselors are equivalent to those for clinical social workers and marriage and family therapists - two other disciplines that require a master's degree for independent status. In order to become licensed in New York, one must meet the following state requirements:

- Complete a minimum a 48-credit hour Masters (as of 2010 the minimum will be a 60 credit masters) in SED-approved counseling program with specified content areas including assessment, psychopathology, counseling theory and practice, group dynamics. As well as complete a minimum of 600 clock hours of a supervised internship;
- Perform 6,000 clock hours of supervised experience in a SED-approved setting. The experience must be supervised by a licensed mental health professional, including: LMHC, LCSW, psychologist, psychiatrist, physician's assistant, psychiatric nurse practitioner, marriage and family therapist, creative arts therapist or psychoanalyst;
- Pass a National Clinical Mental Health Counselor Exam administered by the National Board for Certified Counselors (which may only be taken after 3,000 supervised clock hours have been completed);
- Complete Child Abuse Reporting Training.

The Department has already registered 14 graduate degree programs as leading to licensure in the state on the basis of 48-semester hours and another 35 programs are registered as license qualifying for mental health counseling on the basis of 60-semester hours. This number is likely to expand as applicants from different programs seek licensure and the profession gains in popularity.

Licensed Mental Health Counselors (LMHCs) may practice in a variety of settings, including independent practice, community agencies, managed behavioral health care organizations, integrated delivery systems, hospitals, employee assistance programs and substance abuse treatment centers. More than 90% of the nation's managed care organizations either employ or contract with licensed mental health counselors. In New York, LMHCs are steadily being recognized and accepted as qualified providers by insurance companies such as Value Options and Oxford.

The American Mental Health Counselors Association (AMHCA) is the professional membership organization that represents the profession. New York Mental Health Counselors Association (NYMHCA) is the state chapter of the American Mental Health Counselors Association. NYMHCA worked diligently to help bring about licensure and assumes the continuing role to protect and enhance the rights of counselors to practice in the profession. If you would like more information on the profession of mental health counseling or on either of these associations, please visit their respective websites at: AMHCA.org and NYMHCA.org.

The Hudson Valley Interest Group (HVIG), is a pre-chapter of NYMHCA. □

Connecticut Moves to Transform It's Workforce

By Pat Rehmer Silveira,
Barbara Bugella, Manuel Paris, Jr.,
and Michael A. Hoge

Over the last several years, Connecticut has been involved in a major effort to promote and implement a recovery oriented system of behavioral health care. A significant opportunity to move this agenda forward occurred when the state was awarded a federal, five-year Mental Health Transformation State Incentive Grant (T-SIG) from the Substance Abuse and Mental Health Services Administration (SAMHSA). In implementing this grant, Governor Jodi Rell charged 14 state agencies and the judicial branch with responsibility to collaborate with diverse community groups and private organizations to ensure a more seamless array of effective and accessible services and recovery supports. The ultimate goal is to prevent mental illness and promote resilience and recovery across the lifespan.

In keeping with the requirements of this grant, the state developed a Comprehensive Mental Health Plan addressing each of the six goals identified in the report issued by the President's New Freedom Commission. Unique to Connecticut's approach, however, was the decision to place a major emphasis on workforce development in its planning and implementation efforts as a seventh goal area.

Commissioner Thomas Kirk of the state's Department of Mental Health and Addiction Services viewed workforce development as an essential ingredient of reform in this transformation initiative. The behavioral health workforce problems in Connecticut are similar to those facing most state, regional, and local systems across the country. Provider organizations report major difficulties in recruiting and retaining qualified employees, particularly in the private, non-profit sector. It is extremely difficult to recruit a culturally and linguistically diverse workforce and to improve the cultural competency of the existing workforce. There is a critical shortage of personnel trained and skilled in caring for selected populations, such as children, youth, young adults, and older adults. Also, there is considerable evidence that pre-service and continuing education systems have had difficulty keeping pace with the rapid changes in healthcare delivery and, too often, do not use effective educational strategies.

There is a specific concern that resilience and recovery-oriented approaches to care and shared decision-making approaches that actively involve the recipients of services are not adequately taught in educational programs. Direct care staff members often receive little training, supervision, or support. Further, individuals most often seek help for mental health problems outside of the nation's formal behavioral health systems of care, from persons such as teachers, primary care providers, and emergency room personnel. Yet, substantive training about mental health disorders, treatment, and recovery is seldom offered to these caregivers.

In an effort to address such problems, the managers of Connecticut's Transformation Grant established a Workforce Transformation Workgroup to guide the planning and implementation effort and engaged a team from the Yale University Department of Psychiatry to staff the process. The thirty members of the Workforce Transformation Workgroup included persons in recovery, family members, advocates, state agencies, private non-profit providers, educators, researchers, and workforce experts. Input into the planning process was generated through a review of previous state agency reports on workforce problems; information and recommendations provided by workgroup members; a planning retreat on workforce challenges in caring for children, youth, and families; and a special session focused on the interface between the higher education and behavioral health systems within the state. In addition, members of the Workforce Transformation Workgroup conducted over 40 focus groups across the state on workforce needs, resources, and recommendations, engaging a diverse group of stakeholders in this dialogue. As part of this process, a consumer was hired to organize and conduct a special series of focus groups with persons in recovery in order to ensure their full input.

This process generated a set of recommendations, which, along with proposals from other workgroups, were reviewed and ranked by a statewide Transformation Oversight Committee. Ultimately, a broad recommendation to expand and enhance mental health training was selected for implementation planning and budgeting, which is a task now underway. The planning is focused on five strategies. The first is to establish the *Connecticut Behavioral Health Workforce Collaborative* as a permanent body charged with planning,

see Connecticut on page 42

Addictions Workforce: Crisis and Response

By Barry T. Hawkins, PhD, CASAC Director of Chemical Dependency Services, Orange County Department of Mental Health

Back in the spring of 1981 I sat in a tiny room in Manhattan, across from three large gentlemen who were quizzing me as part of the written and oral exams required to qualify as an addiction counselor. I had to make an extemporaneous presentation on a case that had been handed to me moments before. I was required to both describe a treatment plan for the person described and answer probing questions by the examiners. At that time, the process was rumored to be one of the most demanding of any credentialing process. Some friends thought I was crazy to go through such a process for something that wasn't even a license to practice independently. The New York State Credential was then called the Credentialed Alcoholism Counselor (CAC), and was in its infancy. Over time, a separate substance abuse credential was added, and eventually both merged into one Credentialed Alcoholism and Substance Abuse Counselor (CASAC). Thankfully, the examination process also changed to one more applicant friendly. In those early years, thousands of applicants were either "grandparented," or sat for the exams. It was hard to recruit enough test examiners and proctors to staff the packed rooms of would-be counselors. A large portion of the addictions workforce used this credential as verification of their knowledge and skills in delivering quality services. The human services community and the State addiction agencies agreed about the need to develop this portion of the workforce. The current agency, the Office of Alcoholism and Substance Abuse Services (OASAS), which represents the merger of prior separate entities for alcoholism and substance abuse issues, remains aware of the central role of the line worker.

"The addictions workforce exists for two primary reasons: to save lives and offer those in need with the opportunity to find a better way of life. The addictions professional offers a steady hand and a source of support, compassion and direction."

Director, Bureau of Workforce Development, OASAS

However, since the time I entered the discipline accompanied by a throng of enthusiastic co-workers, various factors have altered the picture. Qualified addiction workers have been leaving the workforce in far greater numbers than those entering the field. Between 1996 and 2002, there was a continuous decline in the number of credentialed counselors (CASACs) in New York State. From 9,272 in 1996 the number of CASACs declined to 6,049 in 2002, a loss of over one-third the total. In addition many of

Barry T. Hawkins, PhD, CASAC

these CASACs are persons not working in direct treatment services, or in some cases, not even working in the field. A related factor is an aging workforce, as the average age of CASACs in New York is currently 53 years of age. The situation in New York is consistent with the national picture, as described by the Center for Substance Abuse Treatment (CSAT) in its 2000 report, *Changing The Conversation.* One factor is that insurance credentialing requirements often make the possession of a license necessary for reimbursement, so those who are able, may seek advanced education and licenses, or leave the addictions field entirely.

Responding to this dilemma, the New York State Office of Alcoholism and Substance Abuse Services in partnership with Alcoholism and Substance Abuse Providers of New York State, Inc. (ASAP) and the Institute for Professional Development in the Addictions (IPDA), began an initiative in 2001 that resulted in a document and call-to-action titled, *The Addictions Profession: A Workforce in Crisis*. Based on the input of eleven focus groups with 125 participants, the report outlined some of the major issues and needs, as well as recommended action to ensure "a qualified and competent workforce will continue to support our service delivery system in the years ahead."

"We've never known more about how to help people, but never been so shorthanded on resources to keep the people we need here to help them."

A Focus Group participant

One of the first responses to the findings was formation of a Task Force on Workforce Development , involving the original partners as well as representatives of the Conference of Local Mental Hygiene Directors and volunteer participants from the community. Working together with the newly established Bureau of Workforce Development at OASAS, the Steering Committee has been working since that time to analyze and follow-up on recommendations distilled from the hundreds generated in the focus groups. The final 19 recommendations fell into five categories: Compensation, Administrative Relief, Marketing, Credentialing/Licensure, and Organizational Culture/Best Practices. Workgroups were formed by the Task Force to address each of these areas. Examples include:

- Compensation: A salary and benefit enhancement package should be developed to make AOD (Alcohol and Other Drug) staff salaries and benefit packages more competitive.
- Administrative Relief: In an effort to reduce/minimize the paperwork burden on clinical staff, OASAS should examine administrative and reporting requirements and re-examine how Units of Service are defined.
- Credentialing/Licensure: OASAS should streamline and simplify the credentialing process.
- Organizational Culture/Best Practices: Best practices would include provision of strong, continuous clinical supervision and the expansion of training opportunities.

At the same time as the Task Force explored these issues, OASAS began responding to the recommendations through such actions as a re-engineering of the Credentialing process and providing for expanded training opportunities.

"We cannot solve every problem, but we can certainly explore strategies and raise awareness of the issues to be tackled."

A Task Force member

After a year of work, the Task Force became the "Steering Committee" on Workforce Development and published a report, Combating the Crisis: A one year update to the 2002 Report, which described progress by the Task Force and OASAS. In the report, many of the original recommendations had led to suggestions of strategies and tactics. In some cases, such as the re-working of the credentialing process, actual progress has been made that seems to be producing measurable change. In other areas, recommendations required identification of new funds, revision of Mental Hygiene Law or State Regulation, or action of external organizations to succeed.

Four years later, progress has been uneven. In the area of compensation, there have been two cost-of-living adjustments that provided a modicum of relief to addiction providers, but certainly not equivalent to the losses of a negative inflation cycle. OASAS officials state their efforts are continuing in this area, though it is a difficult to find additional resources in times of fiscal austerity. Line-staff continue to be compensated at a rate that is not very competitive. In addition to CASACs, Chemical Dependency Programs employ a variety of Qualified Health Professionals ("QHP"s), who often have the opportunity to work in other fields at a higher rate.

"There is consensus that until compensation improves, it will be difficult to have significant change in the forces buffeting the workforce."

A Task Force member

Major initiatives have been accomplished in the area of Marketing. The IPDA and OASAS have generated attractive print and media products, although the long-term success of these recruitment efforts will not be measurable for some time.

Efforts to update the credentialing process appear to be having a positive effect, including the creation of a CASAC – Trainee certification that allows an applicant to work in the field and count toward a program's required percentage of QHPs, while working to satisfy all of the requirements to sit for the CASAC examination and become fully credentialed. The declining number of credentialed workers seems to have leveled off, with around 6000 still credentialed at the end of 2006. More encouraging, is the fact that there are over 3300 CASAC Trainees, workers who are "in the pipe-line" towards becoming fully credentialed. Currently, over 500 applicants a year take the oral examination, the final step in credentialing.

As a new administration assumes power in Albany, the OASAS Bureau of Workforce Development continues to be dedicated to addressing these issues.

"…in 2007, OASAS' commitment to the addictions workforce will remain strong, as well as its pledge that the services provided to those suffering from addiction and its effects on the family and society-at-large will be of the highest quality."

Director of Bureau of Workforce Development, OASAS

Recently, as a member of the Credentials Board I was given the opportunity to take an on-line version of the CASAC written exam. To my relief, I had no problem passing, but I'm glad they didn't ask me to try the current oral exam. Once was enough! Since then, I have gotten additional degrees and a State Ed. License, but I am still proud of that CASAC.

Barry Hawkins is Director of Chemical Dependency Services with the Orange County Department of Mental Health. He has served on OASAS' Workforce Development Task Force since its inception, as well as several sub-committees. He is a member of the CASAC Credentials Board and the Chemical Dependence Committee of the Conference of Local Mental Hygiene Directors. □

Hall-Brooke Offers Psychiatric Services For Older Adults with Mental Health and Substance Abuse Issues

Staff Writer
Mental Health News

A comprehensive Geriatric Psychiatry Service for older adults experiencing acute psychiatric disorders is now available at Hall-Brooke Behavioral Health Services, 47 Long Lots Road, Westport.

"Physical illness, psychological and social stresses of getting older, loss of a loved one, loneliness, the inability to take care of oneself and family and other life transitions can have a significant impact on the mental health and wellbeing of an older adult," says Thomas E. Smith, MD, Medical Director at Hall-Brooke. "We are proud to offer a service that will provide the best quality of care to aging adults with mental health and substance abuse issues, alleviate symptoms and improve their quality of life."

The Geriatric Mental Health Foundation reports that 15 out of every 100 adults over age 65 in the United States experiences depression and that approximately 2 million individuals ages 65 and older in a given year have a diagnosable depressive illness. Depression also affects upwards of 50% of nursing home residents and suicide rates are the highest among the elderly. According to the American Foundation for Suicide Prevention, white men over 50 make up less than a quarter of the population, however are responsible for almost 40% of all suicides.

Thomas E. Smith, MD

"Hall-Brooke's program can benefit older adults with depression, mood disorders, anxiety, disorientation, substance abuse or difficulty coping with transitions and losses," states Dr. Smith.

According to the US Census projections, 14% of the residents in the state of Connecticut are persons ages 65 and older. In 2020, the number will increase to almost 18%. The Connecticut General Assembly also reports that the number of people ages 65 or older in the state of Connecticut grew by about 30% from 1980 to 2005.

Hall-Brooke's Geriatric Psychiatry Service consists of a comprehensive evaluation to determine the psychiatric needs of the patient and an inpatient unit staffed by experienced psychiatrists, nurses, psychologists, social workers and other mental health professionals. Each patient receives an individual and multi-disciplinary treatment plan including a psychiatric diagnosis, psychopharmacologic assessment, individual and group psychotherapy and rehabilitation services. In addition, patients have access to a full range of medical consultants at St. Vincent's Medical Center in Bridgeport.

"Aging adults may be ashamed to talk to their family about a mental health or substance abuse issue," says Dr. Smith. "It is important to speak to a loved one about seeking treatment if they are experiencing depression, severe memory loss, loss of interest in appearance or self-care, increased social withdrawal, suicidal thoughts or behaviors, sleep disturbances and extreme fluctuations in weight."

Hall-Brooke is a wholly-owned subsidiary of St. Vincent's Health Services of Bridgeport and is affiliated with the Department of Psychiatry of Columbia University's College of Physicians and Surgeons. □

The Future of Our Mental Health Care: A Consumer's Point of View

By Glenn Slaby
A Consumer in Recovery

We depend greatly on those who want to devote their professional career to our disabilities. Society throws us enough curves. There are many injustices in this world and humanity may not have the will power or the ability to face and correct them, but in our society we are lucky to have avoided many of them. With mental illness, however, there are obstacles that need to be overcome. A key component to well being is the relationship between the patient and their team of professionals. Proper coordination with this care is essential, but the future, is as usual too uncertain.

To view how the future may deal with us, the consumer, and the future possible shortage of professional care in our community facilities, we should take a long, hard look at our current care and availability. As one who receives care from a non-profit facility, I admire and appreciate the responsibilities taken by our professionals and the respect that is reciprocated. As a former accountant, I also understand some of the basic trials and financial stress that these organizations face. Both, us consumers and the institutions providing care, face many hardships with the current political and monetary outlook very unclear. Sometimes the consumer may view these health care facilities as adversaries, but we are on the same side with the same goals – finding a purposeful, useful and respectful life for those suffering from mental illness.

To view the future treatment for the mentally ill, some questions must be asked, such as:

· How will new developments and changes in medications, consumer population, stigma and treatments affect the delivery of care?

· Will facilities be flexible enough to adapt quickly to these new unseen situations and opportunities in an appropriate time frame?

· How will consumers' care be affected in the long and short term?

· Will the universities offer more courses, expand their curriculum, and encourage students to the discipline of treating us, the mentally ill?

· Will the practice of medicine in these community hospitals be able to maintain these caregivers with enough challenges and rewards for them to continue practicing there, or be tempted to leave for the rewards of private practice?

· Finally, to which primary motive will insurance, governmental and political institutions adhere to: the profit motive or the well being of the caregivers and the consumers?

· And will there be enough incentives and encouragement legislatively, for our well being and for our caregivers, in our culture and capitalist society?

As with this nation's overall healthcare and financial problem(s) and/or crisis, we see how our caregivers appear to be at the limits of proper treatment. There are times and situations we all face in which the caregivers cannot open their limited schedules. The constraints facing these healthcare professionals appear to leave little room for growth and flexibility. Is it a reflection of society's values, trends and regulatory constraints or a lack of concern by the general population?

Corporate medicine has a place in dealing with the many types of diseases affecting humanity, but is it functioning at its optimum? How does the corporate world mirror what is best for the consumer? There are benefits to large community facilities: such as the delivery of quality long term care, providing proper diverse services for the present and flexible planning for the future, etc. There is a delicate balance between these and maintaining an on going viable operation.

I see our facilities struggling to provide and maintain services. From the physical upkeep of the units to treatment, there is a daily struggle, a balancing act, between operating as a business and performing as a service. They must provide appropriate care with enough financial payback/ insurance reimbursement within a strict legislative framework, and maintaining a professional staff from doctors to maintenance and security. Where one link fails, the systems/institution fails and one of us may take a backwards step. We consumers must maintain the correct attitude, be responsible and respectful. We all have failed or will. Somewhere some time. But our responsibility is to do our best and listen, discuss and follow directions.

There is one thing we, the consumer and the caregivers can all have in common – faith. It is the key to hope. My current facility is a religious based one and that adds a lot of comfort to my situation and I assume, to others, as well. Being able to sit quietly in the chapel for a few moments offers a great advantage. Here, there can be hope beyond human understanding/contemplation. Here strength can be accumulated, (but not always), where one can express both gratitude and fears. Faith is the key to hope. Hope is the key to living a life of purpose and fulfillment.

We all must struggle with imperfections and disabilities; hopefully society, our neighbors and friends can partake and join us as we proceed forward in this life. There are injustices in life; unfortunately some can result in tragedy. As each generation faces its challenges, those with mental illness face their future with additional stress and much trepidation. The sad part apart this is that some of these problems can be corrected with a bit of foresight. I see the future with some restrained hope.

Glenn Slaby, a former accountant, is currently in outpatient treatment. He writes and works part-time as a library clerk. □

Westchester Independent Living Center Provides Vital Services to Consumers

Staff Writer
Mental Health News

The Westchester Independent Living Center (WILC) is a community based, consumer driven resource organization whose mission is to enhance life's opportunities for people with disabilities by providing supports that empower them to explore choices and work toward their goals. WILC is part of a national network of centers that provide non-residential and non-medical services. Its programs and services are provided free of charge to any individual with a disability and to his or her family members.

The philosophy of the Independent Living Centers is that each person should have the opportunity to be as self-determined and as self- sufficient as possible. Independent Living does not replace traditional service providers. We work in a complimentary fashion, promoting better access and utilization of services and building self-esteem and self-actualization for every consumer we serve.

WILC offers many different programs and services some of those are; Benefits and Entitlements advisement, Community Outreach, and Information and Referral.

Partners For Success Project
Vocational Readiness

Initiated in the spring of 2006, the Partners For Success Program has proven to be one success to the challenges that that face mental health consumers in the workforce. Partners For Success (PFS) is a Vocational Rehabilitation (VR), Readiness Training Program designed by Westchester Independent Living Center (WILC). The program is based on 3 key tenets:

- Personal Awareness
- Personal Responsibility, and
- Personal Empowerment

The PFS program consists of 2 parts. Part A consists of classroom training that is mandatory for every participant. Part B consists of One-to-One Peer mentoring and Follow-Up Services and is for participants who would benefit from further instruction/support. Part B reinforces the lessons learned in Part A and also provides support, information, methods of dealing with obstacles, and/or referrals to other agencies/programs that will facilitate the participant's VR readiness.

Mental Health consumers face a multitude of challenges to obtaining and maintaining employment and/or employment training (preconceived beliefs that the mental health consumer is limited in experience; unaccountable, irresponsible, not stable, will never "fit" in, etc.). Consistently and constantly being held to a higher standard of irrational behaviors/ responses such as, they must never be without fault; must always be perfect, never get angry, upset, or emotional, and never make an error, especially in judgment.

Partner For Success offers a different way for Mental Health consumers in understanding and moving towards inclusiveness, information sharing, personal awareness, personal responsibility and personal empowerment! Partners For Success helps validate one's strengths, reassess their challenges, take responsibility for themselves; their choices, their actions, their inactions, and their reactions.

"The Partners For Success is not about getting people jobs, or resume writing, or any of the multitude of assistance that's already out there. Partners For Success is about creating positive, effective attitudes, effective communication; recognizing and defining empowerment for yourself; Partners For Success is about understanding and validating that you are good at whatever you do and it's their loss (employers) if they don't hire you! Partners For Success is about accountability, responsibility."

The Mental Health Advocacy Project

The Mental Health Advocacy Project is one of our premier programs. This program is geared toward supporting individuals labeled with a mental illness, including those with psychiatric and emotional disabilities. The program helps individuals make life choices, increases opportunities, and provides advocacy and benefits counseling through our Mental Health Peer Advocate. A focus on systems advocacy encourages change within a traditionally non-consumer oriented service system. The Mental Health Systems Advocate works on a grassroots level to educate and organize consumers around legislative issues affecting their futures.

All of our services are FREE of charge. For more information please contact us at Voice (914) 682-3926 (TTY (914) 0926) or go online at www.wilc.org □

Hope Works from page 36

County to display proudly as a commitment to recovery and to reinforce what is possible…with HOPE. And as I started in opening remarks of the Conference, "we have all the players here today that can make a difference." A giant step of recognition was taken that day in December. But the work of change – of the training and implementation of recovery principles – is our challenge in 2007…and beyond.

Photo: Dan Fisher, Executive Director, National Empowerment Center, Steve Greenfield, Executive Director of Mental Health Association of Nassau County, Harvey Rosenthal, Executive Director New York Association of Psychiatric Rehabilitation Services, Jacki McKinney, co-founder of National People of Color Consumer/Survivor Network, John Javis, Co-Chair, Director of Special Projects, Mental Health Association of Nassau County, Barbara Tedesco, Co-Chair, Director Consumer Link, Mental Health Association of Nassau County, Sharon Mullon, Commissioner, Department of Senior Citizen Affairs, Arlene Sanchez, Commission, Mental Health, Chemical Abuse, and Developmental Disabilities Services, Jeffrey Toback, Nassau County Legislator, David Denenberg, Nassau County Legislator. □

Connecticut from page 37

coordinating, and implementing interventions to strengthen the workforce, with a specific charge to link behavioral health and education systems within the state. This is in keeping with the *infrastructure* emphasis in this federal grant. A second strategy is to increase the number and percentage of persons in recovery, youth, and family members who are employed at all levels of the workforce. Developing a workforce skilled in caring for children, youth, and families by identifying core competencies for this work and implementing competency-based curricula constitute a third critical area of focus. A fourth strategy is to strengthen the workforce for adults by improving recovery-oriented, culturally informed, and gender responsive training on mental illness and co-occurring disorders for direct care, pre-professional staff in the behavioral health system and for other health and human service personnel who are not part of the specialty behavioral health workforce. The final cross-cutting strategy is to increase the use of web-based training for consumers, youth, and family members and all sectors of the workforce.

There is broad consensus in Connecticut that strengthening the workforce is essential if efforts to transform the state's system of mental health care are to succeed. The workforce is the principal vehicle through which access to care is provided and effectiveness of care is assured. The vast majority of the state's behavioral health expenditures are, in fact, expenditures on human resources. A concerted and coordinated effort is required to assure effective recruitment, retention, and training of those who care for persons with mental health problems and illnesses. This transformation initiative has provided Connecticut an opportunity to intensify its efforts on this urgent agenda.

Pat Rehmer Silveira, RN, MSN, is Chairperson, Connecticut T-SIG and Deputy Commissioner, CT Department of Mental Health and Addiction Services. Barbara Bugella, RN, MSN, MBA, is Assistant to the Chairperson, Connecticut T-SIG, CT Department of Mental Health and Addiction Services. Manuel Paris, Jr., Psy.D., is Assistant Professor of Psychology (in Psychiatry), Yale University School of Medicine. Michael A. Hoge, Ph.D., is Professor of Psychology (in Psychiatry), Yale University School of Medicine Convener, Workforce Transformation Workgroup, Connecticut T-SIG. For further information, contact Michael Hoge at michael.hoge@yale.edu. □

Benefits from page 8

Also participating in the study were Amanda Patrick, Dr. Jerry Avorn, Brigham and Women's Hospital; Dr. Francisca Azocar, Joyce McCulloch, United Behavioral Health; Dr. Evette Ludman, Dr. Gregory Simon, Group Health Cooperative. The research was also supported by the Robert Wood Johnson Foundation.

The National Institute of Mental Health (NIMH) mission is to reduce the burden of mental and behavioral disorders through research on mind, brain, and behavior. More information is available at the NIMH website, www.nimh.nih.gov. □

NIH Director from page 8

Medicine and member of the Council of the AAP.

MARY-CLAIRE KING, PH.D., is the American Cancer Society Professor in the Departments of Medicine and Genome Sciences at the University of Washington. Dr. King was an undergraduate mathematics major at Carleton College. She completed her Ph.D. in genetics at the University of California, Berkeley, demonstrating in her dissertation that human and chimpanzees are 99 percent identical in protein and DNA sequences. She was a postdoctoral fellow at the University of California, San Francisco and a faculty member at University of California, Berkeley prior to joining the University of Washington. Her current research focuses on the genetics of complex human traits, particularly inherited predisposition to breast and ovarian cancer.

ALAN I. LESHNER, PH.D., is chief executive officer of the American Association for the Advancement of Science (AAAS) and executive publisher of its journal, "Science." Previously, Dr. Leshner had been Director of the National Institute on Drug Abuse at the National Institutes of Health (NIH), and Deputy Director and Acting Director of the National Institute of Mental Health. Before that, he held a variety of senior positions at the National Science Foundation. Dr. Leshner began his career at Bucknell University, where he was Professor of Psychology. He received an A.B. in Psychology from Franklin and Marshall College and M.S. and Ph.D. in Physiological Psychology from Rutgers University. Dr. Leshner is an elected member of the Institute of Medicine of the National Academies of Science; and a fellow of AAAS, the National Academy of Public Administration, and the American Academy of Arts and Sciences. In 2004, he was appointed by President George W. Bush to the National Science Board.

JOHN C. NELSON, M.D., MPH, is a board certified obstetrician and gynecologist from Salt Lake City, Utah. A graduate of Utah State University and the University of Utah, Dr. Nelson has been in active clinical practice since 1975. He has served as deputy director of the Utah Department of Health and was president of the Salt Lake County Medical Society, the Utah Medical Association, and served as the 159th president of the American Medical Association. He is a fellow of the American College of Obstetricians and Gynecologists as well as the American College of Preventive Medicine and is currently serving as medical director for HealthInsight, the Quality Improvement Organization (QIO) for Utah and Nevada. He has served on numerous federal committees, most recently the Medicaid Advisory Commission. He has long been concerned with access to health care coverage for all Americans, the elimination of racial and ethnic disparities in health care, prevention of disease, and quality improvement in health care delivery.

BARBARA L. WOLFE, PH.D., is Professor of Economics, Population Health Sciences, and Public Affairs and Faculty Affiliate at the Institute for Research on Poverty at the University of Wisconsin-Madison, where she also is currently serving as Director of the La Follette School of Public Affairs. Dr. Wolfe did her undergraduate work at Cornell University and her doctoral work in economics at the University of Pennsylvania. Her research focuses broadly on poverty and health issues. Current projects examine the effect of expansions in public health insurance on health care coverage and labor force outcomes; the role of income on health using a natural experiment; whether housing voucher programs lead to higher earnings, higher quality child care, and less reliance on other public assistance programs; the adequacy of resources when individuals retire and during their first decade of retirement; and the increasing selectivity of high quality universities. She is a member of the Institute of Medicine www.iom.edu/ and vice chair of the National Academy of Sciences/Institute of Medicine Board on Children, Youth and Families.

Additional information is available at www.nih.gov/about/director/acd/index.htm.

The Office of the Director, the central office at NIH, is responsible for setting policy for NIH, which includes 27 Institutes and Centers. This involves planning, managing, and coordinating the programs and activities of all NIH components. The Office of the Director also includes program offices which are responsible for stimulating specific areas of research throughout NIH. Additional information is available at www.nih.gov/icd/od/.

The National Institutes of Health (NIH) – "The Nation's Medical Research Agency" -- includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. It is the primary federal agency for conducting and supporting basic, clinical and translational medical research, and it investigates the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit www.nih.gov. □

visit: www.mhnews.org

Awards from page 7

education, and direct services. MHA serves all regardless of ability to pay full fee.

The Mental Health Association of New York City (MHA of NYC) is a leading mental health advocacy, public education and direct services organization serving the metropolitan area. The MHA of NYC also operates 1-800-LIFENET, New York's official mental health crisis, information and referral hotline, which responds to more than 90,000 calls annually from New Yorkers seeking mental health services for themselves or a loved one.

The A.H.M.H.P. is a not-for-profit organization founded in 1983 by a multidisciplinary group of Hispanic mental health professionals to address serious gaps in the mental health delivery systems affecting the Hispanic Community. Its members include nurses, psychiatrists, psychologists, social workers and other mental health professionals of Hispanic backgrounds as well as non-Hispanic mental health professionals interested in Hispanic issues. □

Timothy's Law from page 1

his 18th birthday and graduated high school last year.

At the end of June, 2006 the NYS Assembly and Senate reached a last-minute compromise on Timothy's Law. The Senate returned to Albany and unanimously approved it in September, and it won unanimous passage when the Assembly brought the legislation to the floor in December. Lawmakers stood in ovation to recognize the vigilance of Timothy's father, Tom O'Clair, who had spoken with many of them personally, with both poise and passion. He often shared that he felt he is doing Timothy's work, that he is his late son's hands in the fight to end insurance discrimination against those who need mental health care and addiction treatment.

It has been my great privilege to work with Tom and all of the Timothy's Law advocates these last few years. Everyone including the sponsors, co-sponsors and legislative leaders made Timothy's Law a reality. Senators Tom Libous, Joe Bruno, Tom Duane, Tom Morahan, and David Paterson (now Lieutenant Governor) and Assemblymembers Paul Tonko, Sheldon Silver, Pete Grannis, Peter Rivera, and Jim Tedisco, and all of their colleagues have our eternal gratitude for staying with us all the way, even when the going got a little rough and tumble.

Background

For the last four years more than 350 organizations comprising the Timothy's Law Campaign (TLC) have worked closely with Timothy's family, other parents, and mental health as well as addiction treatment advocates for a broad "parity" law for New York. Thirty-nine other states had parity laws, and advocates here have pushed various bills over the last 20 years, without success. Before January 1st, New York health plans were merely required to offer a mental health option to employers along with 60 days of outpatient care for chemical dependency.

Opposition from the business community as well as the very powerful health plans had long stalled the effort in the State Senate. Attempts at compromise were soundly rejected by both houses as too weak or too much.

Most arguments against parity are rooted in myths about its potential impact upon small employers - that their premiums would rise to such a degree that many would drop health insurance altogether.

However, parity laws in other states have not proved burdensome - not a single state has repealed this mandate. Studies show that the real result is lower out-of-pocket costs for consumers, and even savings under the most comprehensive laws. Businesses elsewhere have not dropped coverage or switched to self-insured status to avoid the requirement.

Several years ago a Pricewaterhouse-Coopers actuarial analysis for New York estimated that comprehensive insurance parity would cost $1.26 more per member per month to provide unlimited mental health and addiction treatment coverage for all employers not exempt under federal law (ERISA).

It became clear that only a well-orchestrated campaign with a very strong grass roots element and expert lobbying could hope to win the day on this issue. And that is what TLC did in 2006. Along with coalition partners and Timothy's father, Tom O'Clair, local groups sponsored crucial grass roots activities that took place in Suffolk, Nassau, Westchester, Rockland, Utica, Binghamton, Watertown, and in several Capital District communities including Albany, Saratoga, and Hudson. Local legislatures passed resolutions calling upon the Senate and Assembly to enact Timothy's Law.

The culmination of this campaign came over the last two weeks of the Legislative Session in Albany.

In the end a worthy compromise was struck with the help of expert lobbying by Artie Malkin (Malkin & Ross), representing Coalition for the Homeless, and Richard Gallo (Gallo Associates) representing the NYS Psychiatric Association, as well as constant grass roots pressure in the halls of the capitol, on the phones, in e-mail campaigns, on editorial pages, and in lawmakers' districts where marches, rallies, vigils, and even lawn signs helped bring the message home.

The Timothy's Law Agreement

The agreement specifies a two-tiered mental health benefit structure that can best be understood as two mandates for large employers and a subsidized mandate paired with a "subscriber option" for the same coverage for groups with 50 or fewer employees.

Basic Mental Health Mandate

The first mandate, applicable for all employers that offer health insurance including inpatient care and not exempt under federal law (self-insured plans) or state law (Healthy New York, Child Health Plus, Family Health Plus) requires employers offering comprehensive health coverage to provide broad based mental health coverage including at least 20 outpatient visits and 30 inpatient days per year, with co-payments and deductibles comparable to those used for physical ailments (financial parity). Exclusions may be no more restrictive than the state's parity-based coverage for civil servants (and lawmakers), the Empire Plan. Exclusion of chronic mental illnesses would thereby be prohibited, and the vast majority of diagnoses found in the Diagnostic and Statistical Manual of the American Psychiatric Association would be included, provided the care is medically necessary.

Chemical Dependency

Regrettably, the hard-fought effort to include a specific requirement for addiction treatment failed. Under current law there is a 60 visit per year mandated outpatient treatment benefit for chemical dependency, often a 5-day detoxification benefit included in the major medical coverage, plus optional coverage for 7 days of detoxification, and 30 days of rehabilitation, but these are not expressly mandated under Timothy's Law.

Hold Harmless for Small Employers

Importantly, the law requires the superintendent of insurance to "develop a methodology to fully cover the cost" of the base benefit mandate for employers with fifty or fewer employees. The price tag for this state subsidy has been estimated to be $100 million per year and that

Shelly Nortz

sum is included in the Executive Budget proposal for 2007-2008. Notably, this subsidy (expected to be about $3.85 per member per month for 2 million subscribers employed by 450,000 small employers) will benefit both small employers and the health plans, for which it ends up being an indirect subsidy. The cost would would be offset by improved productivity and reduced absenteeism as well as taxpayer savings to Medicaid and other public funding for mental health care. Consumer and state spending account for 80 percent of mental health care in New York, with only 20 being covered by private insurance. This balance will shift as Timothy's law takes effect.

Mandated Parity Benefit
with Small Employer Option

Above and beyond this base benefit is a parity benefit. The parity benefit also includes "financial parity," and is required for all non-exempt employers with more than 50 employees. This same coverage is optional for small employers. It provides unlimited mental health coverage of medically necessary care for children and adults with diagnoses in the following groups: schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, anorexia, and bulimia.

An early analysis shows that scores of individual diagnostic codes, including some disorders that are substance-induced, satisfy the definition of biologically based mental illnesses.

This requirement also provides broader unlimited coverage for children under age 18 who have serious emotional disturbances and are diagnosed with attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, where there are serious suicidal symptoms; significant psychotic symptoms; behavior that places the child at risk of causing personal injury or significant property damage; or behavior that places the child at substantial risk of removal from the household.

The children's list includes all of the following: Asperger's Disorder, Autistic Disorder, Childhood Disintegrative Disorder, Rett's Disorder, Pervasive Developmental Disorder, Atypical Autism, Attention-Deficit/Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder, and Disruptive Behavior Disorder.

Notable among the many diagnoses covered in the base but not included in the parity mandate are Post Traumatic Stress Disorder, many cognitive impairments, a variety of anxiety and personality disorders, eating and sleep disorders, as well as many addiction-related disorders. As has been the trend in other states with limited parity laws, we anticipate that those who cannot obtain sufficient care because of limits in the base benefit, and a diagnosis that is not included in the parity benefit, will join with the Timothy's Law Campaign in the future to seek a full parity law for New Yorkers.

What is Next?

The outcome of this campaign is obviously bittersweet for those who sought a full parity law covering all diagnoses and addictions. It is so terribly disappointing to know there are those who have been counting on winning a strong law to address their own needs or those of their loved ones, who are now left without that which they need. Even so, this outcome provides a solid foundation offering strong mental health benefits from which the law can be strengthened going forward.

As TLC works for full coverage for all employees and all mental health conditions, including addictions, it is gratifying to know that this crucial initial step will help millions of New Yorkers.

The task for the near term will be to get the word out about Timothy's Law and make sure that people make use of their benefits - rationing care should become a thing of the past. We want to make sure small employers receive their subsidies and that many will use this financial assistance to help them purchase the subscriber option for the full parity benefit. We will press for legislation providing parity within the state-subsidized Family and Child Health Plus health benefits programs, thereby adding parity for over a million more people. And we will work with the NYS Insurance Department and Office of Mental Health to ensure that they conduct the study required by the law so that when it is time to renew it in 2009, everyone will have ample information to help inform our anticipated push for a full parity law covering all employers and employees with comprehensive mental health and addiction treatment benefits for all diagnoses for children and adults.

The Timothy's Law Campaign is led by key statewide organizations including Alcohol and Substance Abuse Providers of New York State; American Foundation for Suicide Prevention; Coalition for the Homeless; Families Together in New York State; Long Island Recovery Advocates; Medical Society of the State of New York; Mental Health Association in New York State; National Alliance on Mental Illness of New York State; National Association of Social Workers – NYS Chapter; New York Association of Psychiatric Rehabilitation Services; New York State Coalition for Children's Mental Health Services; New York State Council for Community Behavioral Healthcare; New York State Psychiatric Association; New York State Psychological Association; New York State Rehabilitation Association; and the Schuyler Center for Analysis and

see Timothy's Law on page 44

Mental Health News
Upcoming Themes and Deadline Dates

Summer 2007 Issue

"Child and Adolescent Mental Health"

Deadline: May 1, 2007

Fall 2007 Issue

"Understanding and Treating Bipolar Disorder"

Deadline: August 1, 2007

Winter 2008 Issue

"Understanding Family Mental Health Services"

Deadline: November 1, 2007

Spring 2008 Issue

"Housing for People With Mental Illness"

Deadline: February 1, 2008

Timothy's Law from page 43

Advocacy. TLC was supported with the active advocacy of the NYS Catholic Conference as well as dedicated sponsors, co-sponsors, and legislative staffers.

Shelly Nortz is Deputy Executive Director for Policy with Coalition for the Homeless where she has worked on public policy issues since 1987. Coalition for the Homeless is based in Manhattan and serves 3,500 homeless New Yorkers with hot meals, emergency help, job training, housing, and more each day. You can learn more at www.coalitionforthehomeless.org □

Report from page 7

The Coalition is focused on strengthening the behavioral health workforce through policy development with federal and state agencies and though the provision of technical assistance to all types of behavioral health organizations.

Enriching the Knowledge Base. Building on the momentum of the initial meeting, a second phase of work for the Coalition focused on dissemination of the recommendations from the first Annapolis Conference and continued efforts to raise awareness nationally about the workforce crisis. This phase saw the publication of two special issues of the journal Administration and Policy in Mental Health (Vol. 29, Nos. 4&5; May, 2002; Vol. 32, No. 2; November, 2004). The Coalition gave testimony before the President's New Freedom Commission and provided background information workforce issues for the final report.

The Coalition recognized that one of the greatest areas of consensus among workforce experts was the need to place increased emphasis on competency development and assessment. To move this agenda forward, the Coalition convened a national summit on competencies in Annapolis in May, 2004. Experts from business and 13 sectors of behavioral health reported on the status of competency development in their workforce sector. A summary of these reports and recommendations to guide future work on competencies were published as a third special issue of Administration and Policy in Mental Health in May 2005 (Vol. 32, No. 5-6).

As the momentum in attention to workforce issues grew, the Coalition was pleased when the Institute of Medicine (IOM) convened a Committee on Crossing the Quality Chasm, Adaptation to Mental Health and Addictive Disorders. This seemed a perfect venue for the Coalition's efforts, and so in order to promote attention to workforce issues in this process, the Annapolis Coalition organized a panel of mental health and substance use disorder workforce experts, persons in recovery, and family advocates that developed recommendations for consideration by the IOM Committee. Two senior members of the Annapolis Coalition (Michael Hoge, Ph.D, and John Morris, M.S.W.) along with Eric Goplerud, Ph.D., an expert in substance use disorders workforce issues, were commissioned by the Center for Mental Health Services to draft a detailed background paper for the IOM Committee. Chapter seven of the IOM's Improving the Quality of Health Care for Mental and Substance-Use Conditions, is devoted to workforce issues.

An Action Plan with National Scope. The work entered its most ambitious phase during 2005-06. With support from the SAMHSA, the Annapolis Coalition managed the development of a national action plan on behavioral health workforce development. The New Freedom Commission report called for the development of such a plan, and both the Center Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP) had organized efforts to examine and address workforce issues relevant to their scope of interest. The current work builds upon that strong foundation.

In creating the plan, the Coalition used a variety of planning vehicles to gather input, analyze existing workforce plans and recommendations, and craft comprehensive recommendations that would be broadly applicable to all sectors of the field. Senior workforce experts convened expert panels or advisory groups around a dozen topics such as: substance use disorders treatment; substance abuse prevention; children, youth, and families; adults in recovery from mental illness; cultural competency, rural healthcare, and workforce financing. Experts also examined the impact of technology on the workforce and the role of accreditation organizations in workforce development.

Final recommendations and the content of the plan were shaped by the National Steering Committee of the Annapolis Coalition, a group of some of the foremost experts in the nation on workforce issues in particular content areas. A first draft of the plan was delivered to SAMHSA in 2006 and reviewed by approximately 200 stakeholders at a SAMHSA-sponsored meeting held in Washington, D.C. in July, 2006.

The draft plan is centered around seven strategic goals that emphasize three primary themes: (1) broadening the concept of "workforce" to include persons in recovery, youth, families, and community coalitions; (2) strengthening the workforce though systematic recruitment and retention efforts, more relevant and effective training, and sustained leadership development; and (3) improving the structures that support the workforce, such as information technology and financing. The goals emerged from the rigorous process of listening to and sifting among the wide array of recommendations that emerged from the planning process.

An Action-Oriented Future. In addition to the seven goals, the report includes detailed implementation tables that are specific to different sectors of the behavioral health field. The goal is to drive targeted action by stakeholders to move the field forward dramatically. The Coalition envisions this as only the beginning of a process in which the field is reinvigorated to take on the challenges of creating the workforce of the future. □

John A. Morris, MSW., (jmorris@tacinc.org) is Professor and Director of Health Policy Studies in the Department of Neuropsychiatry & Behavioral Sciences, University of South Carolina School of Medicine, Director of the TAC, Inc., Human Services Practice, and Executive Director of the Annapolis Coalition. Ann McManis, MA, (director@annapoliscoalition.org) is the Director of Operations for the Annapolis Coalition.

NAMI Agenda from page 14

as of January 1, 2007. They can find a way to make retrospective payments.

NAMI-NYS was pleased to see that Governor Spitzer fully funded the first year's implementation of Timothy's Law as it was passed by putting $100 million in the budget of the Department of Insurance.

Housing

Last year's New York/New York III agreement was a good first step to resolving the longstanding critical housing shortage for citizens living with mental illness in New York City. In ten years, it is expected to provide 5,000 units of the at least 35,000 additional units needed to make stable, safe, decent, affordable and permanent supportive housing available to persons with psychiatric disabilities in New York State.

NAMI-NYS and all of the mental health advocates were very pleased to see that Governor Spitzer put funding in his budget for 2,000 new beds of mental health housing and fully funded those in the pipeline from prior years. This is a tremendous step in the right direction and we commend him and thank him for it.

What is now desperately needed is a viable, long-term program to provide at least 35,000 more units, and to support and improve the housing that already exists, on Long Island and upstate as well as in New York City. The state should be developing at least 3,500 additional units a year. Presently, state-assisted housing is available to only 13.7% of those New Yorkers with a serious mental illness.

NAMI-NYS supports the Campaign for Mental Health Housing's call for $100 million in the Executive Budget this year to begin a multi-year commitment to building 35,000 additional units of housing (with support services) for New Yorkers with serious mental illness. A broad range of housing models is needed for New Yorkers with serious mental illness.

Funding is also needed this year for improvements to adult homes that house persons with psychiatric disabilities, including $5 million for nonprofit agency case management services and $3 million for legal advocacy.

The Office of Mental Health's Single Point of Entry process does not assign any priority to adult children who are living at home with their aging parents. According to an OMH study requested by the State Senate, the mortality rate of family members who provide housing to their psychiatrically disabled loved ones is up to 1,200 per year. The state needs to do its share when the family members can no longer do theirs.

Medicare and Medicaid

For hundreds of thousands of New Yorkers with serious mental illnesses, Medicaid is the lifeline for access to life-saving, recovery-fostering treatment, medication, housing and support services. And Medicare has become the provider of drug benefits for this vulnerable population.

The 2006 advent of the Medicare Part D prescription drug "benefit," under which primary drug coverage for "Dual Eligible" New Yorkers shifted from Medicaid to Medicare, added yet another safety net role to the program through its "Wraparound" drug benefit. On January 1, 2007 that benefit was reduced to just four classes of medications (including antipsychotic medications). Because persons with mental illness often take multiple medications, NAMI-NYS calls for re-instatement of this comprehensive wrap-around.

In its efforts to rein in the costs of this vital program, New York State must ensure that cost-containment not lead to "care containment;" that the health and safety of our most vulnerable citizens not be placed at the mercy of HMOs; that prescribing decisions be made by physicians and their patients, not bureaucrats in Albany or Washington, and that "nominal" drug co-payments not place an undue burden on the disabled and destitute.

NAMI-NYS calls for increased efficiencies in the Medicaid program through long-term care reform and reducing or eliminating rampant fraud and abuse. The savings from these efficiencies should be used to expand coverage and better manage and improve the health care of New Yorkers.

True reform must begin with creating a system of care that is coordinated, accessible and based on evidence-based practices such as the disease management approach successfully utilized by other states to serve high-need, at-risk populations, improving lives and saving money without scrimping on care.

Governor Spitzer's budget preserved the physicians' final say on medications for their Medicaid patients under the state's Medicaid Preferred Drug List and he also preserved the "carve-out" for antipsychotic medications. However he did remove the carve-out for anti-depressant medications and we would like to see that preserved, as well.

Research

NAMI-NYS advocates for research into the causes and treatment of mental illness. Of the ten leading causes of disability worldwide, five are psychiatric disorders; unipolar depression was the # 1 cause of missed work for the entire world population; followed by alcohol use, bipolar disorder, schizophrenia, and obsessive-compulsive disorder. Brain research is key to treating and eradicating these no-fault neurobiological illnesses.

Efforts to slowly starve mental health research must cease and we have reason to believe they will. The world-class Nathan Kline and Psychiatric Institutes MUST be kept intact, fully-staffed and working toward new treatments, such as a much-needed third generation of antipsychotic medications.

First of all, NAMI-NYS was very pleased to see that Governor Spitzer put $1.5 million in the budget for research positions at the two research Institutes, Psychiatric Institute and Nathan Kline. This is a most positive sign.

OMH's Psychiatric Institute is pioneering new research into developmental psychobiology, autism, early symptoms of schizophrenia, seasonal affective disorder, and Magnetic Seizure Therapy to treat unresponsive depression. It has initiated two programs that bring expert psychiatric consultation to rural New York State communities via live teleconferencing, and empirically-based research results to clinicians throughout the country via its Center for the Advancement of Children's Mental Health. PI boasts Nobel Laureate Eric Kandel among its staff.

OMH's Nathan Kline Institute is focusing on two of the most significant public mental health problems: schizophrenia and Alzheimer's disease. The research is aimed at improving treatments and service delivery, finding ways to prevent and ameliorate these diseases, and offering recovery and hope for patients and their families.

NKI brings in $15 million and PI $90 million annually in outside research funding. It would be penny wise and pound foolish to reduce these invaluable institutions that are, in fact, money-makers for New York.

For several years the State has left research positions vacant and later eliminated them at these institutes. Tell your legislator to fully fund the OMH research budget. Research is our hope for the future.

Community & Safety Net Services

NAMI-NYS advocates for shoring up the community services funded by the Office of Mental Health that represent the safety net for many New Yorkers with serious mental illness.

Many of these services cannot be switched over to Medicaid under the Personalized Recovery-Oriented Services (PROS) program and are at risk of being lost. These include such essential community support services as vocational, case management, self-help, transportation and some housing services.

According to the 2003 OMH Patient Characteristics Study, only 22 percent of the individuals identified as having serious mental illness received the most essential community support services, such as vocational, case management, self-help and housing services. That percentage has probably gone down through the funding cuts and attrition that has happened since then.

The number of the state's Assertive Community Treatment (ACT) teams and Intensive Case Management must be expanded. Too many people are at risk when they could be recovering with their help. Innovative and supported employment opportunities must be available to help the large number of individuals with mental illnesses who want to work. Services that will help families to better help their ill loved ones – such as Family Education -- are also greatly needed. ACT and Family Education. All are evidence-based practices that work. More is needed!

Integration of Physical and Mental Health Care

Diabetes is striking people with serious mental illnesses in large numbers. Studies show that persons with schizophrenia are up to four times more likely to develop diabetes than the general population—and they are less likely to be diagnosed and treated. Untreated diabetes has devastating consequences: heart attacks and strokes, blindness, kidney failure, and amputations.

Investing in diabetes prevention and management programs for people with mental illnesses makes sense. Studies show that psychiatric patients are as interested in their physical health and as motivated as the rest of the population in maintaining it.

Integration of physical and mental health care requires: universal diabetes screening; treatment of psychiatric patients with diabetes, heart disease, and metabolic disorders with the same standards as the general population; Medicaid funding of preventive care for psychiatric patients at risk of diabetes, heart disease and obesity; diabetes self-management education; trained staff to help patients lower their risks; cross-training of health and mental health professionals; peer-counseling programs; psychiatrist leadership of patient-centered wellness programs, and creation of wellness clinics in mental health centers.

A recent study of Medicaid utilization patterns in New York City showed that 75 percent of patients visited multiple provider systems and averaged 3.2 provider organizations a year. Of patients with schizophrenia: 68.3 percent had a chronic disease, 43.1 percent had multiple chronic diseases, averaged 2.5 psychiatric hospitalizations per year, averaged 2 non-psychiatric hospitalizations per year, averaged 3.3 ER visits per year not resulting in hospitalization.

As you can see, we have full agenda and a busy legislative season. But we begin in a way that we have not in many years. Yes we are still angry; yes we are still frustrated; but now we have hope! □

Nursing Shortage from page 10

year for all employees. On-going encounters as well as exit interviews are conducted by the Retention Specialist to learn how the hospital can work better to retain nurses.

Nurse Appreciation Week provides a celebratory opportunity to share evidence-based projects with the entire hospital community. Additional events that week include a nursing Grand Rounds speaker and Excellence in Nursing Awards Ceremony.

A nurse from each inpatient unit gives input to the Nurse Recruitment and Retention Council to support and develop recruitment strategies, and to improve retention efforts. Family and Psychiatric Nurse Practitioners and Clinical Nurse Specialists, working primarily in the out-patient areas, have a monthly meeting to address issues specific to their advanced practice roles and enhance skills and job satisfaction.

Patient Care Directors attend national conferences that educate them on even more positive ways to support and supervise staff. The VP of Patient Care Services makes personal contact with any staff member who goes the extra mile with a patient or staff member, or has a personal or family crisis. In addition, the hospital has many venues to award and formally recognize those who excel in service excellence.

At PWW, behavioral health nurses advance patient care and nursing practice initiatives. They seize opportunities for change amidst the current challenges. To address the nursing shortage, PWW, like other facilities and programs, must continue to develop effective recruitment and retention strategies, enhance the treatment environment, and maintain the focus on patients and their families. When these elements are in place a hospital can flourish even with the shortage looming.

If you wish to contact us, please visit our website at www.nyp.org/nursing. □

Both Carolyn Castelli, APRN, BC and Linda Espinosa, MS, RN, were recruited and have been successfully retained by PWW for the past thirty years.

Reference: (1) Vance, DeLuca, Keepnews, Castelli, Who Will Care for Me? Nursing Spectrum, NY/NJ, November 20, 2006.

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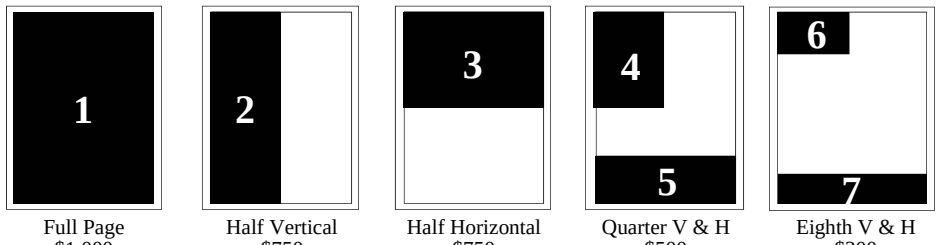
November 1, 2007	January 2008 (winter issue)
February 1, 2008	April 2008 (spring issue)



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