MENTAL HEALTH NEWS™

YOUR TRUSTED SOURCE OF INFORMATION, EDUCATION, ADVOCACY AND RESOURCES

SPRING 2008 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 10 NO. 2

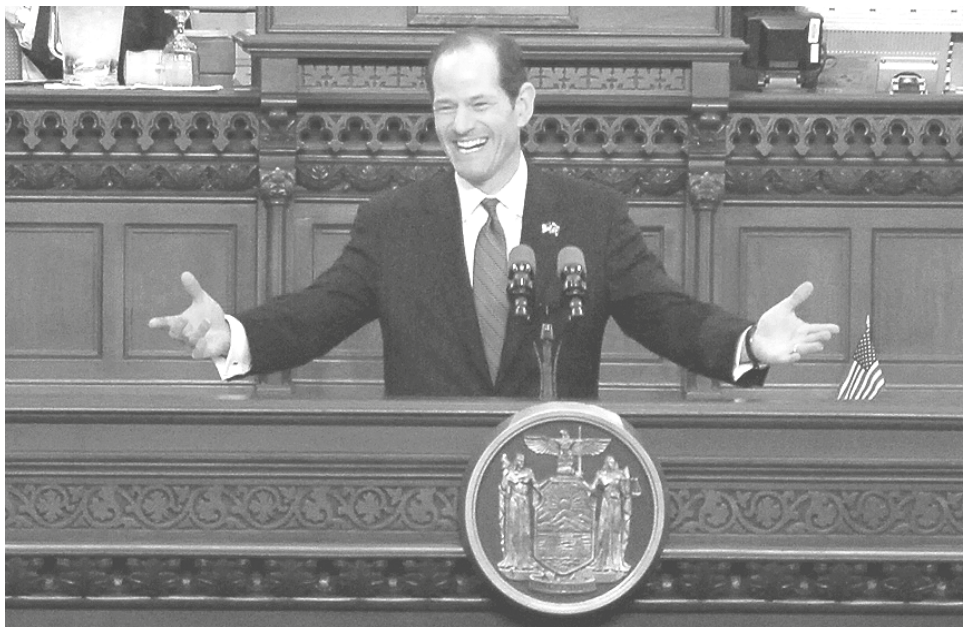
Housing for People with Mental Illness

Governor Eliot Spitzer Proposes Historic Housing Initiative

Vision to Build Supportive Housing Praised by Mental Health Community

Office of The Governor
New York State

Governor Eliot Spitzer today visited the Rheingold Houses in Bushwick, Brooklyn, to highlight steps his administration is taking to increase affordable and supportive housing throughout New York. Housing advocates, developers, community and business leaders applauded the Governor's historic $400 million Housing Opportunity Fund, which was announced during the State of the State address last week. The proposal is part of a $1.5 billion infrastructure and economic development plan to enhance economic growth and opportunity across the state, and part of Governor Spitzer's plan to ensure New York is the best place to live, work, raise a family and run a business.



"Good homes are the key to making a community livable. For over 100 years, New York led the nation with a progressive, visionary housing policy that helped to ensure that people had housing they could afford," said Governor Spitzer. "In recent years, that vision has dimmed. In too many parts of our State, our children cannot afford to come back to the neighborhoods that they grew up in, and their parents cannot afford to stay in the homes where they raised their families. I will propose the biggest housing initiative in a generation, a $400 million Housing Opportunity Fund. This fund will build homes for the men and women who teach our kids and police our streets. This fund will also build supportive housing that enables persons with disabilities and others with special needs to live independently."

see Governor Spitzer on page 42

Mental Health Housing Waiting List Legislation Introduced in the New York State Senate

Office of NYS Senator
Thomas P. Morahan

New York State Senator Thomas P. Morahan (R-C-I-WF, New City), Chairman of the Senate Committee on Mental Health and Developmental Disabilities today reintroduced legislation (S 568) establishing a waiting list for people with mental illnesses seeking community housing and support services.

"Matching an individual's needs with suitable housing and services in the most integrated setting is very important and needed. This bill is a powerful first step in identifying current and future needs for mental health housing in New York State. The legislation would help to bring the state in line with the Americans with Disabilities Act," said Senator Morahan.

In 2007 the legislation passed the Senate and Assembly, but was vetoed by Governor Spitzer. "I anticipate that the merits of this legislation will result in passage in both houses of the legislature. And I am also confident, that when the Governor reviews the facts, data, as well

Thomas P. Morahan

as the needs of those with serious mental illnesses, he will concur that the time has indeed come for this legislation to become law," said Morahan.

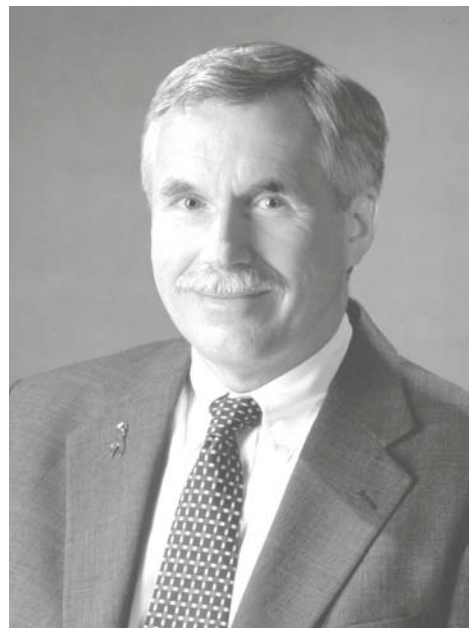
see Senator Morahan on page 41

Mental Health Housing in New York State: An Interview with OMH Commissioner Mike Hogan

Staff Writer
Mental Health News

Q How important is housing for someone recovering from mental illness? Safe, decent and affordable housing is a cornerstone of recovery from mental illness, as well as a mainstay of "the American Dream." Stable access to good housing is a fundamental problem for many people with mental illness because of their poverty, the limited supply of very-low-income housing, the rising cost of rental market housing and discrimination.

Q. How do you respond to those who say that we need more mental health housing? New York and the nation face a crisis in affordable housing. Many factors contribute to this problem, including the federal government's abdication of a low-income housing development role and distress in the housing finance marketplace. With the highest proportion of renter-occupied housing among the states, very high housing prices, and large numbers of poor people with a disability, New York State (especially in the Metro NYC



Michael F. Hogan

area and on Long Island) is the epicenter of a national mental health housing crisis.

Governor Spitzer's proposal to establish a $400 million Housing Opportunity Fund

see Commissioner Hogan on page 25

Mental Health News Education, Inc.
16 Cascade Drive
Effort, PA 18330

NON PROFIT
ORGANIZATION
U.S. POSTAGE PAID
WHITE PLAINS, NY
PERMIT NO. 153

Table of Contents

Upcoming Theme and Deadline Calendar

Summer 2008 Issue: "Employment for People With Mental Illness"
Deadline: May 1, 2008

Fall 2008 Issue: "The Interrelationship Between Physical & Mental Health"
Deadline: August 1, 2008

Winter 2009 Issue: "Understanding & Treating Posttraumatic Stress Disorder"
Deadline: November 1, 2008

Spring 2009 Issue: "Follow-up Care After Hospitalization"
Deadline: February 1, 2009

Mental Health News™

**is a publication of Mental Health News Education, Inc,
a federally approved tax-exempt nonprofit organization
that is registered with the New York State Charities Bureau.
Mailing Address: 16 Cascade Drive, Effort, PA 18330**

**See page 43 for subscription and advertising information.
Note: all articles sent to the publisher must be e-mailed.
Group photo credits always view from left to right.**

Phone us at (570) 629-5960 or E-mail us at mhnmail@aol.com

Please visit our website

www.mhnews.org

From The Publisher

In My Room: Reflections on The Lifeline of Supportive Housing

By Ira H. Minot, LMSW
Founder and Executive Director
Mental Health News Education, Inc.

I was 12 years old when I first heard a beautiful song by the Beach Boys called "In my Room". The year was 1963. It was the year President John F. Kennedy was assassinated in Dallas and when 200,000 people marched on Washington in support of civil rights and heard Dr. Martin Luther King deliver his "I Have a Dream" speech. It was also the year AT&T premiered touch-tone telephones, the post office introduced zip codes, and the sedative Valium was made available to the public.

This issue of *Mental Health News* is devoted to housing for people with mental illness. Let's talk about supportive housing. Supportive housing provides people with a safe and stable living environment. It's a key factor in enabling consumers to better receive the psychiatric treatment and rehabilitation programs designed to aid in their recovery process.

In my late thirties, I became ill with a serious form of depression. I would spent the next 10 years of my life trying to recover. I would not have made it without supportive housing. I will tell you the details shortly. First, imagine my memories of that time. I am in my room in my supportive housing apartment. As in the song, it's a room where I could go and feel safe and secure, even though the ravages of my depression were working to tear my world apart.

I dusted off my record player and played that Beach Boys song. The melody and the harmonious lyrics harkened happy and innocent thoughts of my teenage years in the 1960's; trepid thoughts of growing into adulthood in the 1970's; sad thoughts of falling ill to depression in the late 1980's; and rising out of the ashes of a shattered existence to begin life anew in the 1990's.

As I sit here listening to the song I again I realize I would not have survived, had it not been for a lifeline that was thrown to me during my illness—a lifeline called supportive housing. I know there are people right now reading this that are struggling with mental illness. If you are fortunate to live in supportive housing, you may feel as I did. Even when it was dark and I was alone, my room was a place where I could go where I wouldn't be so afraid.

What is Supportive Housing?

According to The Supportive Housing Network of New York (SHNNY), supportive housing is permanent, affordable housing that is linked to services. It provides low-income, disabled and formerly homeless people with the help and support they need to stay housed and live more independent, healthy and fulfilling lives. Supportive housing is the single most effective, and most cost-efficient, way to reduce homelessness. It strengthens communities and helps integrate people with disabilities and other special needs into the life of their neighborhoods.

Ira H. Minot, LMSW

More Cost Effective

The SHNNY reports that supportive housing is significantly less expensive than the institutional alternatives that homeless and disabled people often cycle through (including shelters, institutions and hospitals). It ends recipients' dependence on emergency services for healthcare and treatment.

A 2004 study by The Lewin Group highlighted these cost savings with the following data:

Cost Per-day, Per-person
In New York City (2004)

Supportive Housing:	$ 42
Homeless Shelters:	55
Prison:	74
Jail:	165
Psychiatric Hospital:	467
General Hospital:	1185

Benefits to Communities

SHNNY adds that supportive housing has additional benefits because it blends seamlessly into neighborhoods. Because providers often build on blighted blocks or rehabilitate unsightly buildings, supportive housing often paves the way for neighborhood renewal. Because it provides services to tenants and often features front-desk security, supportive housing often leads to improved community safety and lower crime rates. Supportive housing is run by locally based nonprofits that must be accountable and responsive to their communities to stay in operation. For these reasons, studies show that supportive housing often increases property values. Because supportive housing is designed to meet tenants' needs, the people who live there thrive. Dozens of studies attest to the positive impacts of this form of housing stating that residents stay housed, get healthy and reconnect to the community.

My Personal Experience

For me, supportive housing was a life saving safety net that was there to catch me when I became so disabled by my illness that I was no longer able to care for myself. Before my illness I had been a productive member of the community. I had a professional career and had always worked hard to be a good father and provider to my family. Becoming ill with depression was the last thing I would have thought could stop me cold in my tracks, but it did. After 10 years of failing to beat it on my own, my illness had left me homeless, destitute, and alone.

Unable to go on, I was admitted to a psychiatric hospital. It all seemed so familiar. I had three prior visits at different hospitals during my illness. After reviewing my case, the doctors gave me the sobering facts that since I had been unresponsive to traditional medication treatments that I would be sent to a state hospital if this attempt failed.

Perhaps it was chance or fate, but this hospitalization proved to be the one that would finally help me get back on the road to recovery and reclaim my life again. I was offered and accepted a three week course of ECT (Electro Convulsive Therapy) treatments. Perhaps a barbaric treatment to some, for me it was the magic bullet that broke the chains of my unresponsive depression. Realizing the serious nature of my illness and the need for a prolonged and stable post-hospital recovery, the hospital's social service team qualified me for vital Social Security Disability (SSD) and arranged for me to be visited (while still in the hospital) by a local supportive housing organization in the community.

Through the caring efforts of my supportive housing coordinator I was able to be discharged from the hospital to a small apartment of my own. It was a place where I could have the dignity of being somewhat independent while maintaining the safety and supervised support of my coordinator as I continued in outpatient programs and care in the community.

The Bottom Line

If you don't have a place to live, it's almost impossible to be in a position to have a successful recovery. All the best efforts at direct mental health treatment may be for naught if consumers do not have a stable and supportive environment in which to get better.

Providing housing must be the cornerstone of a comprehensive mental health recovery system. New York State currently has about 30,000 units of supportive and licensed housing. The NYS Campaign for Mental Health Housing continues to call for preserving and reforming existing units, and developing 35,000 new units of mental health housing statewide over the next ten years. This plan must succeed.

My experience in receiving supportive housing so quickly was the exception, not the norm. It was well known by consumers in my community (at that time) that there was a 3-5 year waiting list to get an apartment. There was an equally long and frustrating application process to simply get put on the list. Many people waited and ended up being hospitalized over and over again. We can't let people fall through the cracks within our community care system. This is not good treatment, it is not cost effective, and strains already burdened community resources.

Perhaps the severity of my last hospitalization was the reason why I was given, a chance, and it gave me an opportunity to reflect on my years of trying to get well. I realized that there was still one other important thing missing from our system of care besides treatment and housing. Outside of the few hours a week I was seeing my doctor and attending outpatient programs, nobody was reaching out to me during my many hours at home in my room. Because of that, I had the vision to create *Mental Health News*. I knew that people with mental illness would benefit from receiving a publication containing information, resources and ongoing messages of hope—so vitally important when you are feeling lost and alone.

Three years ago, I was able to say goodbye to my supportive housing apartment. Hardly a day goes by that I don't think about how supportive housing saved my life and enabled me to learn so many priceless lessons during my recovery.

I want to thank everyone who helped me create this wonderful housing issue of *Mental Health News*. I believe consumers, parents, treatment professionals, provider agencies, and legislators at all levels will gain a great deal of information within these pages. There still isn't enough housing for people with mental illness. We must continue to advocate for more housing in every community.

Thank you for your continued support and participation. We will continue to do our part in giving the topic of housing the recognition it deserves, and spotlight the issues and the many people who are working to make things better. I encourage you to be a part of our vital mission. We love hearing from you and hope you will continue to contact us at our E-mail address: mhnmail@aol.com □

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

MENTAL HEALTH NEWSDESK

Parents Eligible for OMRDD and OMH "Home of Your Own" Mortgages

NYS Office of Mental Retardation and Developmental Disabilities

Parents of individuals with developmental disabilities, mental retardation or mental illness can now apply for mortgages under the Home of Your Own (HOYO) Program, which is financed by the State of New York Mortgage Agency (SONYMA).

The Home of Your Own Program—run jointly by SONYMA, the NYS Office of Mental Retardation and Development Disabilities (OMRDD) and the NYS Office of Mental Health (OMH)—helps people with developmental disabilities or mental illness purchase homes with SONYMA mortgages issued at very favorable terms.

Enabling parents to apply for SONYMA mortgages will ease the financial burdens on families and improve their ability to provide for the needs of their children.

"We are delighted to be able to extend our SONYMA mortgages to parents coping with serving the needs of their children with developmental disabilities or mental illness," said Priscilla Almodovar,

Diana Jones Ritter

President and Chief Executive Officer of SONYMA. "The Home of Your Own Program is very important for our special needs population and we're glad to be able to make it more widely available."

"I am pleased to offer this pioneering opportunity to parents of people with developmental disabilities who want to achieve the American dream—home ownership," said Diana Jones Ritter, OMRDD Commissioner. "This is wonderful opportunity to advance the Governor's housing agenda and work cooperatively with the State of New York Mortgage Agency and the Office of Mental Health. Expanding the Home of Your Own program will help us put people with developmental disabilities on the path to greater independence."

"Recovery from mental illness without stable, decent and affordable housing is almost impossible," said Mike Hogan, Ph.D., Commissioner of OMH. "The Home of Your Own program has already been a great housing and recovery resource for people with a mental illness. We know that many individuals with mental illness live with family, and this expansion of the Home of Your Own program will assist even more New Yorkers when it comes to financing a home."

The Home of Your Own Program offers very favorable mortgage terms for eligible applicants. Under the program, OMRDD and OMH refer applicants—and now their parents—to SONYMA after they complete a homebuyer counseling program. To be eligible, applicants must be first-time homebuyers and have incomes of no more than 80 percent of the area median income in the region where they live. There is also a limit on the purchase price, which varies by location.

The program offers a very low 4 percent fixed interest rate on mortgages of 30 or 40 years, 100 percent financing and reduced closing costs. Closing cost assistance is also available from SONYMA. The program is offered exclusively through M&T Bank, which has agreed to forgo or reduce some of its normal closing costs.

The program is available for homes, condos, co-ops and double-wide mobile homes permanently affixed to real property. Accessibility improvements are funded by OMRDD or OMH as needed.

Since the program was introduced in 1996, 189 households have used $13.2 million to finance their homes.

For more information on how to apply for the Home of Your Own Program, contact Lucinda Grant-Griffin, director of the HOYO program at OMRDD, at (518) 473-1973 or contact OMH at (518) 474-5191. □

Congress Passes Gun Law: Retains Vague, Stigmatizing Language

The National Alliance on Mental Illness (NAMI)

Just before adjourning for the holidays, the U.S. Senate passed a bill, the NICS Improvement Amendments Act of 2007 (HR 2640), to provide incentives to states to report the names of certain people with mental illnesses who are prohibited from purchasing guns. The House passed the bill several months ago and President Bush is expected to sign it into law.

Background

Since 1968, federal law has prohibited certain categories of people, including persons "adjudicated as mental defectives" from owning or purchasing guns. In 1998, the National Instant Criminal Background Check System (NICS) was established as a way to instantly provide gun shop owners with the names of those prohibited from purchasing firearms. The NICS system is maintained by the FBI.

In the aftermath of the Virginia Tech shootings earlier this year, it was revealed that many states have not been reporting names to the NICS system and that some of these states do not have adequate systems in place to comply with reporting requirements. HR 2640 is intended to strengthen reporting by providing states with resources to develop reporting systems and by penalizing states that continue to fail to report names to the NICS system.

What does HR 2640 require?

The new law authorizes grants to states to create or improve systems for reporting the names of individuals who are prohibited from possessing or purchasing firearms, including people who are involuntarily committed to psychiatric hospitals, people found by a court of law to lack capacity to contract or manage their own affairs, and people who are found not competent to stand trial or not guilty by reason of insanity. The bill provides financial incentives to states to create reporting systems, and penalizes them (by withholding federal money) if they fail to comply.

HR 2640 addresses some but not all of NAMI's concerns. The version of HR 2640 passed this week by the Senate contains

see Gun Law on page 16

Britney Spears: Let's Talk About All of Us

The National Alliance on Mental Illness (NAMI)

Statement of Michael J. Fitzpatrick
Executive Director
National Alliance on Mental Illness

In recent weeks, a media circus and reckless speculation has surrounded events in the life of pop singer Britney Spears and her family.

Professional ethics require that mental health professionals who have not examined or treated individuals not presume to diagnose them. A person's treatment and recovery from any illness also is entitled to privacy—which in fact may be an important factor in recovery.

In the case of Britney Spears, professional ethics also are involved which the media must confront. Roy Peter Clark, vice-president of the Poynter Institute, a leading center of journalism training and ethics, recently wrote. "There is clearly a danger zone, when life and health are at stake, when the best thing the press can do is back off. That time for Spears is probably now."

At the same time, the case is an opportunity for public discussion about mental illness, which many ordinary Americans confront every year. NAMI believes it is important that such discussions in our homes, offices, schools, and stores, as well as in the media, be based on facts.

What is needed—for anyone—is understanding and support. We encourage everyone to focus not on Britney Spears, but on all the ordinary people in our own communities who deserve our attention.

Getting well can be a difficult process. It takes time. It may involve relapses.

Involuntary treatment may be necessary in some instances, but only as a last resort, and over time, a person's insight often returns and treatment becomes voluntary.

There should be no stigma for a person being hospitalized or treated for mental illness, voluntary or otherwise. Treatment represents medical intervention for a life-threatening medical condition. Treatment also works.

Doctors and families often respond to other kinds of medical emergencies, such as brain seizures or diabetic shock. Being admitted to a hospital under any circumstance should never be a cause for stigma.

To guide public discussion, NAMI offers four resources, as well as a general invitation to browse our Web site: www.nami.org. □

MENTAL HEALTH NEWSDESK

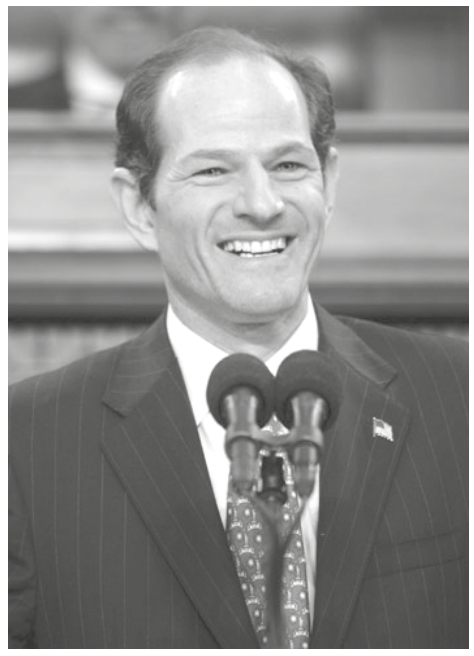
Governor Spitzer Signs Legislation To Enhance The Care And Treatment Of Prisoners With Serious Mental Illness

Office of the Governor
New York State

Governor Eliot Spitzer today announced the signing of legislation that will enhance the care and treatment of prisoners with serious mental illness by limiting the instances in which these inmates can be placed in segregated confinement.

The legislation formalizes the administration's commitment to removing prisoners with serious mental illness from what are commonly known as "special housing units" – where inmates who have committed disciplinary infractions are segregated from the rest of the prison population. The legislation would also implement a more sensitive approach to the treatment of prisoners with psychiatric disorders while meeting prison safety and security standards.

Those inmates with serious mental illness who are not removed from segregated confinement will be offered a heightened level of care, including additional out-of-cell treatment and programming. Mental health clinicians will also conduct periodic mental health assessments of all inmates who remain in segregated confinement.



Governor Eliot Spitzer

"This is historic legislation that demonstrates New York's commitment to providing mental health treatment for inmates with serious psychiatric disorders," said Governor Spitzer. "The legislation also recognizes the need to provide a safe and secure prison environment where inmates and staff will be protected from harm. It strikes an appropriate balance between safety and security concerns and the needs of inmates with serious mental illness."

Lieutenant Governor David A. Paterson said: "This groundbreaking legislation demonstrates New York's leadership in ensuring that the mental health needs of prisoners are addressed. It will ensure that all inmates, including those with serious mental illness, receive appropriate treatment while in prison - enhancing their ability to make a successful transition into communities once they're released."

Senator Michael F. Nozzolio, Chairman of the Senate Crime Victims, Crime and Corrections Committee, said: "This historic agreement is the result of years of hard work. I commend Governor Spitzer for his efforts in ensuring this legislation would be signed into New York State law. The New York State Senate has led the fight to enhance support for our correction officers and staff and I am extremely pleased that our prisons will now be more humane and safer for both inmates and the brave men and women who work there. The Senate remains committed to ensuring that New York State continues to promote and advance initiatives that make our State prison system the best in the country."

Assembly member Jeffrion L. Aubry, Chairman of the Assembly Corrections Committee, said: "This legislation improves the way the state of New York treats inmates who are afflicted with serious mental illnesses. It advances treatment over punishment and better prepares correction officers who interact with such inmates, thereby enhancing safety of not only inmates and staff but of the public as well."

Inmates with serious mental illness who are diverted or removed from segregated confinement will be housed in residential mental health treatment units that are jointly operated by the Department of Correctional Services and the Office of Mental Health. In these units, inmates will receive out-of-cell therapeutic programming and mental health treatment. A formal review process involving the input of mental health clinicians will decrease the likelihood that inmates will cycle back into segregated confinement. A number of these new mental health treatment beds already exist and many more are in development.

The new legislation authorizes the Commission on Quality of Care and Advocacy for Persons with Disabilities to monitor the quality of mental health care provided to inmates and make recommendations about necessary improvements. The legislation Governor Spitzer announced today builds on the State's ongoing efforts to enhance treatment and programming for mentally ill inmates. □

Abilify Approved for Adolescent Patients with Schizophrenia and First Medication for Add-on Treatment of Major Depressive Disorder

Staff Writer
Mental Health News

Otsuka Pharmaceutical Co., Ltd. and Bristol-Myers Squibb Company (NYSE: BMY) announced today that the U.S. Food and Drug Administration (FDA) approved the supplemental New Drug Application for the atypical antipsychotic ABILIFY® (aripiprazole) for the treatment of schizophrenia in adolescents aged 13-17 years. In adolescents, ABILIFY treats positive and negative symptoms of schizophrenia. The FDA first approved ABILIFY for the treatment of schizophrenia in adults on November 15, 2002.

"Until now, FDA-approved treatment options for adolescent patients with schizophrenia were limited," said Robert Findling, M.D., Director of Child and Adolescent Psychiatry, University Hospitals Case Medical Center, Cleveland, Ohio. "The approval of this new indication for ABILIFY provides an additional effective treatment option for these patients."

This approval is based on results from a six-week, randomized, double-blind, placebocontrolled study that demonstrated significant improvement with ABILIFY compared to placebo on the primary efficacy endpoint, Positive and Negative Syndrome Scale (PANSS) Total Score.

"We are extremely pleased that ABILIFY, the first available dopamine partial agonist, is approved for the treatment of pediatric patients (13 to 17 years of age) suffering from schizophrenia," said Tatsuo Higuchi, President and Representative Director, Otsuka Pharmaceutical Co., Ltd. "ABILIFY offers an effective new option to help treat this serious mental illness."

"Schizophrenia is one of the most complex of all mental health disorders," said Elliott Sigal, M.D., Ph.D., Executive Vice President, Chief Scientific Officer and President, Research and Development, Bristol-Myers Squibb. "We remain committed to providing innovative therapies, such as ABILIFY, to help patients, including adolescents, living with schizophrenia."

The findings are from a six-week, double-blind, randomized, placebo-controlled, multi-center study that evaluated the efficacy and safety of ABILIFY® (aripiprazole) in pediatric patients, 13-17 years old, with a primary diagnosis of schizophrenia. The study, sponsored by Otsuka Pharmaceutical Co., Ltd. and its U.S. subsidiary, Otsuka Pharmaceutical Development & Commercialization, Inc. (Princeton, N.J.), was conducted at 101 centers in13 countries and enrolled 302 ethnically diverse pediatric patients.

ABILIFY Used With Another Antidepressant Can Help Adults Living With Depression Who Have Failed to Achieve Adequate Symptom Relief

The U.S. Food and Drug Administration (FDA) approved the supplemental New Drug Application for ABILIFY® (aripiprazole) as adjunctive, or add-on, treatment to antidepressant therapy (ADT) in adults with major depressive disorder (MDD). ABILIFY is the first medication approved by the FDA as add-on treatment for MDD.

"The approval of this new add-on treatment option is critical for adults suffering from depression who cannot find sufficient relief for their symptoms with antidepressants alone," said Madhukar Trivedi, M.D., Professor and Chief-Division of Mood Disorders, University of Texas Southwestern Medical School, Dallas, Texas. "Now physicians have a proven new option they can add to their patients' antidepressant treatments to help them feel better and relieve unresolved depressive symptoms."

The approval is based on results from two six-week, double-blind, randomized, placebocontrolled, multicenter studies (n=743). The results from both studies demonstrated significant improvement in depressive symptoms in adult patients with a primary diagnosis of major depressive disorder who had experienced an inadequate response to monotherapy with one or more ADTs in the current episode and then added ABILIFY to their treatment regimens.

"We are committed to helping those who suffer from depression, one of the leading causes of disability in the United States and worldwide," said Elliott Sigal,

see Abilify Approved on page 14

THE MENTAL HEALTH LAWYER

The Padavan Law and Group Home Placement

By Eric Broutman, Esq.
and Douglas K. Stern, Esq.

The term, Not in My Back Yard, familiarized by the acronym NIMBY, held true with particular force in the 1970's with regard to group homes for the mentally ill in New York. Towns, villages, and cities, often with misplaced and misinformed fears about the effect the mentally ill will have on their neighborhoods successfully barred group homes from their communities. This goal was achieved mainly through zoning restrictions that limited the number of non-related people that live under the same roof.

In 1978, recognizing the need for an integrated placement of the mentally ill in community settings, the legislature passed, N.Y. Mental Hygiene Law §41.34, colloquially called the Padavan Law. The law derived its name from State Senator, Frank Padavan, who shepparded the law's passage through the legislature. In essence, the Padavan Law exempts qualifying group homes from zoning laws, thereby eliminating the main barrier communities erected to their opening. The Padavan Law, however, does place requirements upon the proprietors of group homes before they can open their doors to residents with a mental illness. Municipalities were still legally empowered to object to the opening of a facility because of an over-concentration of facilities in the area.

The Padavan Law

The law applies to facilities that provide a residence to four to fourteen mentally ill people that provide on-site supervision, and is operated by, or subject to licensure by the New York State Office of Mental Health ("OMH"). The law defines these facilities as community residential facilities. The law further directs any organization wishing to open a community residential facility to provide written notice of the location and activities of the facility to the chief executive officer of the municipality where the facility will be located. Within 40 days of receiving notice, the municipality has one of three options: (1) approve the site; (2) suggest at least one alternative site within the municipalities jurisdiction that is suitable to accommodate the proposed facility; or (3) object to the establishment of the facility on the basis that, when taking into account other like facilities in the area, there will be such an over concentration of facilities that the nature and character of the area would become substantially altered. Prior to issuing its response the municipality may hold a public hearing to debate the pros and cons of the facility in its neighborhood.

If the municipality recommends an alternate site, the facility has up to 15 days to accept this site or reject it. Where a disagreement persists between the facility and the municipality over the suitability of an alternate site, OMH will intervene and render a decision on the appropriateness of the municipality's alternate site suggestion.

Douglas K. Stern, Esq.

When the municipality chooses the third option, and objects to the facility outright, OMH will conduct a hearing within 15 days to determine if the proposed facility will in fact create such an over-concentration of facilities that it would alter the nature and character of the area. The law also allows for judicial review of any decision by OMH.

The Padavan Law in Practice

Since the Padavan Law's inception, some communities have continued to challenge the opening of group homes for the mentally ill. Accordingly, these communities have attempted to use the law itself to further their NIMBY goals as opposed to challenging the validity of the Padavan law. There has been a great deal of litigation where communities have opposed the facility invoking the Padavan's Law's over-concentration language. However, no community has ever successfully challenged an OMH determination that a facility should open because it will not fundamentally alter the nature and character of an area. Communities have argued that opening facilities will effect such disparate concerns as overloading the septic system, increasing traffic, eroding of the tax base and fears of residents over what they perceived to be the unsavory nature of the proposed residents. Yet, Courts have concluded that these concerns are not valid and the only consideration is whether or not an over-concentration of facilities will result from the opening of the proposed facility.

Concerns with the Padavan Law

While on its face the Padavan Law would appear to do nothing but good for the mentally ill and those wishing to erect housing on their behalf, there is some ambivalence. Clearly, there is some concern over the Padavan Law's allowance for a community to conduct a public hearing in order to discuss the pros and cons of the opening of a group home. Which of us would appreciate our future neighbors and colleagues gathering at a public meeting and debating whether or not they want us to move into their community?

Secondly, the process that the Padavan Law dictates takes a substantial amount of time. If a community wishes to challenge OMH's determination in court, that process has taken upwards of three years to conclude. In that time, those whom the facilities would be a home to are either left homeless or in much more restrictive facilities, like a psychiatric hospital.

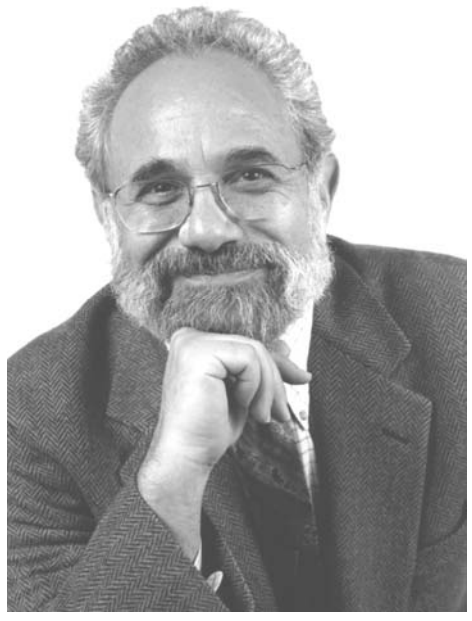
Some have argued that the Padavan Law, and similar laws in other parts of the country, are in fact unconstitutional because they conflict with the federal Fair Housing Amendments Act ("FHAA") of 1988. The FHAA extended the protections of the 1968 Fair Housing Act, which eliminated housing on the basis of sex, race or religion, to the physically and mentally disabled. This includes barring land-use regulations and special use permits, which leads to de-facto discrimination. From a legal perspective, the question then becomes, does the Padavan Law conflict with the FHAA? In reviewing similar laws in other states some courts have concluded that they do and some have concluded that they do not. No Court has yet to rule on a direct challenge to the Padavan Law in New York.

Apart from the legal question is a question of practicality. For 30 years the Padavan Law has guided the opening of group homes for the mentally ill. And while there has been difficulty with the law as described above, the procedures and practices are well known to providers of housing for the mentally ill. Moreover, the Padavan Law has established firm legal rights and housing for the mentally ill has flourished during its tenure. The question is despite its problems is doing away with the law riskier than it is worth? □

POINT OF VIEW

Housing for Older Adults with Serious Mental Illness

By Michael B. Friedman, LMSW and Kimberly A Steinhagen, LMSW



Michael B. Friedman, LMSW

Kimberly A Steinhagen, LMSW

It's great news that the Governor's Budget Request contains a major affordable housing initiative, some of which will be set aside for people with disabilities, and that it contains a proposal for 2000 new units of housing specifically for people with serious mental illness. This is such an important advance in housing policy in NYS that we don't want to add a "but" to it. But, in fact we are very concerned about whether these housing initiatives will be beneficial to older adults with serious mental illnesses.

Why? Because many aging people with serious mental illness will develop serious physical problems and will need to have housing that addresses their physical as well as their psychological needs if they are to be able to remain in the community rather than going to adult or nursing homes. Of course, most community-based residential programs that serve people with serious mental illness provide some supports for people with complex problems, but very few are able to provide adequate care for those with co-occurring, serious physical and mental disorders.

What is needed?

Accessibility for people with physical disabilities: The most obvious need is housing that is accessible to people with physical disabilities. Not walkup apartments or upstairs bedrooms or doorways and hallways too narrow for wheelchairs or walkers.

Safety and accident prevention: Falls are a major cause of avoidable disability and mortality for older adults. Housing, therefore, needs to be designed to prevent both falls and injuries from falls.

Assistance with activities of daily living: People with long-term psychiatric disabilities who do not recover as they age (and some do) generally have reduced cognitive functioning due to schizophrenia, severe depression, and the like. They are as susceptible to developing dementia as any other population and therefore sometimes have double cognitive impairments, vastly reducing their self-management abilities. Of course, they could be sent to a nursing home, where ADL management is routine. But if there were significant supports available in community-based housing—at home; in complexes with private apartments; or in small, homelike community residences—many people with serious mental illnesses who go to adult or nursing homes could live in settings that are more integrated into the general community.

Assistance with health problems: Poor physical health is the core problem that must be addressed to help older adults with serious mental illnesses to remain in the community. People with long-term mental illnesses are at very high risk of obesity, hypertension, diabetes, heart disease, pulmonary conditions, and communicable diseases.

The most recent study on their life expectancy indicates that adults with serious mental illness die 25 or more years earlier than the general population, largely due to poor health and poor health care. Earlier studies put the difference at about 10 years. Whichever, it is terrible to think that people with serious mental illness will die substantially younger than the general population because their health is neglected. It has got to be the responsibility of the mental health system to increase life expectancy; and this has got to be a major goal of residential programs for this population.

That entails five programmatic thrusts, which are in fact as important for younger adults with serious mental illness as for older adults.

(1) Housing programs should place an emphasis on health promotion, with particular attention to smoking cessation, exercise, and good nutrition.

(2) Housing providers need to be equipped to manage multiple medications, especially as people age and present with co-morbid chronic conditions.

(3) Housing programs should take responsibility for assuring that their residents get good health care. They can do that by developing formal relationships with health providers. They can do it by assiduously developing informal working relationships with local health providers. They can do that by persuading health providers to establish satellites in congregate housing programs. And they can do it by developing their own health centers, centers that cater to people with mental disabilities.

(4) Housing providers should also introduce medical care management into their programs. Medical care management means that someone follows up with a person who has diabetes, for example, to make sure that he or she eats well, takes their insulin, etc. Nurses are widely viewed as the professionals most able to do this work. But we believe that there could be peer medical care managers who could do much of the follow up—perhaps more effectively than professionals.

(5) Housing programs should work collaboratively with home health providers to provide on-site services. They can even help foster the development of, and train cadres of, home health providers to specialize in serving people with psychiatric disabilities.

Adapting the concept of recovery to older adults: In principle, the concept of recovery in mental health calls for the achievement of totally individualized goals in ways that permit a person with a mental illness to experience his or her life as satisfying and meaningful. But in practice, recovery focuses heavily on work. Some older adults, of course, want to work and should be helped to do so. But some want to retire, and this should be a legitimate path for older adults with mental illness. This means that some older adults will want to spend more time at home than at a program. Most supervised residential programs cannot allow this because of regulatory expectations and because they don't have enough staff. This should be changed for residences for older adults.

Suicide prevention: Housing providers have the frequent opportunity to observe changes in mood among residents. Being sensitive to those changes and screening for depression could help identify suicidal risk.

Permanent housing with onsite supervision: In the mental health system, the most extensively supervised residential programs are designed to be transitional. The expectation is that people are making their way from hospitalization to independent living. This expectation often does not make sense for older adults with an over-abundance of problems. There needs to be supervised congregate care in small homelike settings where older adults can remain for the rest of their lives—remain, that is, in the places that have become their homes and with people who have become their families.

End of life care: Permanence, of course, becomes particularly difficult for people with terminal health conditions. Most housing programs are simply not prepared to provide the kind of health and hospice care that many people need as they approach the end of the lives. Many of us who are not seriously mentally ill expect to rely on in-home hospice care at some point. Why can't people with serious mental illness have the same expectation?

Not just OMH funded programs: We want to be clear that the principles of care we have outlined above are not meant to be applied only to housing provided or funded by the Office of Mental Health. Older adults with serious mental illness can be, and are, successfully housed in "supportive housing" and senior housing—if there are adequate supports.

It goes without saying that the service and support needs we have identified are not easy to address outside the health system. The housing needs of older adults with both serious physical and mental illnesses aren't part of the basic expectations of what the mental health system does, nor are they part of the portfolio of the supportive or senior housing systems. That is why so many move to adult and nursing homes. But it is possible to help older adults with co-occurring health and mental health disorders to remain in the community. We hope that some of the new housing initiatives will be carried out with this in mind.

Michael B. Friedman is the Director of the Center for Policy and Advocacy of The Mental Health Associations of NYC and Westchester. He is also Chair of the Geriatric Mental Health Alliance of New York. Kimberly A. Steinhagen is Director of The Alliance. The opinions expressed in this column are their own and not necessarily the views of the MHAs. Mr. Friedman can be reached at center@mhaofnyc.org. Ms. Steinhagen can be reached at steinhagenk@mhaofnyc.org. □

The NYSPA Report

Electronic Medical Records

By Glenn Martin, MD
Vice President
New York State Psychiatric Association

For anyone with one or more chronic illnesses, or who cares for someone who does, the need to coordinate medical information from multiple sources is very challenging. Be it the relatively simple task of having one physician, hospital or clinic forward the record to another, or having a comprehensive list of allergies and medications available to share with all prescribers, or trying to maintain a comprehensive record to be used when visiting an emergency room, the logistics can be daunting. To address these and other needs there has been an increasing movement to promote the adoption of computer technology and the internet to improve healthcare. The advances include electronic medical records, e-prescribing, regional health information exchanges or community data repositories and personal health records. While all of these have the potential of increasing safety, improving outcomes and lowering costs, they also come with risks.

For those with chronic psychiatric conditions both the benefits and risks of these electronic transformations may be even more evident. Persons with serious mental illness frequently take multiple medications, have complicating medical conditions and over their lifetime have received care from a multitude of professionals at many different locations. And so, while those with mental illness stand to benefit from these advances, because of discrimination and stigmatization the risks from the potential misuse of the data or a loss of confidentiality are also increased.

Electronic medical records allow doctors and health care facilities to maintain comprehensive legible organized records. It is rather easy to misfile a paper record or to inadvertently file a piece of paper (a referral note, lab results, etc.) into the wrong chart. An electronic record minimizes those problems. Good software also incorporates "decision support" that provides clinical advice at the point of care. A physician can be alerted if a drug being prescribed might interact with another drug already being taken. Necessary laboratory studies can be suggested at the appropriate time to properly monitor a condition. The latest practice guidelines can be made readily available as the physician is developing a treatment plan.

E-Prescribing allows a prescriber to transmit a prescription directly to a pharmacy to be filled. The system that supports this function will generally also provides some checks for allergies, medication interactions, and improper dosing. As the transmission is electronic the risks of mistakes due to illegible handwriting, spelling errors, etc. are minimized. Neither the patient nor the pharmacist gets a paper prescription to misplace.

Glenn Martin, MD

Regional health Information Exchanges (RHIOs) are planned to link care givers and support services in a community. When implemented they should allow all the physicians involved in a patients care to see all the lab and radiology results and medications ordered. Unnecessary duplicate testing should be significantly reduced and medication mishaps caused by prescribing without access to a full list of active medications or medical conditions will be vastly reduced. Referrals between physicians could be made securely with pertinent information exchanged. Emergency room physicians will have the record available for a potentially confused or unconscious patient being seen for the first time. Secure emailing from patients to their doctors is generally supported. Many of these RHIOs will eventually include patient portals that will give patients direct access to the information. Public health reporting will be facilitated and community health issues can be more closely monitored and improved.

Just as a given medication can be life saving but come with significant risks of adverse effects, so do the technologies described. Nationally and internationally the loss of personal private data, financial and medical, by theft, accident, carelessness or negligence is a growing problem. In 2007 the Identity Theft Resource Center reported that there were 448 data breaches exposing over 128 million records. Medical and Health care data breaches occurred 66 times with the exposure of almost 4 million records. In November the United Kingdom lost CD's containing information on 7.5 million families receiving child health benefits. The disks contained the name, address, date of birth, National Insurance number and, where relevant, bank details of 25 million people.

There is nothing new about the loss of misuse of information. Paper based records have gone missing or have been stolen and misused for centuries. What the electronic world has done is to make it much easier to lose or steal vast quantities of information at a single incident. A misplaced laptop or portable thumb drive that was not using proper data security software can lead to the loss of an astonishing amount of data. A malicious individual with an IPod can use it as a data storage device and leave a business, office or hospital with thousands upon thousands of records.

Exchanging information for a patients benefit is desirable but the control and monitoring of that exchange can be very problematic. Should information be shared automatically among those treating a patient, or should the patient have to give consent to each individual physician to give or receive information? This may be ideal, but practically it may be such a burden for individual practice to obtain and track consent that the doctor may decide not to participate. Should the patient be allowed to withhold certain information even if it leads to a potentially misleading and dangerous situation? For example, it may be reasonable to suppress mental health or HIV/AIDS information, but if a doctor prescribes a medication without realizing a patient is on antidepressant or ant-retroviral there could be a potentially dangerous outcome. Even if a patient says "suppress the diagnoses, but share the medication and laboratory list" will they understand that certain medications or laboratory results strongly imply a given diagnosis, for example lithium and bipolar disorder? Do patients think it is a good idea to have their data used for research without their knowledge, even if their identifying information were first removed, if the research might be used to develop something they are opposed to? Consider the use of information that might promote the development of a better form a birth control, or a medical economic research that might be used to justify limiting access to certain medications or type of care.

All of these issues are currently being debated at the federal and state levels. New York State has already committed to funding exchanges and promoting electronic health records and e-Prescribing, before many of these questions have been fully explored or answered. It is vital for all of us to remain informed and to insist that patients' privacy, autonomy and dignity be respected as we move forward and "electrify" the medical record.

Dr. Martin is Director of Medical Informatics for the Queens Health Network of New York City's Health and Hospitals Corporation. He is also Associate Director of the Program for the Protection of Human Subjects at the Mount Sinai School of Medicine, and has a private psychiatric practice. □

The Economics of Recovery:
Cost Effective Solutions for The Homeless

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

In Westchester County, about half of all single adult homeless refuse to be mentally and/or physically screened or, to sign over their disability checks. The current policy is to then deny them access to the Shelters. They must remain in the Drop-Ins, without medical or psychiatric care. They are offered a chair in a "Warming Center" or "three hots and a cot, no questions asked."

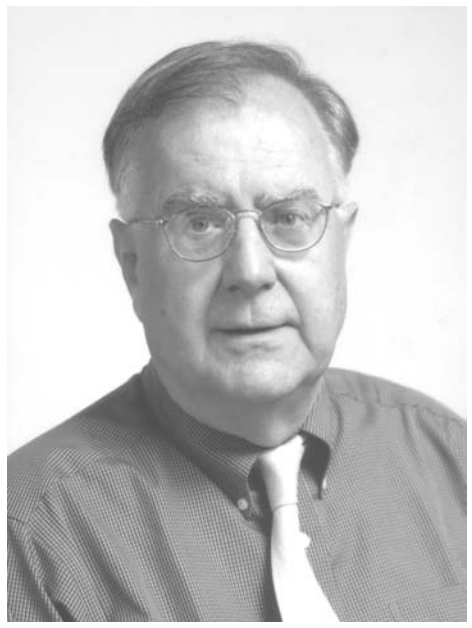
Drop-In residents are our highest risk and least served population. Three-quarters ask for help staying off drugs or alcohol, half take psychiatric medications and over one-third receive Social Security Disability. The critical question is: What would it take to convert the "hard core" homeless to accept shelter services?

Research

To answer this question, the Center interviewed thirty Drop-In residents this past winter to ascertain their interest in four hypothetical procedural and monetary incentives; 1) a waiver of their medical assessment i.e. drug testing, 2) a waiver of the mandated substance abuse program (if they tested positive) 3) increasing their personal needs allowance from $45/Mo to $100/Mo and, 4) allowing disabled residents to keep their Social Security checks ($700/Mo).

Lately, municipalities are using direct cash payments to promote positive behavior, an incentive that businesses have used successfully for centuries.

Under Mayor Michael Bloomberg. New York City instituted cash reward programs to motivate students to earn A's, so they graduate high school, reduce new teacher attrition and to get parents to attend school nights.



Donald M. Fitch, MS

Findings

Surprisingly, our study (Chart below) found almost nine out of ten Drop-In residents would accept the Shelters' rules for as little as $100/Mo personal needs allowance. All of the disabled residents surveyed said they would leave the Drop-Ins and enter the Shelters if they were allowed to keep their SSA Disability checks.

Interestingly, hypothetical waivers of the mandated Shelters' assessment and program rules were found to be ineffectual. Our study confirmed that a few extra dollars is a more powerful motivator than bending the rules.

Action Implications

This study identifies a practical, cost effective solution for converting Drop-In residents to Shelter residency in order to access vital psychiatric and medical services. Next steps are to pilot test and refine a financial incentive program. Shelter "gives backs" of about $700/year per resident drawn from the fifty-thousand dollars they receive, provides a sustainable funding source.

Privacy Wall: Creating New Housing

While the obvious solution for homelessness is a home, accessing permanent supported housing can take years and, the growth in the available housing stock and funds never seem to keep up with the numbers of consumers in need;

"Stable access to good housing is a fundamental problem for many people with mental illness because of their poverty, the limited supply of very-low-income housing, the rising cost of rental market housing and discrimination." (NYS Office of Mental Health 2007).

The average rent for a one-bedroom apartment in Westchester County today is about $1,270/Mo. At 30%, the consumers' share of supported housing (Section 8/Shelter Plus) is $381/Mo. This is about half of the average consumers' Social Security Disability check ($800).

Food, utilities, clothing, personals, co-pays, transportation, debt service, etc. easily exceeds the remaining balance of $419. for most consumers.

The ideal solution to the lack of affordable housing would be to 1) rapidly increase the housing stock, 2) reduce the consumers' rent and, at the same time, 3) increase the landlords' rental income and, 4) reduce HUD's cost for supported housing.

The simple "win-win" solution the Center developed to meet these criteria is to divide the living room of a typical one-bedroom apartment using a "Privacy Wall" to create a second bedroom. (Plan below)

After considerable research, we found the New York Wall Company (www.thewallpeople.com) will install a fire retardant laminated particle board sound proof wall with a specially engineered aluminum frame, door, knob and lock in about four hours, without nails, glue or requiring a building permit (it's considered "temporary") for about $1500 (a portion of the proceeds is donated to the Centers' programs).

Interviews with the Departments of County Planning, Section 8, fire, and building officials found no barriers to implementing this solution. Further consultation with attorneys, accountants, directors of supported housing programs and Section 8 landlords confirmed the feasibility and interest.

The only remaining question was; "how would the homeless and current renters respond to the idea"?

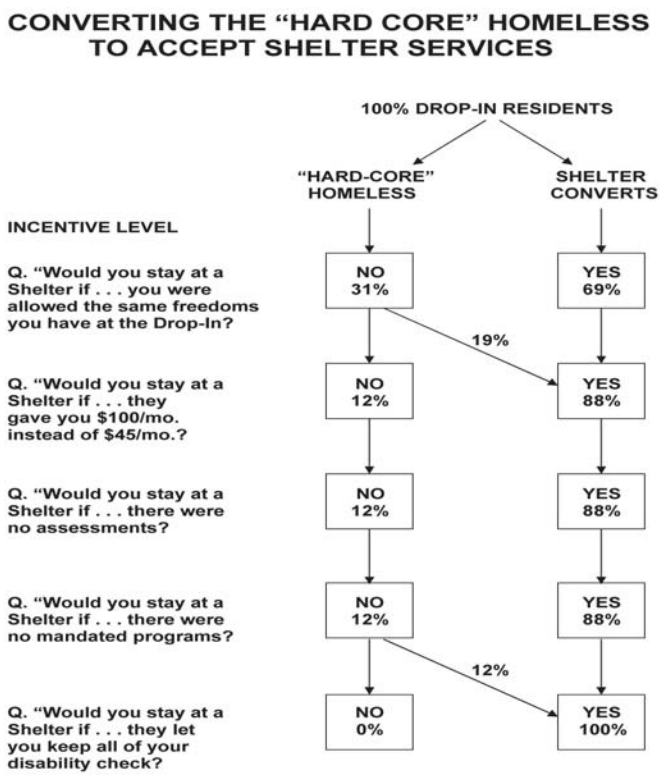
Our survey found one-hundred percent of the homeless persons would "definitely be interested" in the concept, (anything to get out of the shelters). However, only one-third of the current renters felt the same way; "I value my privacy, a roommate would take my food, make a mess, party, I would want to meet them first, there would have to be a trial period, etc." Even a financial incentive of a rent reduction of $150/Mo. did not change their minds.

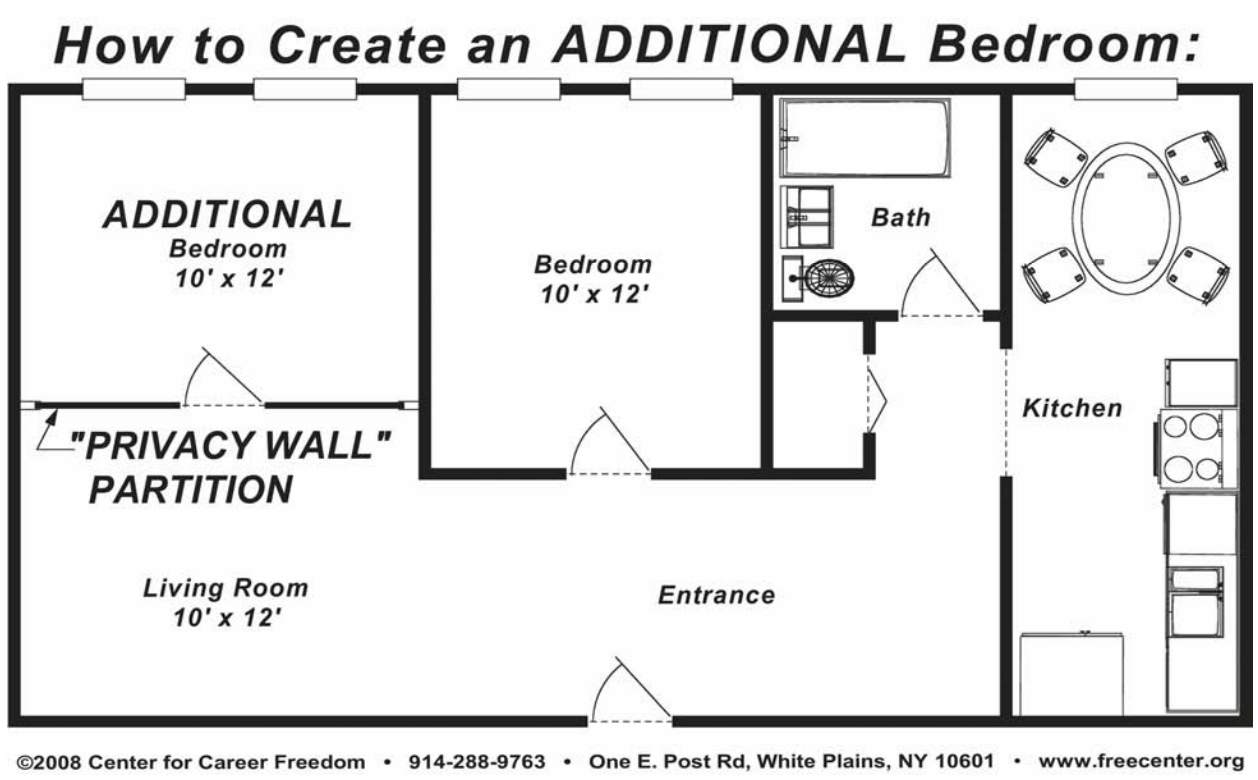
Return on Investment

The financials are impressive; in addition to reducing the consumers' rent by $150/Mo., Section 8 landlords would receive an extra $221/Mo. per unit, a 20% increase in the buildings' cash flow and net worth.

An investment in the "Privacy Wall" of $1500. pays for itself in less than seven months. The annual increase in rental income for twenty units would be over fifty-thousand dollars!

The United States Housing and Urban Development Department (HUD) would save over $9,000 annually for <u>each</u> converted apartment because HUD would not have to pay for two, one bedroom apartments. If HUD invested in 10,000 new apartment units throughout New York State, they would save over 73 Million dollars a year! In turn, this money could be used for over twelve-thousand additional new units. □





NewYork-Presbyterian Psychiatry

NewYork-Presbyterian Psychiatry provides a full continuum of expert diagnosis and treatment services for adults, adolescents, children and the elderly with psychiatric, neuropsychiatric, behavioral or emotional problems.


NewYork-Presbyterian/Weill Cornell


NewYork-Presbyterian/Columbia


NewYork-Presbyterian/Westchester Division

Accomplished specialists in psychiatry, psychopharmacology, clinical psychology and neurology work together to offer the highest quality of care that includes the most scientific advances and state-of-the-art treatment options. With proper diagnosis and treatment, every mental health condition can be effectively addressed.

The psychiatric services of NewYork-Presbyterian Hospital are ranked among the nation's best by *U.S.New & World Report*®.

Referral

To make a referral or for further information, please call:
Columbia Psychiatry (212) 305-6001
Weill Cornell Psychiatry (888) 694-5700

www.nyppsychiatry.org

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

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 Mental Health News
New York City Section

Guiding Principles for The Redesign of The Office of Mental Health Housing and Community Support Policies

By Robert W. Myers, PhD
Senior Deputy Commissioner
NYS Office of Mental Health

Safe, decent and affordable housing is a cornerstone of recovery from mental illness, as well as a mainstay of "the American Dream." Stable access to good housing is a fundamental problem for many people with mental illness because of their poverty, the limited supply of very-low-income housing, the rising cost of rental market housing and discrimination. Given this context any approach to reforming housing for people with a mental illness must stress:

- expansion of low income housing in general
- flexible supports that do not condition housing on services
- expansion of specialty "supported housing" developed for people with a mental illness

Robert W. Myers, PhD

Additionally, to reduce stigma, assuage "community resistance" and provide opportunities for recovery and rehabilitation, housing in normal/mixed neighborhoods and settings is preferable.

Unmet Needs

The unmet need for decent, safe and affordable housing--often with supports--is very substantial for people with mental illness. As a consequence of poor access to community housing, inadequate levels of mental health housing, and clinical programs that do not support people in getting/keeping housing successfully, many people with a mental illness are poorly housed or institutionalized. Thus, many people with a mental illness are "stuck" in:

- homelessness and the shelter system
- institutional settings (nursing homes, adult homes, state psychiatric centers)
- family-supported housing that cannot be sustained (e.g., with aging parents)
- staffed residential programs (instead of a home)

Reform must balance improved access to housing for all of these individuals with the need to improve "old" models of residential care, to move toward local systems of care that can arrange, provide, and support people in housing that is appropriate to their needs and preferences at any level of recovery.

Current Services

The New York State Office of Mental Health funds and oversees a large array of housing resources and residential rehabilitation programs. These resources include:

Adult Programs

Congregate Treatment
(Group Homes): 5,071 units in 348 sites

Residential Care Centers for Adults
(Treatment and Support): 802 units in 7 sites

Licensed Apartments: 4,133 units

CR-SROs: 1,720 units in 35 sites

Supported (uncertified)
SROs: 2,453 units in 65 sites

see Guiding Principles on page 25

Six-Agency Coalition Receives Grant to Address Health Crisis

Staff Writer
Mental Health News

The not-for-profit Institute for Community Living (ICL) announced today that New York State Health Foundation (NYSHealth) is providing a $572,419 24-month grant that will enable a coalition of NYC behavioral health agencies to impact the way the mental health care system works with people with serious mental illness and co-existing (or at risk of acquiring) Type 2 Diabetes. This project does not rely on new medication or new treatment, but rather, a new way of approaching and making lifestyle changes to address diabetes.

ICL has spearheaded the Integrated Wellness Initiative: Diabetes and brought together The Bridge, Federated Employment and Guidance Service (FEGS), The Jewish Board of Family and Children's Services (JBFCS), Services for the Underserved (SUS) and The William F. Ryan Health Center (Ryan Center) to form a ground-breaking coalition. The Urban Institute for Behavioral Health, a consortium of 21 behavioral health agencies which specializes in multi-agency implementations of best practices, is working with ICL to coordinate this initiative. The goal of the Initiative is to make sure people with mental illness can look forward to a better quantity of life, as they work to achieve a better quality of life.

The Crisis

"All my friends are dying out there," says Marvin, a client of ICL's mental health services. Marvin refers to a crisis within an overlooked population; people with mental illness die 25 years younger than the general population, and they die from the same diseases – diabetes, heart disease and cancer.

By middle age, adults with serious mental illness often suffer a significant physical decline secondary to chronic medical conditions. With an average reduction in life expectancy of 25 years, the average consumer lifespan hovers between 50-60 years, near that found in undeveloped countries such as Sudan and Haiti. Estimates are that 60% of excess mortality has been due to medical conditions that were largely preventable or treatable and that despite advances in the treatment of these life threatening disorders, people who are seriously mentally ill rarely receive the full range of recommended interventions.

The dilemma is further compounded by the fact that some pharmacological treatments for serious mental illness increase risk factors for and exacerbate chronic medical conditions. Rarely are behavioral and medical medications coordinated on an individual level to achieve optimal outcomes and avoid iatrogenic effects. Likewise, preventive and early intervention screening, assessment and intervention for medical conditions are rare in the era of community-based care. Their predominant access to health professionals is within the mental health community where there is a lack of attention and focus on medical issues because the psychosocial issues being confronted tended to overshadow other concerns.

The Challenges

Many people living with mental illness, especially those with histories of poverty and homelessness, have a high tolerance for discomfort. This tolerance can create difficulty in motivating an individual to make changes to improve health and well-being. Additionally, many ICL clients have worked hard to kick an addiction or develop new habits to manage their mental illness, and thanks to the Smoking Cessation Program, many have quit smoking. When issues of lifestyle changes to improve physical health come up, many clients equate that to eliminating yet another source of enjoyment – food.

How does one motivate them to change yet another part of their lives for the better without their feeling there is nothing left for them to enjoy? The needs of the client, in this sense, have to be kept in delicate balance, and a case manager has to understand the relationship of physical, mental and emotional health concerns in the client – and keep all of them in mind when determining recommendations for treatment and lifestyle changes. For example, one client, who was having difficulty finding an effective anti-depressant, remarked to his case manager, "I'm so depressed. I don't see the point of staying sober."

The Integrated Wellness Initiative:
Diabetes

Integrated Wellness Initiative: Diabetes is an ambitious plan that proposes

see Health Crisis on page 14

House Proud

Making a House a Home, Making Recovery a Value

By Geraldo Ramos, Regional Director, Community Residence & Homeless Services, Melanie Germain, Regional Director, Apartment Programs, Sara Smith, Director, 124th St. SRO, and Ellen Stoller, Assistant VP Community Services, Training and Consumer Affairs, F.E.G.S. Health and Human Services Systems

This year F.E.G.S. Behavioral Health Residential Services celebrates 20 years of providing residential services to adults who have a mental illness. In 1988 we opened our Brooklyn Apartment Program housing 36 people. Today we have over 700 people living in the full range of supportive housing opportunities in Manhattan, the Bronx, Brooklyn, Queens and Nassau County. In this array, we operate specialized services for people who are deaf, deaf/blind, homeless, HIV+ and adolescents with both serious emotional problems and substance abuse. We continue to develop new approaches to supportive housing, including one for young adults.

The availability of safe housing seems so basic to recovery, yet there is nothing simple about it. Our partnership with consumers has taught us to listen to what they want and need, respect where they are and not where we "assess" that they should be. Our focus is on a person's individual journey towards recovery, their wishes, dreams, strengths and struggles. This consumer-centered approach challenges our staff to always think creatively. The goal is to break down barriers that hold someone back from living the life they want. Every recovery is a thumbprint, unique to that individual. Here are some illuminating stories.

Sometimes living with our family holds us back. That was the case for Candace (pseudonym). Born deaf, Candace also developed a major depressive disorder while still a teenager. Candace, who is 21, grew up with her mother and three half-sisters in a small apartment, where she struggled constantly with her family because she was the only deaf child. Her father was both physically and emotionally abusive. He sometimes used an iron cord, knives, or a gun to threaten her mother. When Candace was 5 years old her father abandoned them. Her family had to move to a smaller apartment because the three-bedroom apartment they were living in was too expensive. Feeling misunderstood most of the time fed her growing depression. At the same time, Candace was regularly absent from school without permission because her mother was too depressed to escort her. Throughout her high school years, Candace had trouble organizing her day-to-day activities and fell behind in her schoolwork. She was isolated and had few friends. Although her family thought she should drop out of school, Candace had other hopes for herself. With the help of her school guidance counselor she was referred to F.E.G.S. Tanya Towers Apartment Treatment Program supported by the NYSOMH.

When Candace moved into Tanya Towers in March 2006, the staff immediately saw her strengths and with guidance she has been able to become self-sufficient. Candace's motivation and determination never stopped. She graduated high school and is currently applying to college. With her increasing confidence in herself she was able to meet people and now has a much broader social support network. Candace's mother and sisters have come to appreciate her strengths and abilities.

Supported housing with others who were coping with similar complex needs was the start for opening Candace's world. Feeling "at home" is as much about support as it is about place. In F.E.G.S.' network of housing options for people with mental illness, people aged 14 - 80+ receive the level of support and treatment they need to both feel "at home" and work on their recovery goals.

Diego, 62 years old, was born and raised in Cuba, where he obtained a college degree and taught school. As a political prisoner seeking freedom, he came to the United States, where he had family. Unable to verify his prior academic achievements, he sought to obtain a GED so that he could begin to pursue to the American dream.

Diego owned a record store in upper Manhattan when he started using cocaine. He soon found himself addicted, eventually losing his business and his apartment. After losing a rented room, he ended up in the street, living underneath Riverside Park in the Amtrak Tunnels. He was homeless for four years. During his homelessness, the concern of a writer from the neighborhood lead to his being photographed and interviewed for a book on those living under the city of New York. As the blight of those living underground was brought to public attention, outreach workers from many agencies went out to these areas to offer help and support. Diego, diagnosed with schizophrenia, as well as substance abuse, was assisted with case management and a referral to the FEGS 124th Street CR/SRO (community residence single room occupancy).

Diego was drug-free one year prior to his arrival at 124th St. SRO. Over the past 11 years, he has maintained his sobriety. Determination and hard work helped him to reach those goals important to him: taking medication on his own, relearning the skills he needs to live independently, staying clean and sober and learning about his mental illness and how to stay well physically. Diego is a regular face at the in-house community meeting, advocating for the rights of all residents. Diego attends a program five days a week where he was recently honored for his achievement in teaching computer skills to students of English as a Second Language class.

In a recent article, Diego is quoted, "*it is the loneliness that is the main problem for homeless people.*" He credits the family-like atmosphere and staff support provided at his F.E.G.S. residence for his success at

see House Proud on page 41

Innovation in Housing: Three Model Programs Developed by The Bridge to Meet the Needs of Special Populations

By Peter D. Beitchman, DSW, LMSW
Executive Director
The Bridge Inc.

For more than 25 years The Bridge Inc., the mental health rehabilitation agency that provides services to 1500 men and women in Manhattan, Queens and The Bronx, has been providing housing to adults with serious mental illness. As the profile of the mentally ill has changed over the years – the long-term hospital "chronic patients" of 30 years ago have been replaced, often by persons with multiple needs stemming from long-term homelessness, co-occurring chemical abuse, HIV/AIDS, aging or involvement in the criminal justice system - The Bridge has developed innovative approaches to meet their needs. This has often involved using multiple funding sources to support services, working in partnerships with other agencies, and providing staff with the specialized training and support that they need to provide quality services. This article describes two currently operational models and a third in development that are specifically designed to meet the needs of today's special populations.

With the community mental health movement now more than fifty years old, and with the vast majority of persons with serious mental illness living in the community, The Bridge and other agencies are facing the challenges of providing services to an aging population. Although recent studies have documented and deplored the 25-year reduction in life expectancy for persons with serious mental illness, those involved in good treatment and rehabilitation services are surviving into old age with its inevitable medical complications – an even greater challenge for mental health agencies.

Peter D. Beitchman, DSW, LMSW

The Bridge has developed a model residential program, Sheridan Hill House, to address the needs of aging, medically-compromised clients. In doing so, the agency has addressed two goals: to improve and sustain the quality of life of its residents in familiar community surroundings, and to avoid placement in much more costly and alienating nursing homes. The model created by The Bridge combines Federal, State and City funding and uses essential service partnerships.

With capital funding from HUD, the City of New York (HPD) and the Federal Home Loan Bank, a 24-studio apartment building was constructed in The Bronx. Given the special needs of the residents, special attention was given to handicap accessibility and sufficient office and program space was created to allow for allow for enhanced services.

The program is designated as a Supported SRO by the State Office of Mental Health, which is providing the lion's share of services funding. A grant from the New York City Council is also being used to enhance services, along with City Department of Homeless Services SRO Support funds. HUD is providing ongoing funding for building operations.

At the heart of the program are two additional partnerships: The Jewish Home and Hospital, which is a licensed home care agency in Manhattan and The Bronx, provides an on-site Nurse Practitioner at Sheridan Hill two days a week. The NP not only works with individual clients on their medical conditions, including monitoring their medical regimens, she also runs educational groups for both clients and staff. An additional Bridge LPN will be introduced into the program this spring.

A second resource for the program is a new primary care clinic at Bronx Lebanon Hospital specifically tailored to the needs of persons with serious mental illness. This program offers comprehensive primary care and integrated specialty care at the hospital.

Another component that will be introduced this spring is an internship program with students from The Bronx High School of Medical Science. Students who are aspiring to medical careers will participate in the program, assisting staff and participating in training and education activities.

Staff training is a major focus of the project. In order to be effective as care managers, residential staff need basic education on the medical conditions and treatments of the residents. An extensive training program is being developed to establish staff competencies in these areas.

The residents at Sheridan Hill House range in age up to 78 years old. Serious medical conditions include hypertension, diabetes, cardiovascular disease, hepatitis C, lung disease, cancer, stroke, glaucoma and anemia. Many residents have multiple medical conditions.

In the eleven months since it opened, Sheridan Hill House has been highly successful in offering clients a community living alternative to nursing homes that addresses both their mental health and medical needs. Resident hospitalizations and visits to emergency rooms have decreased significantly and they are receiving expert help in managing their medical conditions. As the cohort of persons with serious mental illness becomes "grayer" Sheridan Hill House offers a tested model of community-based housing and services.

The second innovative program that The Bridge has been operating for a number of years is Iyana House, a permanent housing and services program targeted to women with serious mental illness and co-occurring substance abuse who have been released from Bedford Hills State Correctional Facility. The program was

see The Bridge on page 30

City Awards New Housing Contracts

By Laura Grund, Acting Director,
Office of Housing Services, NYC
Department of Health and Mental Hygiene

Adequate housing services for people with mental illness are an essential part of recovery -- and a top priority of the New York City Department of Health and Mental Hygiene (DOHMH). Safe, reliable, supportive housing that promotes independence and stability is necessary for people to take control of their lives.

With this in mind, New York City has joined with New York State in an unprecedented supportive housing agreement. The New York/New York III Supportive Housing Agreement will create 9,000 new units of supportive housing by the year 2016, transforming the landscape of supportive housing in New York. The number of units that New York/New York III will create is nearly double the number of units created by the two previous NY/NY Agreements combined. The City and State investments total close to $1 billion in capital funds and more than $150 million annually for services and operating expenses.

NY/NY III aims to reach populations not served in the past. The first two NY/NY Agreements created supportive housing for single adults with a serious and persistent mental illness who had a history of homelessness. While NY/NY III will also serve this population, housing will also be available for adults in State psychiatric centers who are at risk of homelessness; chronically homeless families with a head of household who has a mental illness; and young adults age 18-24 who have a serious mental illness. A total of 5,500 units will be designated for people with mental illness. NY/NY III will also house other populations, including homeless adults with a substance abuse disorder; chronically homeless families whose head of household has a substance abuse disorder; and young adults age 25 or younger who have "aged out" of foster care.

NY/NY III housing will consist of scattered-site (apartments rented from private landlords that are spread throughout a community) and single-site (newly constructed or renovated congregate) housing. Already, DOHMH has announced 13 awards for 544 of the congregate units and 20 awards for 996 scattered-site units. This new housing has already started to become available and more will open later this year.

Participation in supportive services is voluntary. Tenants in NY/NY III housing will have leases and pay rent that is 30% of their income. The services vary depending on tenants' needs but often include case management; mental and physical health assessment and counseling; drug and alcohol abuse counseling; educational and vocational services; medication management; and assistance in gaining access to government benefits.

Supportive housing is an evidence-based, cost-effective way to serve people with mental illness. To monitor NY/NY III, the City and State are conducting an evaluation that will assess the effectiveness of NY/NY III housing in decreasing the use and cost of publicly funded healthcare and social services; reducing chronic homelessness and incarceration; improving tenants' health; and increasing appropriate substance use and mental health services use. The evaluation will help ensure that the people served by NY/NY III housing receive the support they need to live independently and contribute to their communities.

910 DeKalb Avenue Brooklyn

Supportive housing works. Government at all levels must increase and target resources to provide supportive housing, including appropriate mental hygiene services. □

A Place Called Home:
JBFCS Residences for People Living with Mental Illness

Staff Writer
JBFCS

Day after day, with patience and clarity, Rebecca Wulf, LCSW, explains services, eligibility and the application process for housing for people living with severe mental illness through JBFCS intensive and supported housing programs. Rebecca is Director of the Bronx REAL Center and AMI Apartment Programs for the Jewish Board of Family and Children's Services.

The calls for housing come from different sources -- outpatient mental health clinics, psychiatric hospitals, community residences and homeless shelters.

Throughout the Bronx, Brooklyn and Far Rockaway, JBFCS provides 189 beds in apartments at various or "scattered site" locations (rather than in one apartment building) for clients who need intensive support as well as for clients who are able to live more independently. The agency also offers 138 beds through its community residences.

"Our mission for both intensive and supported or 'graduate' programs is to provide levels of support that help residents develop skills to live as independently as possible," Rebecca explains.

Rebecca Wulf, LCSW, and Jeffrey Clarke, LMSW

Eligibility for intensive and supported housing

In order to be eligible for housing, an individual must have an Axis I diagnosis, which is a severe mental illness such as bipolar disorder or schizophrenia accompanied by functional impairments. The application process begins when a treatment provider submits a Human Resources Administration (HRA) Application Form 2010E on behalf of the person seeking housing. Homelessness is not an eligibility requirement for intensive and graduate housing, although JBFCS does provide Abraham Residence III in Manhattan and Maple House in Brooklyn specifically for people living with persistent mental illness and impairments who have been homeless for two or more years. See below for more information about these programs.

JBFCS intensive (supportive) apartment programs are regulated by the Office of Mental Health. They are funded by residents' Social Security payments and Medicaid, which is billed for restorative services. The program pays residents' rent, utility, and local phone bills and provides residents with allowances for personal needs, food and clothing. In the intensive program, a worker visits residents three times per week in their apartments to assess how residents are doing in terms of maintaining the apartment, taking medication and self care and to provide supportive counseling and skills development training.

Residents in intensive housing typically stay in their apartments two years, until they develop the skills they need to live more independently. While in the program residents must be involved in a day activity such as a continuing day treatment program, an intensive psychiatric rehabilitation program, out-patient clinic, school or work.. In intensive apartments, residents have roommates but not more than three people live in an apartment.

Graduate, or supported housing, has similar eligibility requirements although most residents in graduate housing come to their apartments after living in an intensive housing program first. In graduate housing, one bedroom and studio units for one person are available as well as apartments designed for sharing with a roommate. Residents are required to give thirty percent of their income toward rent, but manage their own finances for food, clothing, utilities and phone.

In graduate apartments, residents who range in age from 19 to 70 often keep their apartments for 15 to 20 years. There is no requirement that residents move out by a certain time as the Office of Mental Health recognizes that individuals living with chronic mental illness need ongoing support.

Unlike intensive housing where visits take place three times a month, in graduate housing, a worker makes home visits twice a month and residents are expected to participate in a daily activity such as work, volunteering or attending school or a day treatment program.

Housing for formerly homeless people with psychiatric disabilities

Since it is widely acknowledged that people living with persistent mental illness may also face homelessness, JBFCS provides residences to address this problem.

"Abraham Residence III is a 68-bed residence in Manhattan that is a collaboration between JBFCS and the Metropolitan New York Coordinating Council on Jewish Poverty," says Jeffrey Clarke, LMSW, JBFCS Director of AMI Community Residences. "The Abraham Residence is for people with an Axis I diagnosis who have been homeless for two consecutive years in New York City homeless shelters or as someone who is known to be homeless."

The Abraham Residence III is a congregant housing program, where all the units are within one building. Referrals often come from shelters, transition centers or women's centers. Staff is on-site 24 hours a day and provide support with medication management, social services, coping with symptoms and activities of daily living. Residents receive psychiatric services through their day treatment program. The average length of stay is four-and-a-half years. Residents usually move from Abraham Residence III to a supported housing program or permanent Section 8 housing.

JBFCS also provides 30 beds for homeless people with chronic mental illness at Maple House in Brooklyn, a Level II residence as designated by the Office of Mental Health. This housing offers four or five single apartments within one suite which share a kitchen and bathroom. Application for Maple house is through the New York City/New York State Agreement ("New York/New York").

Community residence serves many former patients of state hospitals

Another program that helps individuals with an Axis I persistent mental illness often referred by state psychiatric centers is the JBFCS Brooklyn Community Residence. Homelessness is not an eligibility requirement and application to the program is through the New York City Human Resources Administration. Staff at Brooklyn Community Residence provide a variety of services including counseling and case-management on a 24-hour basis and preparing meals for the 40 residents.

"All of the JBFCS housing options share a common goal: to allow individuals to live productively in the community rather than on the street or in a hospital," Jeffrey notes.

If you would like more information about JBFCS residential programs for people living with mental illness, please contact Rebecca Wulf at (718) 931-4045 or Jeffrey Clarke at (212) 828-8500. □

Abilify Approved from page 5

M.D., Ph.D., Executive Vice President, Chief Scientific Officer and President, Research and Development, Bristol-Myers Squibb. "This approval is a reflection of our ongoing commitment to provide innovative therapies, such as ABILIFY, to help adults living with depression."

"We are pleased that ABILIFY® (aripiprazole) has achieved this important milestone as the first medication approved as adjunctive treatment for adults with major depressive disorder," said Taro Iwamoto, Ph.D., Chief Executive Officer, President and Chief Operating Officer, Otsuka Pharmaceutical Development and Commercialization, Inc. "This new add-on treatment option for depression represents hope for many adults suffering from this debilitating illness."

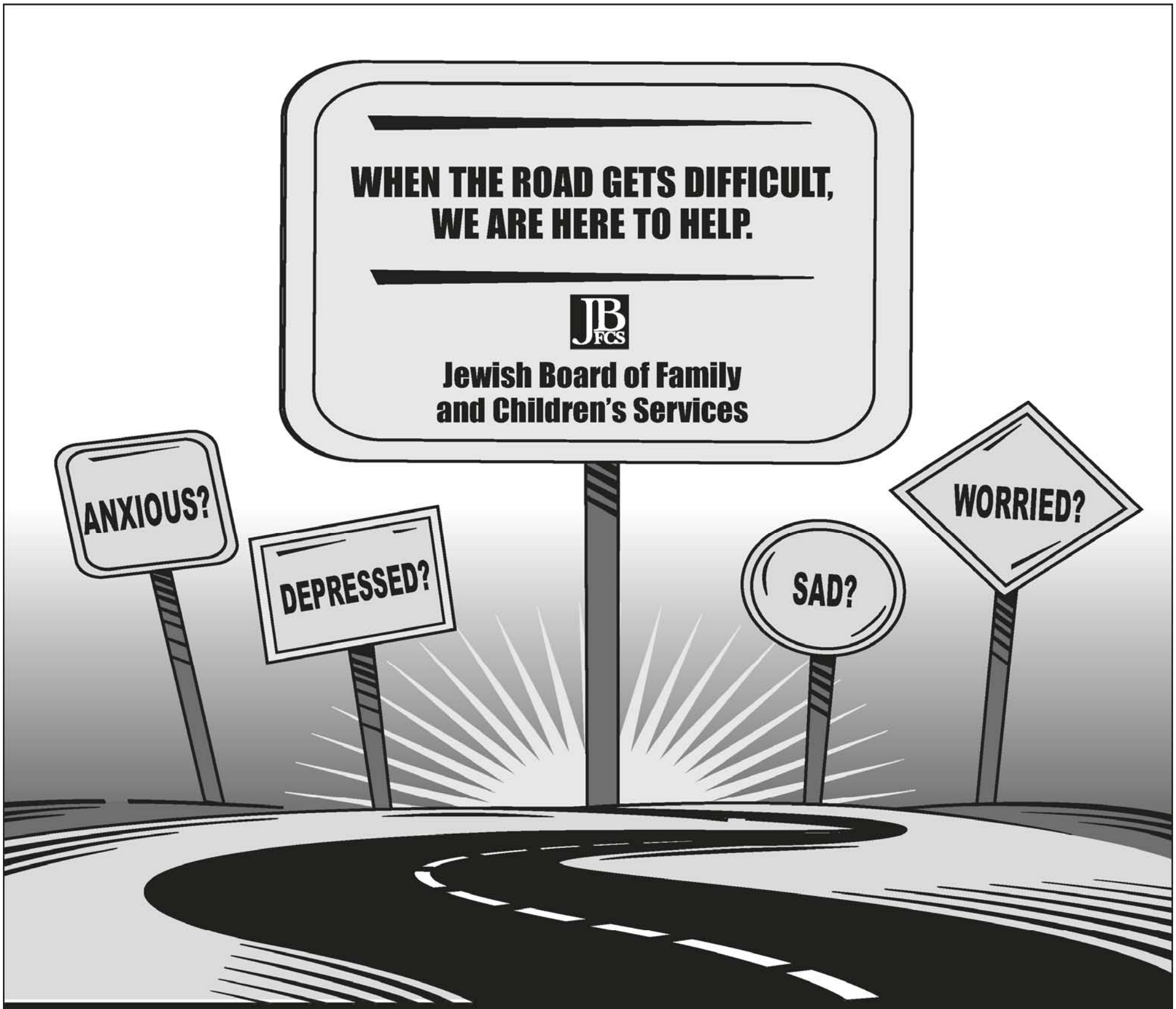
Major depressive disorder affects millions of U.S. adults at some point in their lives. A recent study evaluated different treatment approaches, including adjunctive medications and switching strategies, in patients with MDD. The study found that 63% of patients did not achieve adequate relief of depressive symptoms following the initial treatment with an antidepressant alone. Additionally, the study demonstrated that the use of adjunctive medications in treatment may be useful to improve unresolved depressive symptoms.□

Health Crisis from page 11

nothing short of rapid systems transformation and evaluation. In light of the gravity of the current situation and the number of lives that are at risk, nothing short of an all-out effort is justified.

The Initiative's goal is self-management. The clinical intervention "toolkit" is predicated on a biopsychosocial model so as to address the complex and multidimensional reality of providing care to a seriously mentally ill person who has or may be at risk for developing life-threatening diabetes and may have secondary substance abuse disorder. The objective of the toolkit is to provide a risk-adjusted and disease-specific series of opportunities for interacting with consumers that will promote integration of care, wellness self-management and hope – a critical element. □

Read This Issue Online
www.mhnews.org



At our 12 community counseling centers, caring and highly trained mental health professionals offer a wide range of services, including:

- Individual, family, couple and group counseling
- Psychiatric assessments and crisis interventions
- Medication evaluation and management

JBFCS programs serve all ethnic and religious groups. Confidentiality is carefully protected.

Fees are based on a sliding scale. Medicaid, Medicare and most managed care and private insurance plans accepted.

a beneficiary of UJA Federation of New York

For information about services, please call the Center nearest you:

BRONX

■ Pelham
The Harry Blumenfeld Counseling Center
(718) 882-5000

■ Riverdale
The J.W. Beatman Counseling Center
(718) 601-2280

MANHATTAN

■ Manhattan North
(212) 795-9888

■ Manhattan West
The Alan and Kathryn Greenberg Counseling Center
(212) 397-4250

STATEN ISLAND

■ Staten Island
The Morris L. Black Counseling Center
(718) 761-9800

BROOKLYN

■ Bay Ridge
(718) 238-6444

■ Boro Park
(718) 435-5700

■ Break-Free Adolescent Services
(718) 676-4280

■ Mid-Brooklyn
The Rita J. & Stanley H. Kaplan Center
(718) 676-4210

■ Southern Brooklyn
The Doris L. Rosenberg Counseling Center
(718) 339-5300

■ Starrett City
(718) 642-8955

QUEENS

■ Pride of Judea Community Services
(718) 423-6200

Housing Is Where Recovery Happens

By Donna Colonna, CEO
Services for the UnderServed

Services for the UnderServed (SUS) embraces a philosophy of hope and believes that individuals can recover from mental illness and lead meaningful lives in the community. SUS acknowledges that recovery means different things to different people, but at its core, it places the consumer at the center of their life plan. Recovery is at its root deeply personal.

Supported housing, or perhaps more aptly put housing with supports, can be a powerful platform for a person's recovery. Recovery may be defined as "a process of restoring a meaningful sense of belonging to one's community and a positive sense of identity apart from one's condition while rebuilding a life despite or within the limitations imposed by that condition" (State of Connecticut, 2007). SUS believes that it is in the 24/7 reality of the community where one lives that the substantive work of developing a positive sense of identity, developing a life plan and rebuilding one's life takes root and takes place. An individual's housing community and what it lends to recovery is constant and potentially exists in every interaction. It is at home with one's support system--mentors, friends and neighbors--that addiction is conquered with all the imaginable triggers waiting at the front door. It is there that one moves from disenfranchisement to affiliation. It is the sense of dignity one feels by holding the keys to one's front door, and the respect one receives from one's friends and neighbors that serve as a source of affirmation for rebuilding one's life. Housing (where one lives) is where all this takes place, and, if the tools for recovery are provided, the work of "rebuilding" can genuinely take place.

It is from a belief in those words, that five years ago, SUS' organizational transformation into a culture of recovery was born. Today at SUS the "supported" in supported housing is synonymous with recovery: Housing isn't a service, it is the place where people live and where their recovery happens.

When SUS embarked on its journey to transform its culture, there was acknowledgement that to achieve genuine transformation, values and attitudes would have to be cultivated to promote recovery. These values--Respect for the Individual, Maximizing Individual Potential, Maintaining a Supportive Environment, Integ-

Donna Colonna

rity in all Actions--were at the core of the organization's Ethics in Action curriculum which was designed to touch every SUS employee. As best practices were being introduced, SUS wanted to ensure that a strong culture of respect for the individual would serve as the foundation to support these new recovery-based applications. These would be the tools for recovery, and if they were to be truly effective, they would have to be delivered within a culture of hope, respect and a belief that people with mental illness can make their own decisions and exercise their right to self-determination. The initial rollout of its Ethics in Action curriculum took eighteen months, and it continues to drive its personnel policies from recruitment and hiring to employee orientation, supervision and promotion. Now, it is these core values that characterize the "supported" in supported housing, and it is upon this foundation that SUS continues to build competence in its staff with an array of training in best practice applications.

To reinforce and maximize the value of housing in recovery, SUS has committed to providing its housing staff with competence in applying evidence-based practices. In the last three years, SUS has launched a broad recovery-based training initiative to provide its staff with the skills to engage in the work of recovery. Wellness Self-Management, Motivational Interviewing, Integrated Dual Disorder Treatment and Family Psycho-education are being incorporated into its services toolkit. With the financial support of foundations like The van Ameringen and the New York Community Trust, and affiliations with a learning collaborative sponsored by the Urban Institute for Behavioral Health and the New York State Office of Mental Health, SUS has been able to enhance the competency of its workforce to make recovery truly accessible within its housing settings.

New thinking and new practices inevitably lead to new ideas. One such idea came as the result of SUS examining service utilization data which described the service use patterns of consumers living in its scatter site supportive housing. Over the last 15 years and eight separate contracts with the NYS Office of Mental Health, SUS developed a substantial number of units of scatter-site housing--studio and one bedroom rentals occupied by people in recovery from mental illness. Two years ago, SUS provided minimal case management services to 244 people with serious mental illness living in apartments. Its experience was that one-third of these consumers were fairly independent and managed well with the minimum contract expectation of case management contact of 1-2 times per month. About one-third was in a medical, psychiatric or substance abuse related crisis requiring more frequent staff intervention (6-8 contacts per month) for 30-90 days per year. The remaining one-third was in nearly constant crisis and heavy users of emergency and inpatient medical, psychiatric and detox services. There was also concern that in this last group there was a high incidence of undiagnosed and/or poorly treated chronic disease, e.g., diabetes, asthma, hypertension.

With a better understanding of its consumer needs, and armed with its values and best practices, SUS reorganized its scatter site housing resources and created a new model. The newly created model consists of a team with a Program Director, a part-time Psychiatrist (1 day per week), a full-time Registered Nurse, a Certified Alcohol and Substance Abuse Counselor (CASAC), a Peer Counselor and 4 Case Managers. This new **Scatter site Mobile Team** has also adopted the communication and tracking strategies used by ACT teams along with best practices endorsed by the NYSOMH. No longer a model that provides case management only, the model now offers greater flexibility for varying service intensity, and greater direct access to integrated interdisciplinary expertise with increased capacity to address the complex interaction of co-morbid conditions associated with homelessness and serious mental illness, i.e. substance abuse and chronic disease.

Reports from the field indicate the following preliminary outcomes:

- Case Managers are trained in chronic disease management by working alongside medically skilled colleagues and become better able to advocate on behalf of consumers for better primary care. Wellness is addressed more comprehensively with an approach that integrates motivation and skills for managing mental health, chronic disease and addiction.

- Staff are empowered by the information and skills they have acquired and the assistance they can provide, making them more potent partners with consumers in managing wellness and supporting lifestyle change.

- Consumers report feeling more supported and are more trusting, engaged and encouraged by a team of individuals who can all assist with a variety of wellness issues. Better engagement leads to earlier detection of emerging health risks.

- Consumers more readily avail themselves of health monitoring and information about treatment options

- Staff are better equipped to challenge the denial that is characteristic of individuals who just don't want "another diagnosis in their lives".

SUS' Scatter site Mobile Team nurse, Kathleen Hartmann put it very well: "We've kicked things up a notch and that is having an impact on quality of life, longevity and more efficient use of healthcare dollars."

The concept that housing is the platform for recovery has generated many good things for SUS. It has served as the impetus for transformation of its organizational culture, it has fostered the enhancement of competencies in the workforce, it has led to meaningful collaborations and the addition of resources, and most importantly, it has led to better outcomes for consumers. □

Gun Law from page 4

some compromises and modifications to the original bill. In testimony provided last summer at a hearing on federal gun reporting laws, NAMI expressed a number of concerns about HR 2640 including:

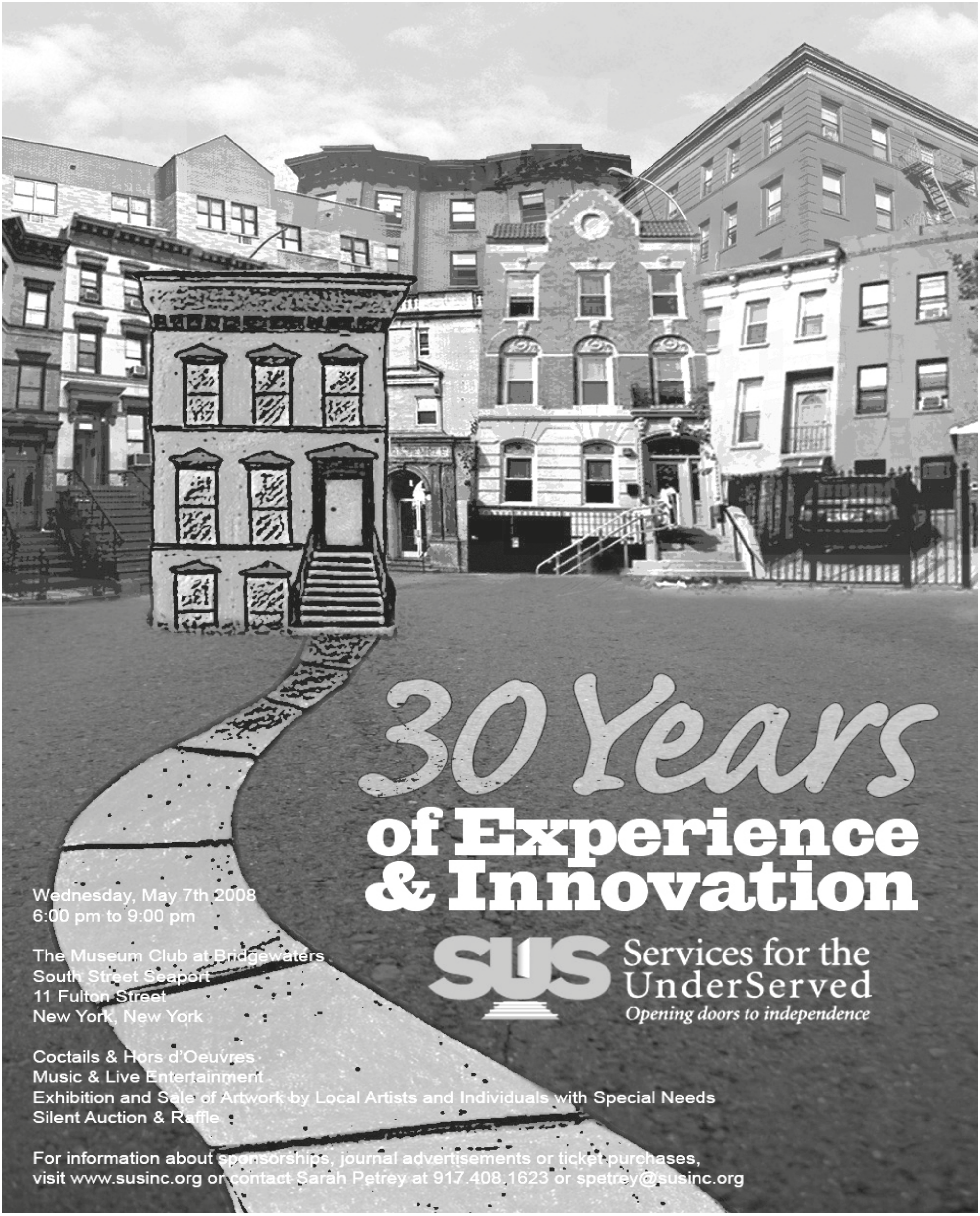
- Concerns that the definition in existing law of those who should be included on the NICS list is vague and overly broad, using terminology that is outdated and stigmatizing ("people adjudicated as mental defectives"). HR 2640 does nothing to change this stigmatizing and vague language.

- Concerns that there are inadequate protections in current law against breaches of privacy or sharing of information with other agencies. HR 2640 attempts to address this concern by directing the U.S. Department of Justice to draft regulations addressing privacy protections.

- Concerns that people had no way of knowing whether their names were on the list and that once on the list, there were no mechanisms to have one's name removed from the list. HR 2640 partially addresses this concern by requiring that states create mechanisms to allow individuals who are no longer dangerous to have their names expunged from the list.

- Concerns that Congress, by focusing on guns, was failing to address the real problem implicated in the Virginia Tech tragedy, the lack of a mental health system to respond to people like Cho who are in crisis and in need of treatment.

NAMI is pleased that some progress has made on HR 2640, but we remain concerned with certain aspects of the bill, particularly that the criteria for inclusion on the list and for removal from the list is vague and confusing, and therefore creates potential for misinterpretation and misapplication of the law. □


30 Years
of Experience
& Innovation
Wednesday, May 7th 2008
6:00 pm to 9:00 pm
The Museum Club at Bridgewaters
South Street Seaport
11 Fulton Street
New York, New York
Coctails & Hors d'Oeuvres
Music & Live Entertainment
Exhibition and Sale of Artwork by Local Artists and Individuals with Special Needs
Silent Auction & Raffle
For information about sponsorships, journal advertisements or ticket purchases,
visit www.susinc.org or contact Sarah Petrey at 917.408.1623 or spetrey@susinc.org
SUS
Services for the
UnderServed
Opening doors to independence

Home at Fountain House

By Kenn Dudek, Director
Fountain House

Fountain House began its apartment program in 1958. The initial set up was two or three people sharing an apartment and rent with the support of Fountain House. Until 1980 we had about 40 apartments. What we discovered was housing alone was not enough, people needed other support and at Fountain House that comes in the form of a job, an education, financial advice, and social networking. Most of our members lived for years in many of the old SRO's which were all over the city or in apartments or with their parents. In the early 80's many of the SRO's started to close and so Fountain House decided to delve into the housing business in order to assist our members to obtain a decent place to live. The other reason we started to develop more housing was that both the Department of Mental Health (DMH) and the Office of Mental Health (OMH) at the state and city level decided to fund housing for people with mental illness. Prior to this time DMH and OMH did not see community based housing as their job. In those days the models were more transitional; based on the concept of a half way house with practices borrowed from psychiatric hospitals. Many of these old designs are still in place to this day and need to be changed. Long ago we became convinced that permanent housing is the best approach for housing for our members but that is not how we began. The first building we built was the first HUD 202 project for people with mental illness and it houses 19 people in studio apartments. From that point we worked with the city and state mental health people and developed a whole array of housing programs in the eighties. Many of these were the old fashion transitional models which we were never comfortable with and which we have been trying to unravel for the past ten years. The difficulty in converting to permanent housing has to do with a combination of the original federal and state funding formulas and the New York State reliance on Medicaid funding. Medicaid funding for housing as well as clubhouses is a mistake and does not work.

Kenn Dudek

In the early nineties OMH introduced supported apartments and we had come full circle to our ideal housing model for the majority of our members. People living in their own apartments with a subsidy and a varying amount of support as people want or need it. We feel we have an ideal arrangement with our clubhouse as the center or base of support for our apartment network. Not all the people who live in our apartments are active members of Fountain House but the vast majority are and receive much of the needed support in that manner. In addition to our clubhouse we have an Active Reach Out Team that works with the people who are not active in the clubhouse. It is our experience however that if a person is active in the work or school they need less support on a regular basis for their housing. While we applaud the concept of housing first we know that without a flexible set of additional support services people will not be successful in the long run. It is our observations that the most successful supported housing programs tend to have additional service support like ACT teams or clubhouses. It is a myth that housing with minimal support is successful. While there are long periods of time when people do not need extensive support it is also true that there are times when they do. so the ideal support is flexible, long term and without time limits. It is our hope that new funding models will be developed to allow for this type of permanent housing with support.

In the last few years Fountain House has decided to seek new approaches to housing. We have developed a partnership with a not for profit housing developer called the Lantern Group and this January we are opening a 135 bed SRO called Hunters Moon on the upper Westside of Manhattan. We will provide the supportive services and the Lantern Group will be the landlord. With the addition of these beds we will house over 500 people throughout the city but we still do not consider ourselves a housing agency. We end where we began; a home, a job and a chance. □

Blending Housing and Mental Health Services

By Susan Chiappone, Director of Marketing and Public Relations
STEL, Inc.

The idea of blending housing for persons with a mental health diagnosis and affordable housing in the community may seem complicated enough; add to the mix an idea to preserve community landmarks and the idea becomes visionary. The vision is reality for Southern Tier Environments for Living, Inc. – known as STEL.

Under the leadership of Executive Director Thomas Whitney, the organization based in Dunkirk, NY has expanded its visions throughout the western areas of New York State and offers a total of 159 beds in a variety of housing situations under its own name. As a partner – many more housing options exist including a recently completed 75 bed facility with DePaul in Buffalo, NY.

"Our partnership with STEL enabled DePaul to bring a cutting-edge housing option to persons with serious and persistent mental illness residing in Erie County" said Mark Fuller, President of DePaul.

"Buffalo is now home to Seneca Square, a service-enriched 75-bed Single Room Occupancy Program that features a residential atmosphere with individual bedrooms, inviting common areas, outdoor courtyards, and a host of supportive services," Fuller said.

Thomas Whitney

"STEL combined their expertise in mental health service delivery and knowledge of innovative funding streams to assist DePaul in developing a program that will serve as a model for other future programs. The dedicated staff at STEL worked hard to understand DePaul's vision, enabling it to become a reality," Fuller concluded.

The variety of housing options allow persons with a diagnosed mental health disability to achieve higher levels of independence while staying within the STEL, Inc. system. They can begin in a highly supervised setting and graduate to apartment living according to their goals, skills and abilities.

The jewel in the crown of the STEL, Inc. housing options is the former Cardinal Mindzenty High School in Dunkirk. The school was closed by order of the Diocese of Buffalo in the late 1970s and remained vacant for many years. Various plans were proposed for the multi-story structure located in the heart of this small rural city. Eventually Whitney and his development team decided on a walk-through of the building and saw potential.

"Buildings like this one were solidly constructed and offered some distinct advantages," said Whitney. The building was built in 1954. For many years it housed a parochial high school. The building features 37 units of one, two and three-bedroom apartments. In addition, there is a play area, community room and ample off-street parking. The construction project took 11 months.

City of Dunkirk Mayor Richard Frey is highly complementary. "When my wife and I toured the building we couldn't believe how nice the apartments were; they were nice enough that we joked about moving in," said Frey. The construction went fairly quickly with acquisition in 2005 and the first tenants moving into their homes in January 2006. "There have been relatively few issues and the property is very well maintained," he added. "Tom Whitney is the kind of person that I can call and know that he will respond," the mayor added. "He has been a great partner and one who we hope to work with again in the future," said Frey. Frey also praised the re-location of the STEL, Inc. main offices to the vacant mansion next door to the school.

Whitney uses what was once a home for priests serving the Catholic high school as the executive offices and conference center for STEL, Inc. He has preserved the graceful building and maintained the integrity of the structure including massive oak woodwork, stained glass windows and fancy pocket-doors. "I love older buildings," declared Whitney. "They have character and culture that the community should be proud of," he added. Visitors to the STEL, Inc. offices are in awe as they are greeted in a large Victorian style foyer and ushered to wait in the offices library or dining areas that are complete with fireplaces.

Distinctive buildings have been saved in several other communities where STEL, Inc. has housing. Currently there are apartments or residential housing in Jamestown, Olean, South Dayton, Wellsville and Gowanda. New sites are always being reviewed by Steven Ald, Housing Development Coordinator for STEL, Inc. Ald and his staff work on the compliance and permit issues as well as the initial phases of all projects that involve funding.

see Housing on page 40

Using Psychoeducation as a Treatment Approach With Adolescents

By Jennifer A. Powell-Lunder, Psy.D.
Program Director, Child & Adolescent Partial Hospitalization Programs,
Four Winds Hospital

Reese, a 16 year old girl who has had several psychotic episodes over the last few years and is diagnosed with Schizoaffective Disorder, walks into my office and plops down on my couch with a loud sigh.

"I'm feeling pretty hopeless," she says. "My parents think because I am in treatment I can just snap out of this and be fixed. They just don't get it. No one gets it!"

"I know," I reply, "It's frustrating." "You know, Reese," I continue as I decide to take a chance and say out loud what I am pretty sure she is already thinking. "You're not crazy. Those things that you hear and see that other people don't--your brain is really sending you messages that they are there."

I then proceed to offer her a simplified physiological explanation of her symptoms. When I am done I notice that she is crying.

"Reese, what's wrong?" I ask, concerned that I have simply made her feel more frustrated.

"Thank You!"

"For what?" I ask.

"You are the first person who has ever explained things to me that way. I just thought I was crazy!"

Charlie, a 17 year old boy with a long history of depression and substance abuse is brought to my office by one of the program staff members after he has become verbally aggressive toward one of the other kids in the milieu. The look on his face says it all. Before I have opened up my mouth, he has decided that I do not have anything good to say.

"So what's up, Charlie?"

"That kid gets on my nerves, he's annoying, and I didn't touch him, I could have."

"No Charlie," I say, "What's up with you? Are you okay? We got your latest tox screen back."

"Hey, I haven't done anything! I haven't smoked a single joint in over a week."

"I know," I say. "I am guessing you are feeling agitated, irritable and more depressed." I continue on as I notice his face soften slightly.

"You feel as if everyone and everything annoys the hec out of you."

I then continue on and offer psychoeducation regarding the impact of smoking marijuana on depression as well as on symptoms associated with the cessation of smoking marijuana. I end by explaining to him that my role isn't to make judgments about smoking marijuana but to explain why given his ongoing battle with depression, smoking marijuana is not a good choice for him.

He is looking down at the floor when I hear him murmur "Thanks. It kind of makes sense. No one ever explained it like that, they just told me I shouldn't smoke."

Raquel is 14 year old girl who reports that she has been depressed her whole life. She is sarcastic and often crass. Her intellect can be intimidating to her peers and as a result she has few friends. She has also made it abundantly clear that she does not "believe in using medication, unless of course someone is really crazy." She is open to more natural ways of treating her depression and talks about the herbal teas she has heard about. I point out to her that in reality these are drugs, and add that they are not even FDA tested.

"What ever," she says, "I don't care what you say, I do not need meds. I am not CRAZY!"

I know she is going to be a tough customer but realize that her intellect is my only tool to help her help herself.

"So if you had diabetes or a heart condition," I start.

She cuts me off mid-sentence and blurts out "that's different."

I go on to offer psychoeducation about the physiological effects of depression. I can tell she is listening, but the look on her face still says she's not buying. My assumptions are confirmed when she argues back that she has been depressed forever, and that it will not kill her if she does not take meds. "Plus," she adds, "it's just not natural."

In a last ditch attempt I say " You like air conditioning in the summer?"

She gives me a tentative look but affirms that she does. I then proceed, pointing out that air conditioning is not natural; finally, I have her.

I explain why and how antidepressants work, and respond to her inquiries about the side effects including misconceptions surrounding the highly publicized "black box warnings." I explain to her that because she is in treatment she would be closely monitored for all side effects. I close by offering "If there is one chance in a million that I may be right and medication could help you, isn't it worth it? After all, people have written whole books describing how antidepressants changed their lives!"

I have succeeded; she agrees to try.

Psychoeducation works! My work with adolescents has revealed to me that so many of them want to be treated maturely. They understand that until they are 18, their parents have the right to make decisions for them but as they themselves begin to prepare for the adult world, their interest in the world around them is at a peak. They begin to think and talk about politics and religion, philosophy and art. They are thirsty for new knowledge. In becoming an adolescent their cognitive ability to understand things increases tremendously, as does their ability to use abstract thinking and insight. It only seems logical that many adolescents would have a positive response to psychoeducation. Adolescents often report feeling very awkward. For teens in crisis--suffering from a mood disorder, psychosis, battling addiction, managing a learning disability-- these feelings are often more frequent and intense. Many of these teens report wanting to "fit in," to be like everyone else, but feeling that they are somehow different. It can be frustrating to feel so different, and have no explanation as to why.

Most mental health professionals would agree that offering psychoeducation to clients is important. However, my work with teens has convinced me that it often goes beyond being just essential, but pivotal. It can give a teen feeling hopeless, hope; it allows a teen feeling out of control, to feel in control. Psychoeducation offers explanations and meanings; the result--a teen who may realize for the first time, I am not alone, others have been through this. Offering the physiological "why" about what they may be experiencing is often a great relief. It can also be the first step in helping an adolescent to work in treatment. By starting with a fact-based presentation of information, adolescents begin to feel more in control. At a stage when peer relationships are so important, explanations regarding why they may feel different from their friends, can open up doors and represent hope. This approach also suggests to teens that the

see Psychoeducation on page 24

FOUR WINDS HOSPITAL • SPRING 2008

April 2008

SAVE THE DATE!

Tuesday • April 8, 2008 • 4:00 – 7:00 pm

NURSING CAREER DAY

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 1st to 1-800-546-1754 ext. 2413

GRAND ROUNDS

Friday • April 11, 2008 • 9:30 – 11:00 am

A Focus on Clinical Interventions for the Long Term Effects of Childhood Sexual Abuse: The "Traumagenic" Dynamics Model*

Kerry Pertchik, Psy.D.
Director of Dialectical Behavior Therapy** Training & Psychologist, Adult Services, Four Winds Hospital, Saratoga Springs, NY

Through the use of a case presentation, this program will explore the complexity of the long-term effects of childhood sexual abuse and the difficulties this poses for treatment, and enable participants to:

- Gain an understanding of the prevalence, incidence rates and comon factors influencing a patient's experience of childhood trauma.
- Become familiar with the "traumagenic" dynamics model for understanding the aftermath of trauma and learn to develop individualized treatment plans.

Fee: $25.00 payable to Four Winds Foundation, a not-for-profit organization

1.5 CME Credits Available

* Model developed by David Finkelhor, Ph.D., University of New Hampshire

**Adapted from the concepts of Marsha M. Linehan, Ph.D., University of Washington

May 2008

GRAND ROUNDS

Friday • May 2, 2008 • 9:30 – 11:00 am

The Arc of Eating Disorders: Co-Morbid Diagnosis Contained Within

Judy Scheel, Ph.D., LCSW,
Executive Director, CEDAR Associates

Eating disorders are complex conditions that regularly include co-occurring diagnoses such as anxiety and depression and are often accompanied by Axis II diagnoses or substance abuse. This presentation will enable participants to:

- Explore co-morbidity within the eating disorder diagnosis.
- Discuss OCD and trauma/abuse issues, as separate categories contained within an eating disorder diagnosis.
- Describe the similarities and differences between eating disorder and substance abuse treatment methods.

Fee: $15.00 payable to Four Winds Hospital

1.5 CME Credits Available

A COMMUNITY SERVICE

Wednesday • May 7, 2008 • 2:00 – 4:00 pm

National Anxiety Disorders Screening Day

A program for consumers designed to provide an anonymous screening and educational information about anxiety and depressive illnesses.

For information, or to schedule a confidential appointment, please call **1-800-546-1754 ext. 2413.**

Free of Charge

SPECIAL TRAINING

Thursday • May 8, 2008 • 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

Community and Professional Education Programs

June 2008

GRAND ROUNDS

Friday • June 6, 2008 • 9:30 – 11:00 am

Successfully Integrating Treatment of Co-Occurring Psychiatric and Substance Abuse Disorders

Merrill Herman M.D.,

Associate Professor of Clinical Psychiatry, Director, Addiction Psychiatry Fellowship, Albert Einstein College of Medicine / Montefiore Medical Center; President of the New York Society of Addiction Medicine (NYSAM)

Dr. Herman will provide an overview of diagnostic issues and guidelines for prescribing medications to clients with dual disorders, including the

use of medications to achieve abstinence and maintain recovery from substance dependence. At the conclusion of this program, participants shall:

- Describe philosophical barriers to the use of medications.
- Enhance their knowledge of the appropriate use of psychotropic medications to treat co-occurring psychiatric disorders.
- Better understand the rationale for using medication to treat addiction in a mental health or addiction treatment center.

Fee: $15.00 payable to Four Winds Hospital

1.5 CME Credits Available

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.

Register online at www.fourwindshospital.com

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 acredited 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.

Four Winds HOSPITAL

OUR UNIQUE APPROACH TO CHILD AND ADOLESCENT TREATMENT

Children and adolescents are treated in distinct, age-appropriate programs with the treatment milieu focused on each age group's developmental issues.

Programs include:

- **5-9 years old:** provides a nurturing, therapeutic, home-like environment
- **10-13 years old:** focuses on developing social skills, mastering impulse control and promoting healthy communication
- **14-17 years old:** focuses on empowering adolescents through peer support and feedback

Each unit, led by a multidisciplinary clinical team, mirrors a school setting that promotes shared competencies and encourages bonding. Family/care-givers are a primary focus within all age groups and we encourage their active participation. Four Winds' on-grounds school works closely with the home school district to assist the child/adolescent in a smooth transition back to the classroom.

For further information or to arrange a tour of our campus please contact Marketing at

1-800-546-1754

ext. 2413

Psychoeducation from page 21

clinician respects their intelligence. Many adolescents are used to adults telling them to do things without offering explanations regarding "why". It is the offering of the "why" that can encourage an adolescent to accept counseling from the clinician about the "how" (how to manage and ameliorate the effects of presenting symptoms). Through psychoeducation teens learn about the mechanisms underlying presenting symptoms as well as the consequences related to the rejection of treatment (Vieta, 2005). Biologically based explanations validate for teens that what they are experiencing is real. This fact-based approach also suggests to teens that there is hope-symptom relief is not only possible, but plausible. Suddenly it seems rational to adolescents that if information regarding the underlying causes of symptoms is fact-based and readily available, then treatment protocols offered by clinicians may be fact-based and possibly successful.

The use of psychoeducation as a treatment tool may not be successful for all teens. Some simple guidelines regarding teens most likely to benefit include the following:

- Teens with higher levels of intelligence
- Teens who demonstrate an ability to use abstract thinking
- Teens who demonstrate insight

The use of psychoeducation in treatment protocols is not a new concept. In fact research consistently confirms the success of psychoeducation in reducing symptoms, preventing relapse and encourage medication compliance, especially in patients diagnosed with schizophrenia or Bipolar Disorder. The greatest benefits have been noted when the families of these individuals are offered psychoeducation as well (Colom, 2002; Hornung, Kieserg, Feldmann, & Buchkremer, 1996; Lincoln, Wilhelm & Nestoriuc, 2007; Rouget & Aubry, 2007; Vieta, 2005). Research focusing on the use of psychoeducational interventions, specifically with adolescents, has confirmed the efficacy of the approach for use in the treatment of, including, but not limited to anxiety disorders (Micco, Choate-Summers, Ehrenreich, Pincus, & Mattis, 2007), suicide prevention (Esposito-Smythers, McClung & Fairlie, 2006), treatment of substance abuse (Kirk, Chapman & Sadler, 1990) the development of positive coping skills (Hayes & Morgan, 2005), managing sickle cell disease (Martin, 2005), epilepsy (Snead, Ackerson, Bailey, Schmitt, Madan-Swain, & Martin, 2004), and in building self-esteem in adolescents at high-risk for dropping out of school (Wells, Miller, Tobacyk, & Clanton, 2002).

It is important to acknowledge however, that the greatest treatment gains are noted when psychoeducation is provided as a component of a treatment protocol (Rouget & Aubry, 2007). As indicated in the scenarios offered above, psychoeducation can be used as a tool to help adolescent clients make the choice to accept treatment.

Although guidelines have been offered regarding who may benefit best from this approach, clinicians should not rule out trying this approach with other clients. The key is to offer the psychoeducation at a level that the client can best understand. Explanations do not need to be complex. For example, in working with teens who suffer from learning disabilities, I am quick to point out that although they have told me they feel frustrated because they feel stupid, by definition, in order to be diagnosed with a learning disorder an individual must demonstrate a statistically significant difference between their IQ (defined as a minimum of two standard deviations) and achievement (DSM-IV-TR). This clearly indicates in laymens terms, a person is diagnosed with a learning disorder because they are not achieving the academic level that would be expected given their level of "smartness" (as measured by a standardized IQ test).

In work with adolescents, it is the way psychoeducation is offered that can make all the difference. A straightforward approach suggests that the clinician acknowledges and respects the adolescent's level of intelligence. Toward that end, it is important that psychoeducational explanations are offered using simple, understandable language and terms. The goals is to encourage the adolescent by offering them a new understanding, not make them feel stupid because they are unable to comprehend the explanations being offered.

Most adolescents respond well to treatment approaches which are direct and honest. By offering psychoeducation, clinicians suggest to their adolescent clients that when presented with the facts they are mature enough to make decisions related to their own treatment. When adolescents are armed with the treatment related facts, psychoeducation can be used as a tool to empower them to take the first step forward in treatment.

References

American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washinton, DC, American Psychiatric Association

Colom, F. (2002). The mechanism of action psychotherapy. *Bipolar Disorders*, 4 (suppl1), pp. 102, 2000.

Esposito-Smthers, C., McClung T.J., & Fairlie, A.M.(2006). Adolescent perceptions of suicide prevention group on an inpatient unit. *Archives of Suicide Research*,10(3), 265-275.

Hayes, C., & Morgan, M. (2005). Evaluation of a psychoeducational program to help adolescents cope. *Journal of Youth and Adolescence*, 34(2), 111-121.

Hornung, W. P., Kieserg, A., Feldmann, R., & Buchkremer, G. (1996). Psychoeducational training for schizophrenic patients: Background, procedure and empirical findings. *Patient Education and Counseling*, 29(3), 257-268.

Kirk, D., Chapman, T. & Sadler, O.W. (1990). Documenting the effectiveness of adolescent substance abuse treatment using public school archival records. *The High School Journal*, 74(1), 16-21.

Lincoln, T.M., Wilhelm, K., Nestoruic, Y. (2007). Effectiveness of psychoeducation for relapse symptoms, knowledge, adherence and functioning in psychotic disorders: A meta-analysis. (2007). *Schizophrenia Research*, 96(1-3), 232-245.

Martin, G.M. (2005). The effects of a psychoeducational intervention on improving psychosocial functioning and disease management of adolescents and young adults with sickle cell disease. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 65(9-B), 4839.

Micco, J. A., Choate-Summers, M. L., Ehrenreich, J. T., Pincus, D.B., Mattis, S.G. (2007). Effacacious treatment components of panic control treatment for adolescents: A preliminary examination. *Child & Family Behavior Therapy*, 29(4), 1-23.

Rouget, B. W., & Aubry, J. (2007). Efficacy of psychoeducational approaches on bipolar disorders: A review of literature. *Journal of Affective Disorders*, 98(1-2), 11-27.

Snead, K., Ackerson, J., Bailey, K., Schmitt, M, Madan-Swain, A., & Martin, R.C. (2004). Taking charge of epilepsy: The development of a structured psychoeducational group intervention for adolescents with epilepsy and their parents. *Epilepsy & Behavior*, 5(4), 547-556.

Vieta, E. (2005). Improving treatment adherence in Bipolar Disorder through psychoeducation. *Journal of Clinical psychiatry*, 66(suppl1), 24-29.

Wells, D., Miller, M., Tobacyk, J., & Clanton, R. (2002). Using a psychoeducational approach to increase the self-esteem of adolescents at high risk for dropping out. *Adolescence*37(146), 431-434. □

Commissioner Hogan from page 1

will increase the amount of affordable housing in New York. A portion of these units will be targeted toward persons with disabilities. In addition, OMH is currently working with private developers that have expressed interest in working with OMH on the development of integrated, affordable housing.

Q. How much mental health housing is there in New York State? New York State has the nation's most extensive mental health housing program, with 39,000 units or housing opportunities in place or under development by OMH. These programs, many developed through the "New York New York" partnerships, have become national models for supportive housing and urban redevelopment.

Q. What do you mean when you say there is housing under development? OMH has a significant housing development pipeline, in addition to what is recommended in the 2008-09 Executive Budget. OMH will continue the development of these units and will emphasize integration of new housing into mainstream housing. OMH will explore the conversion of 24-hour staffed housing into supported housing and blend new OMH housing resources with existing OMH housing/residential programs to achieve reform. Finally, it will increase the supply/focus on treatment/support programs that help individuals with a mental illness choose, get and keep their housing.

Q. Are there any plans to make more housing available for New Yorkers with mental illness? During this year's State of the State and Budget messages, Governor Spitzer announced a historic $400 million Housing Opportunity Fund that will support affordable and supportive housing across the state. OMH has launched a broad and multi-year approach to reform its approach to mental health housing and acting with partners in the Administration (HFA, DHCR, OTDA), housing production is being increased faster than by OMH acting alone. OMH is also working with residential providers to emphasize a supportive housing model: providing safe, decent and affordable housing that is available long term, linked to flexible services that can be increased/ decreased as needed.

Q. Do you think this new partnership approach will have any positive results? It already has. In a speech at the 34th annual awards luncheon of the New York Housing Conference, Governor Spitzer highlighted an affordable housing project being developed on Washington Avenue in the Bronx. This 118 unit project will include 30 units for persons recovering from a serious mental illness. The project developer, The Arker Companies, is planning additional housing development in the NYC, and has expressed interest in working with OMH on these projects. Other developers have also expressed interest in working with OMH on the development of affordable housing.

Q. Is OMH doing anything to help housing providers keep up with the rising costs we all face? Existing OMH funded housing received a 2.3 percent cost of living adjustment (COLA) effective April 1, 2007 and will receive another 2-2.5 percent COLA effective April 1, 2008. In addition, there was an eight percent operating base increase for licensed community residences in January 2008; an additional 8 percent increase is anticipated (subject to appropriations) in January 2009, and 7.5 percent is anticipated in January 2010. These funding increases show a commitment by the Spitzer administration to support those individuals who need safe and affordable housing as part of their recovery.

Q. Can we expect any changes in the near future? OMH has begun a review of housing and related support services throughout its vast mental health system of care. Additional flexibility is needed for the mental health housing system to be responsive to individual recipient wishes and needs system goals, and to work effectively as a tool in the creation of local systems of care that reduce institutionalization, homelessness, persons stuck in acute care settings, and waste.

Q. Is the mental health community involved in this review? OMH has reached out to all funded or licensed housing providers, county mental hygiene directors, and other interested organizations to submit agency-specific ideas regarding how it would reorganize housing programs to become more recovery oriented, flexible, and responsive to individual recipient wishes and needs. Our guiding principles are posted on the OMH website at http://www.omh.state.ny.us/omhweb/News/housing_policy.html We look forward to working with local government, consumers, family advocates, and providers to incorporate flexibility into housing funding, regulation, and oversight into OMH funded housing.

Q. We've talked a lot about housing for adults, is there anything happening around services for children and teens? Youth facing the challenges of serious emotional disturbance may receive residential services from a number of state agencies, so an interagency approach is critical to effective planning of these services. New York State child serving agencies are beginning to engage in a comprehensive discussion to effectively evaluate what role residential interventions will have in the next ten to fifteen years in New York. State child and family serving agency leadership are beginning to assess who will be served, what types of residential interventions will be needed, what types of services and supports will be most effective to those served, and the expected numbers of those who will require in these restructured programs.

Q. Is there anything being done to meet the housing needs of adolescents transitioning into adult services system? The needs of children transitioning into adult services (18-25 years old) are uniquely different from those individuals already being served in the adult programs. OMH has contracted with the Coalition of Children's Mental Health Services to research and develop a residential program model to specifically address the needs of young adults, incorporating the input of interested community members, service providers, consumers of service and their families. The research findings will be shared with counties, municipalities and elected officials to facilitate an interagency approach to services and supports. Additionally, this project provides funding for two transitional housing demonstration projects to enhance existing mental health services to better meet the needs of this population. □

Guiding Principles from page 11

Supported Housing: 11,135 units

Family Care: 2,413 units

Children's Programs

Congregate Treatment
(Group Homes): 272 units in 38 sites

Family Based Treatment: 490 units

27,285 of these units are operated by not-for-profit agencies and 1,204 are State operated. In addition, 8,843 units are in development including 1,825 units of supported housing, 6,738 SRO units and 280 children's units.

These are valuable and also expensive resources that are assets for the local mental health systems throughout the State. Many of these units were developed using approaches put in place in the 1980s and early 1990s, which emphasized a "residential treatment" strategy with services and supports provided in and sometimes as a condition of housing.

The New York State community-based mental health system has expanded dramatically during this time. Treatment, rehabilitation and pharmacological interventions have made great strides forward and the consumer empowerment movement has taken hold. Recovery is truly possible with the proper access to these resources.

Guiding Principles

It is time, then, to revisit the structures that govern the mental health housing assets in New York. Additional flexibility is needed for this housing to be responsive to individual recipient wishes and needs, system goals and to work effectively as a tool in the creation of local systems of care that reduce institutionalization, homelessness, people stuck in acute care settings, and waste. To achieve this it is appropriate to outline guiding principles which can be used as a compass to focus these restructuring efforts. These principles include the following:

- Housing is a basic need and necessary for recovery. Most people want permanent, integrated housing that is not bundled with support services (housing as housing).
- Within an accountable system of care there is also a finite need for staffed specialty housing and time-limited residential treatment programs.
- The primary goal of housing reform will focus on the individual and emphasize expanding access to supported housing. Person-centered principles of recovery will guide the work.
- On the community systems level, the local mental health housing resources will be viewed as an asset to expand access to supported housing and to facilitate broader reforms (i.e., accountability, recovery focus).
- As restructuring progresses recipient satisfaction and recovery outcomes will be monitored.
- The new resource commitments in the 2007-08 budget will be used to facilitate restructuring.
- OMH will partner with affordable housing agencies to develop integrated, permanent housing.

OMH will work with stakeholders (local government, consumers, family advocates, providers) to incorporate flexibility into housing funding, regulation and oversight to introduce the above stated principles into OMH funded housing.

Action Implications

- Continue development of additional housing units:

  - in/via mainstream housing programs

  - via OMH resources

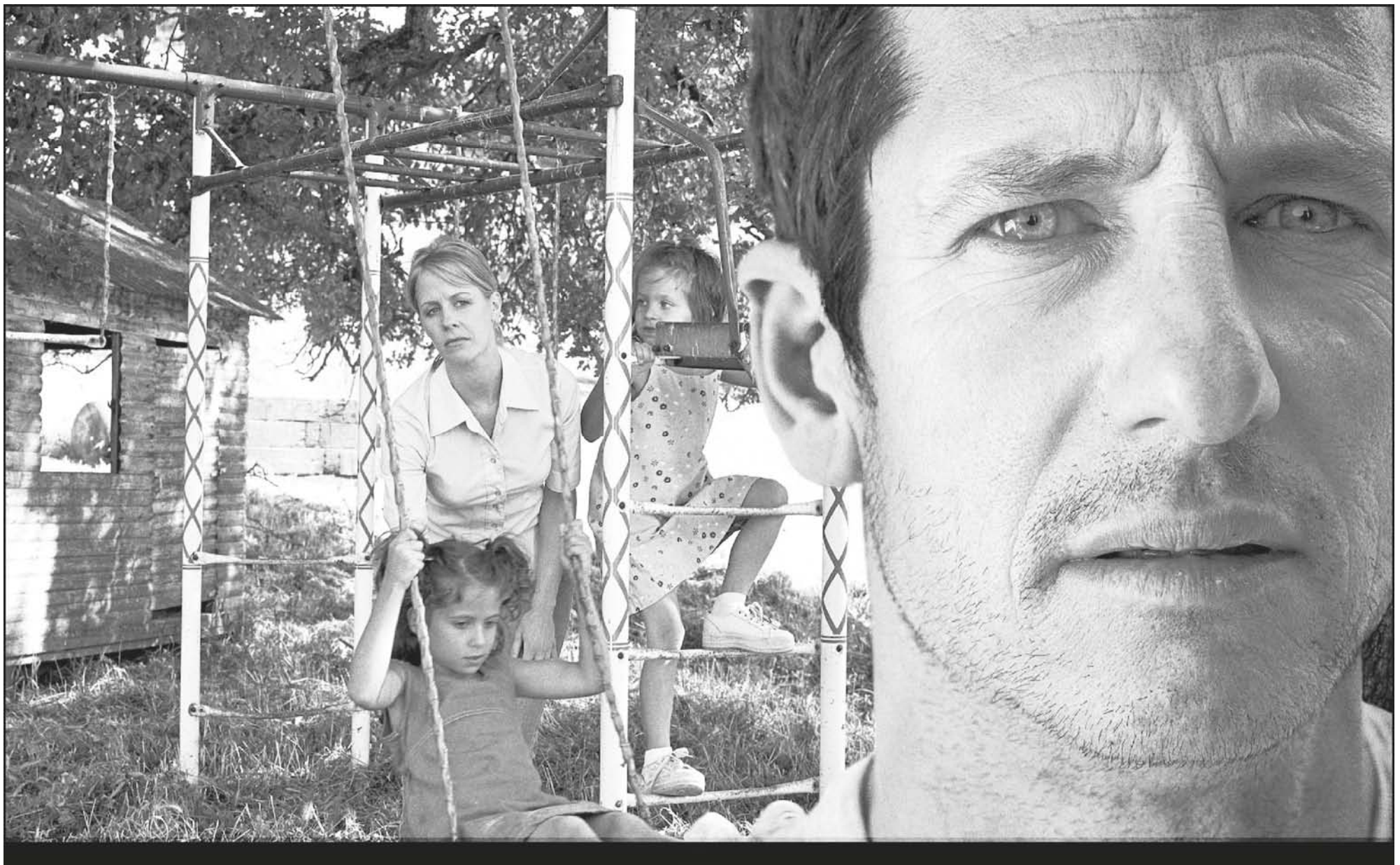
- Emphasize supported housing models and integrated mixed settings.
- Explore conversion of staffed housing programs to:

  - neighborhood-based supported housing

  - more specialized staffed housing

- Blend new OMH housing resources with existing OMH housing/residential programs to achieve reform.
- Balance these development goals with meeting needs of identified populations.
- Increase the supply/focus on treatment/support programs that help individuals with a mental illness choose, get and keep housing.

We welcome comments and feedback on these principles and look forward to working with all stakeholders in this ambitious and timely effort. Please send any feedback or suggestions to: Robert W. Myers, Ph.D., Senior Deputy Commissioner, NYS Office of Mental Health 8th Floor – Adult Services, 44 Holland Avenue, Albany, New York 12229, rmyers@omh.state.ny.us □



Open Access: for the patients, for the people

All too often, people who depend on public assistance are denied access to newer, safer, and more effective treatments for mental illness. This inability to obtain the treatment they need can trigger a pattern of deterioration — becoming unemployed, being hospitalized, imprisoned, and often ending up homeless. This destructive cycle is costly for taxpayers and devastating to the families of people with mental illness.

That's why Eli Lilly and Company continues to support open and unrestricted access to all available treatments for mental illness.

Scientific advances have resulted in medications that are effective in delaying relapse[1], provide more effective symptom control, fewer side effects, and offer longer-term treatment than in the past.

Give them access to the treatments they need, and give them hope for taking their lives back.

1 Fenton WS, Blyler CR, Heinssen RK. Determinants of medication compliance in schizophrenia: empirical and clinical findings *Schizophr Bull.* 1997;234:637-651.

Lilly
Answers That Matter.

Sponsored By
The Nassau County Department of Mental Health, Chemical Dependency and Developmental Disabilities and The Mental Health Association of Nassau County

The Mental Health News
Nassau County Section

Achieving Positive Outcomes

By James R. Dolan, Jr., DSW, LCSW
Assistant to the Commissioner
Nassau County Department of Mental Health, Chemical Dependency and Developmental Disabilities Services

James R. Dolan, Jr., DSW, LCSW

It began one day when I woke up with an ache in the middle of my stomach. I went to work, however, since the discomfort was only a mild concern. As best I could, I followed my usual routine, but by mid afternoon the discomfort seemed to be moving to my lower right quadrant. At this point, I still had not eaten, so I decided to have an apple. Soon thereafter, this seemed like a mistake because as I digested it, the discomfort I had turned into pain, and it was quite intense for a minute or so, until it subsided somewhat.

At this stage I still did not think there was any reason to worry. In fact, when I got home, I fit in a baseball catch with my son. As we played, however, I felt pain when I stretched or reached upwards. That evening I was beginning to think that I might need to see a doctor, but I decided to wait and see how I felt when I woke up the next morning.

When I did arise, the discomfort was still with me, so I determined that I had to figure out how to best describe to myself, and to a doctor, what I was experiencing. By this point the pain had clearly moved from my stomach, to what seemed like the lower right side of my intestines. Therefore, based on its location, and the type of sensations I was having, I thought that my condition would be referred to as intestinal cramping. With this phrase in mind, I proceeded to do some research on the computer. I typed in the words "intestinal cramping" but did not find a match; but what I did find is that the symptoms I had were referred to as "severe abdominal pain". It also stated that severe abdominal pain could be a medical emergency.

As the day progressed my condition worsened and the pain had gotten to the point that it was difficult for me to stand erect. I had probably waited too long, but I realized that I must get myself to an emergency room. So I drove to the hospital, that being a facility with an excellent reputation. When I entered the ER, however, I was surprised and disconcerted. The place looked very disorganized. Many people were sitting and some were standing, but what was most astounding was that there was nothing to indicate that a system was in place to assure that people received care in an ordered manner. I could not determine if there was a line to see the triage nurse, and if one existed, there was no indication as to who was first on line.

Off to the corner of this fairly large room there was a nurse who was sitting in a cubicle with a patient. I walked over to that area and I as entered the cubicle the nurse abruptly told me to go find a seat. I had no idea of where an arriving patient should sit, so I positioned myself nearby the nurse's cubicle. As I was waiting a number of new patients were arriving and everyone had the same disoriented expression that I must have had when I first came in.

The ER was now crowded, there was milling around and a number of people were expressing their pain through groans or complaints. In addition, one of the medical billing clerks was complaining that patients were using her chairs. The triage nurse must have realized that some order needed to be brought to the situation, so she eventually exited the cubicle area and walked around the ER to ask the patients for a brief statement describing their problem. When she got to me, I knew, based on my research, how to explain my condition. I told her that I have "severe abdominal pain". In response, she said that I would be the next patient to be evaluated by her.

There was another patient who was sitting beside me who could overhear my exchange with the nurse, so of course that person also told the nurse that they too have severe abdominal pain. When I now tell this story in a joking manner, I will state that the ER records for that night probably show that, at a particular point, the entire patient population reported that they had "severe abdominal pain".

The lesson learned, from a psychoeducation perspective, is that one must be conversant in the areas that relate to their own health care. Being able to describe one's condition, that being the precipitating factors, and the type of symptoms experienced helps to assure that one is diagnosed correctly and that responsive and timely care is received. Therefore, we need to understand ourselves and, to the degree possible, develop the knowledge that enables one to partner with health care practitioners in the treatment

see Positive Outcomes on page 42

Re-framing the Mental Health Needs of Iraq-era Veterans

By Steven Greenfield, Coordinator of Special Projects, Family Residences and Essential Enterprises (FREE)

The large number of military men and women returning from Iraq and Afghanistan who are experiencing mental health needs requires a shift in perception and perhaps terminology if we are to re-integrate these veterans effectively. First, the facts:

- 34% of returning veterans who have sought Veterans Administration health care have been diagnosed with a mental health disorder.
- During 2006, 99 confirmed suicides occurred among U.S. Army soldiers, the highest rate in 26 years. The suicide rate for veterans is twice the national average
- The incidents of domestic violence and marital break-up following deployment has reached alarming levels
- Post-traumatic stress disorder (PTSD) and depression are the leading diagnoses. Treatment is complicated by the high rates of traumatic brain injury which often results in mental illness-types of behavior
- Numerous studies have shown that the symptoms of depression and PTSD often do not become evident until months and even years later, often triggered by another event, or even a noise or a smell.
- Soldiers and families have continued to report a shortage of qualified mental health personnel within the VA, resulting in delays in care and inadequate treatment.

see Veterans on page 40

Headlines That Perpetuate Stigma

By Andrew Malekoff, Executive Director
North Shore Child and Family Guidance Center

Andrew Malekoff

Early in December there were several news stories about a man with a long history of mental illness who took hostages in Senator Hillary Clinton's campaign office in New Hampshire. A headline on the front pages of the *New York Post* read: "Loony Seizes Hostages in Hillary's Office." For two consecutive days the *New York Daily News* printed headlines that read: "Wacko Bombs at Hill's Office" and "Nut's Life from Hell."

By now you know that the headlines were referring to an individual with a known history of serious mental illness. Had there been no such history, then the derisive terms "loony," "wacko," and "nut" would have been a way of highlighting the lunacy of a desperate criminal act versus employing insulting stereotypes to label an individual with a mental illness. Although these headlines are about one man's criminal act, the effect of the language in the headlines is to discredit all individuals with mental illness.

So, you may be wondering, what is the big deal? Or, you may be thinking that you are reading another tired diatribe promoting political correctness. After all, the man did do something undeniably crazy. Nevertheless, although juicy headlines sell newspapers, there is collateral damage when stigmatizing language about individuals with mental illness is used. The headline writers cannot hide behind the crime. Language that appears in the headlines of popular newspapers do influence people's perceptions, attitudes and behavior. In this case they promote an undesirable stereotype and reinforce discrimination. The headline writers who write such headlines are the equivalent of schoolyard bullies except, in this case, the schoolyard is the entire New York metropolitan area and beyond, and the headline writers are more sinister and have more sway than the typical schoolyard bully does.

Stigma experts Bruce Link and Jo C. Phelan from the Mailman School of Public Health at Columbia University, offer insights on how stigma evolves. First, human differences are labeled and assigned undesirable characteristics that lead to negative stereotypes. Labeled persons are then put in distinct categories in order to separate "us" from "them." Finally, labeled persons lose status, and experience discrimination that leads to unequal outcomes in important areas of their lives.

Many individuals suffering with mental illnesses - children, teenagers and adults alike - have long histories of being at the butt end of cruel and stigmatizing taunts and jokes. Most people with physical illnesses, on the other hand, are beneficiaries of widespread understanding, sympathy and support. This is the reality despite the fact that neuro-imaging studies show that physical changes in the brain are associated to mental disorders. Headlines that use terms like "loony" and "wacko" reinforce the notion that mental Illness is a sure sign of dangerous and irrational behavior, versus a disease with a biological basis. Headlines that employ such language also reinforce the idea that mental illness is something that is "all in one's head" and can be controlled only if one has the moral fiber to do so.

It is shameful that the editors of major metropolitan newspapers choose to write about isolated criminal acts in order to promote negative stereotypes and reinforce stigma in people with mental illness. Clearly, simply telling the truth and informing readers about a desperate criminal act by a deeply troubled individual is less important to them than taking the opportunity to exploit and discredit people suffering with mental illness, through malicious name calling that reinforces fear, mistrust and stigma.

This column was previously published by the Anton Community Newspapers, 12/27/07. □

See Page 43 for Details

Transformations:
Made Possible by Supportive Housing at Saint Vincent's Westchester

By Maureen Italiano, Division Director
Saint Vincent Catholic Medical Centers
St. Vincent's Westchester
Residential Services

Much has been written about the cost-effectiveness of supportive housing. To be sure, this model of permanent, affordable, safe housing with flexible supports is a cost-saver when compared to the alternatives of shelters, hospitals or jails.

This article, instead, will focus on the priceless benefits – the transformation we have seen in the 75 tenants of Immaculata Hall, a supportive housing building, sponsored by St. Vincent's Westchester Residential Services, which opened in 2005 in Jamaica, Queens. The tenants, all adults with mental illness, most of whom had been staying in shelters or drop-in centers, had this to say about their experiences before coming to Immaculata Hall:

"I was used to having my own. Staying in shelter took that feeling away from me."

"I couldn't support my daughter when I was in shelter. She needed me then and she needs me now. Back then, I couldn't do anything for her."

"I never dreamed that someone like me could end up in shelter. Then I lost everything in that fire."

"Freedom has always been a particular thing with me. Being in shelter was not free."

Maureen Italiano

At the screening for apartment tenancy, and during the in-reach process, St. Vincent's managers assessed the prospective tenants and answered repeated, questions about house rules, leases, rent charges, and access to public transportation. The managers were mystified by questions such as "What is the curfew?" and "How much allowance do I get?" It took some weeks of reassurance and explanations to help the prospective tenants get comfortable with the idea of their own apartment and the concomitant rights and duties. In a nutshell: fewer rules, more responsibilities.

A visit to the building, as move-in drew near, elicited tears and shrieks of joy from the prospective tenants. The tenants' experiences of having lost everything, however, had taken a toll. Many were fearful, reticent, untrusting and guarded in their communications with staff. Engagement was a lengthy process.

More than 70% of our tenants have now been with us for more than two years. For many, this means that their tenancy in supportive housing, and their tenure in the community, has been longer than their shelter stay.

The staff members are eyewitnesses to an astounding blossoming: a tenant who has completed her undergraduate degree and has applied for admission to social work school; another who has been blessed with a new granddaughter and, due to her stable housing, can offer her home and skills as a babysitter. Tenants have taken on the direct responsibility for the security of the building by providing front desk services; another tenant, now with stable housing and in recovery, has become a resource to a sibling in failing health. Tenants will stop in at the office to inquire about a neighbor who is hospitalized; and one tenant always prepares more food than she can consume so that she'll have some to share with her neighbors. There are even tenants who complain vociferously if they are dissatisfied with a policy or a building service—as it should be.

Supportive housing is not a utopia. The scourges of addiction and crime continue their ravages in some of our most beloved tenants. We work daily to make options for health and recovery apparent to them. Our tenants offered these comments about their experience at Immaculata Hall:

"Being in supportive housing has been such a relief."

"Now I decide when I eat and what I eat. I come and go as I please."

"I'm in charge of my life again, here."

In organizing my thoughts for this article, I considered a metaphor comparing the rooting and blossoming in supportive housing to that in a cutting of a houseplant that can root in a glass of water and then, planted in soil, grows and blossoms into a new plant. However, there is something disrespectful to the tenants in that metaphor. After all, the power to change and grow is within the tenant, all we do is provide the medium. In this setting of stability, safety and support, tenants grow into their God-given potential. With the medium of respectful, compassionate care, the blossoming is thus set in motion.

It's a joy to be a small part of it.

St. Vincent's Hospital Residential Services provides a full continuum of residential and housing options—from transitional community residences to permanent housing—so that persons with mental illness and other special needs can live as independently as possible. Residential Services provides housing options in four boroughs of New York City and in Westchester County. For more information, please call (718) 818-5055. □

We are Now Accepting Articles and Advertising for our Upcoming Summer 2008 Issue:
"Employment for People With Mental Illness" ~ Deadline: May 1, 2008
Contact Us by E-mail at mhnmail@aol.com or by Phone at (570) 629-5960

The Bridge from page 13

developed in recognition of the special needs of the thousands of people with serious mental illness in the State and City criminal justice systems.

The model begins with an in-reach component at Bedford Hills in which Bridge staff work regularly at the prison. In-reach activities, offered in collaboration with Bedford Hills mental health staff, include screening potential clients, who, in addition to their mental illness and substance abuse diagnoses, are nearing release. Bridge staff engages potential clients, preparing them for their release and move to the Iyana House residence.

The Iyana House building contains 16 newly renovated studio apartment, as well as staff office and program space. There is 24-hour residential staffing and a link to the OASAS-licensed Medically Supervised Outpatient Treatment Program at The Bridge, which is licensed specifically to serve persons with severe co-occurring serious mental illness and substance abuse.

Mental health and vocational services are also available at The Bridge for Iyana House clients, and a number of clients have used the vocational programs to prepare for and secure jobs in the community.

The clients also participate in a special trauma treatment program, *Seeking Safety*. This group-modality program focuses on both the traumas related to experiences in the criminal justice system, as well as earlier life traumas.

The project is fortunate in having a strong working partnership with the State Division of Parole. A dedicated Parole Officer, who has special knowledge and understanding of mental illness, works with all of the Iyana House clients. Two additional partnerships support the program: The State Office of Mental Health provides funding for rents and staffing, and services funding is supplemented with a HUD McKinney grant.

Still in the development phase and expected to be launched when residential construction is completed in the Spring of 2009, Project InPACT is a partnership between The Bridge and Bellevue Hospital targeted to chronically homeless persons with serious mental illness and substance abuse who continuously cycle through the hospital, shelter, street and criminal justice system. This is a notable experiment in which a community-based agency and municipal hospital are joining together to offer a comprehensive residential and rehabilitation program to interrupt the cycle of homelessness and hospitalizations with a hope that clients will embark on a positive path of recovery. Akin to the *sectorization* model of mental health services used in many European countries, Project InPACT envisions a single, integrated team working with a cohort of clients as they move from inpatient care to community residential settings.

Borrowing from the Iyana House experience, a major component of InPACT will be the in-reach team that will engage clients during their inpatient stay at Bellevue. The team, comprised of Bridge and Bellevue staff, will work intensively with clients to form a therapeutic alliance to ease and promote sucessful transition from the inpatient unit to the InPACT residence. The residence, being built with tax-credit financing arranged by State OMH and to be licensed by OMH as a CR -SRO, will have shared three-bedroom apartments. On-site substance abuse and vocational services will be offered with linkages to other service providers in the community. Once at the residence, the program participants will continue to work with the integrated Bridge/Bellevue team. Back-up psychiatric services will be provided at Bellevue.

The three models described in this article reflect some of the strategies that The Bridge has developed to address the needs of the special populations that have emerged in the mental health system. Doing so requires a good deal of creative thinking, exploring and accessing multiple funding streams, and forming strategic partnerships to provide the services and supports that are needed to assist clients on their path to recovery. □

Visiting Nurse Services in Westchester's In-Home Mental Health Care Program: A Holistic Approach

Staff Writer
Mental Health News

It is becoming increasingly understood and appreciated how much healing and comfort extend beyond the physical. There is a decided mental well-being component as well, recognized by VNSW with the formation 8 years ago years ago of its program of psychiatric healthcare – in the patient's home, for maximized comfort and effect.

Coordinating these activities is Lisa Sioufas, LCSW-R, ACSW, Manager of the Mental Health Program. "Since I became manager last year," says Lisa, "we've been seeing a significant increase in referrals in both our elderly population and chronically mentally ill population. The elderly are being seen with diagnoses of depression and anxiety related to the changes they're going through, either because of a new health diagnosis, a change in their state of health and ability to care for themselves or a spouse in the home. It is vital for us to monitor their medical illnesses and their complex interaction with the individual's mental health. As they age, we're seeing an increased rate of co-morbidities in the mental health population – cardiac illness, pulmonary illness and diabetes – and we offer various specialty programs to help address these concerns together with their mental health treatment. The need for VNSW's coordinated, quality home-based healthcare services is ever-more compelling."

These services fall generally into 2 categories, long-term for chronic patients and short-term, in the area of 2 to 3 months, for acutely ill patients. The decision is based on a particular patient's diagnosis and history. According to Lisa, "Long-term patients tend to have a history of non-compliance with their medications and need hands-on management to make sure they take their medications, with an often-achieved goal of 100% compliance. We also follow up with their appointments and go to their programs."

"Acute patients," explains Lisa, "tend to be older. They may or may not have had psychiatric diagnoses inthe past, and generally are new to mental heath treatment in the community. They may be under the care of a psychiatrist or are on new or changed medications. We can see them for a shorter period of time, ensuring that their medications are taken, that they're effective or changed if needed, that side effects are identified early, and that the patients keep their appointments. Our nurses may additionally help these patients find a practitioner or other resources in the community."

Lisa's mental health team is comprised at any given time of about 15 nurses, full and part time, covering all of Westchester County. Once the team receives referrals from other professional caregivers – a nurse from the team is assigned to do an evaluation, and a plan of care is developed.

VNSW's mental health team receives referrals from medical doctors, psychiatrists and community mental health programs. On a typical day, Lisa will review the referrals, assign the nurses, problem-solve with the nurses regarding the patients they're currently seeing, help them develop and manage the care plan, supervise them and go out with them into patients' homes. "Because we're dealing with such a senior population," says Lisa, "one particular diagnosis that we're seeing more and more is dementia. For Alzheimer's and other forms of dementia, it is urgent that we keep up with the state of the art in medications, and continuing education of our nurses and staff. Looking for opportunities to access this training is becoming an increasing part of our routine."

The VNSW Mental Health Care Team: Left to right: Rear row, Program Manager Lisa Sioufas, Carol Griffiths, Penny Parham, Margaret Burns, Zef Hot, Miriam Cruz-Soto and Juan Antonio; front row, Judy Bogart and Annie Balzer. Not pictured: Patricia LaMorte, Gerri McGuire, Mary Jody McKeever, Hugh McKenzie, Samuel Thompson, Rosamund Duarte Bovelle, Edward Lewis and Carlos Monserate.

Lisa emphasizes the importance of VNSW's program as an adjunct to community mental health services, as opposed to a segregated, freestanding operation, and of the program's flexibility. "We provide daily visits 365 days per year, if needed. We work collaboratively with supportive and intensive case managers. Our flexible visitation schedule is designed to accommodate patients' day treatment attendance."

"The nurses on this mental health team are unsung heroes. What they do for the patients to enable them to remain at home is absolutely incredible!"

She points with professional pride to the program's effectiveness, citing as an example that the re-hospitalization rate for behavioral health needs for the program's primary psychiatric diagnosis (depressive disorder, schizophrenic disorder, affective psychosis, neurotic psychosis) is under 1 percent.

And she points to various caring, sensitive features that make this program special. "We have the ability to set up and monitor locked medication boxes," Lisa explains, "to support our objective of 100 percent compliance. We provide free support groups at assisted living facilities and senior centers to help address mental health needs of older adults. We employ multicultural and bilingual mental health nurses and social workers. Our experienced psychiatric social workers work with our mental health nurses to assist with accessing entitlements, community resources and appropriate housing. Our staff is available to assess patients at inpatient facilities so that services can begin immediately after discharge and ensure continuity of care. Our patient," says Lisa, "is always our partner – we work together toward recovery and reaching a maximum level of independent functioning. Our staff supports and encourages patient independence and our services strengthen care coordination."

Patient independence and the ability for the patient to recover at home are among the primary objectives at Visiting Nurse Services in Westchester. VNSW's services allow individuals with all levels of mental illness the ability to remain in their homes and involved in the community mental health programs that are an integral part of their treatment. The agency's ability to monitor psychiatric symptoms and medication compliance – in addition to teaching the skills needed by each individual to help manage their specific psychiatric needs – empowers patients to obtain their optimal level of independent functioning/living. VNSW's nurses regularly observe individuals in their homes, enabling the agency to provide feedback to caseworkers on the appropriateness of the patient's housing, and often to assist in obtaining housing with increased or decreased supportive services. Typically, supportive housing provides two supportive contacts a month and VNSW can supplement these services to ensure the patient's ability to remain at home.

Additionally, VNSW's nurses provide support to patients during transitional, stressful periods related to changes in housing. They work collaboratively with the Department of Social Services personal care unit to ensure that patients receive needed support with activities of daily living. VNSW's services are equivalent to on-site nursing, since they are provided as-needed in patients' homes, and, where patients are not in independent housing, the agency works closely with housing staff.

VNSW's services also include high-level support for various ancillary conditions. "For example," explains Lisa, "the mental health population exhibits a high rate of smoking. We introduce such patients to VNSW's smoking cessation program, not only because decreased smoking leads to improved health, but also because it increases patients' desirability as tenants in private housing. For patients with diabetes, we have a mental health nurse who is also a certified diabetic specialist."

Listening to Lisa talk about her calling, you clearly hear her concern about the growing elderly population, as well as the chronically mental ill. She stresses the need to keep evolving strategies to assist them in staying at home, and identifying resources in the community to help achieve that goal. You also hear a heart-warming appreciation of her team.

Says Lisa, "Although it's largely true of nurses in general, the nurses on this mental health team are unsung heroes. What they do for the patients to enable them to remain at home is absolutely incredible!"

For more information call (914) 682-1480, ext. 648, or e-mail MentalHealth@vns.org. □

Industry Statistics

- 70% seriously mentally ill inpatient are discharged without outpatient care
- 20% re-hospitalized in 30 days
- 41% hospitalized in 180 days

VNSW Statistics

- 10,080 home visits 2007
- 513 patients served 2007
- VNSW works with over 30 insurance plans, 20 psychiatric facilities, numerous private physicians and community mental health agencies

Mental Health Treatment in Westchester

The VNSW Mental Health Home Care Program provides:

- **Adjunct service to community mental health programs**
- Structure in the home environment.
- Assistance with home management focusing on inadequate levels of functioning, hygiene issues and compliance with medication regimen.
- Administration of I.M. long-acting psychotropics.
- Liaison with the community treatment team informing them of changes and important symptoms that may indicate decompensation or need for changes in the treatment plan.
- On-going assessment of all health needs relevant to the individual's diagnoses.
- Consultative services for the individual whose primary diagnosis is medical/surgical in nature, however, due to difficulty coping with illness, requires mental health intervention.
- Coordinated home care services for non-compliant individuals and those with complex combined mental health/physical needs that present ongoing problems.

Program Features

- Facilitate psychiatric care from in-patient to home & community
- Prevent in-patient psychiatric hospitalization
- Decrease symptoms & improving functional ability
- Improve knowledge base about medications, illness, coping & staying well
- Improve medication compliance
- Access community services

The Big Picture

Visiting Nurse Services in Westchester (VNSW) believes in a holistic, broad approach to the treatment of mental illness, addressing the "whole person's" life circumstances and environment. VNSW fields nurses with advanced psychiatric training, and in some cases, advanced degrees in related fields. The staff provides home visits for assessment, evaluation and development of a treatment plan with interventions related to mental health issues in conjunction with medical/surgical needs. This program meets the total health care requirements of individuals utilizing a case management approach led by a psychiatric nurse specialist. Adjunct services complementing the mental health component include psychiatric social workers, home health aides, medical/surgical nurses and relevant rehabilitation therapies.

The program serves the elderly, adults, adolescents and children.

To receive further information or make a patient referral, contact:

Lisa Sioufas, LCSW-R, ACSW • Mental Health Program Manager
(914) 682-1480, Extension 648 • e-mail: MentalHealth@vns.org

Visiting Nurse Services in Westchester
Home. Health. Care.

360 Mamaroneck Ave.
White Plains, NY
1-888-FOR-VNSW
www.vns.org

VNSW services are covered by Medicare, Medicaid and other health insurance plans.

WJCS
Westchester Jewish Community Services

When you need help, Westchester Jewish Community Services is here for you

WJCS offers comprehensive mental health services

Out-patient Treatment for People of All Ages

Specialized services for individuals with developmental disabilities

Intensive Community–based Services for Children and Their Families

Learning Center for children and adults

Geriatric Care

Continuing Day Treatment

Mobile clinical services

Case management

Social Clubs

COMPEER

All services are offered on a non-sectarian basis

Call WJCS at (914) 761-0600

HDSW

Human Development Services of Westchester

Creating Community

- ***Human Development Services of Westchester*** **serves adults and families who are recovering from episodes of serious mental illness, and are preparing to live independently. Some have had long periods of homelessness and come directly from the shelter system**
- ***In the Residential Program,*** **our staff works with each resident to select the level of supportive housing and the specific rehabilitation services which will assist the person to improve his or her self-care and life skills, with the goal of returning to a more satisfying and independent lifestyle.**
- ***The Housing Services Program,*** **available to low and moderate income individuals and families in Port Chester through the Neighborhood Preservation Company, includes tenant assistance, eviction prevention, home ownership counseling, landlord-tenant mediation and housing court assistance.**
- ***Hope House*** **is a place where persons recovering from mental illness can find the support and resources they need to pursue their vocational and educational goals. Located in Port Chester, the Clubhouse is open 365 days a year and draws members from throughout the region.**
- ***In the Case Management Program,*** **HDSW staff provides rehabilitation and support services to persons recovering from psychiatric illness so that they may maintain their stability in the community.**

HDSW
930 Mamaroneck Avenue
Mamaroneck, NY 10543
(914) 835 - 8906

HOPE HOUSE
100 Abendroth Avenue
Port Chester, NY 10573
(914) 939 - 2878

Mental Health Association in Putnam County, Inc.

1620 Route 22
Brewster, NY 10509

Promoting a vision of recovery for individuals and families coping with mental health issues

- Peer-Run Information and Referral Warmline
- Consumer-Drop-In-Center
- Peer Bridging Program
- Self-Help Groups
- Education and Support for Family Members
- Community Outreach and Education

all of our services are available free of charge.. call us at

(845) 278-7600

Opportunities to Heal Grow and Recover

PUTNAM FAMILY & COMMUNITY SERVICES INC.

Putnam Family & Community Services, INC.

is a private, non-profit, multi-service agency providing comprehensive mental health and chemical dependency services to Putnam County and surrounding areas.

Mental Health Services

- Mental Health Clinic
- Coordinated Children's Services Initiative
- Children's Case Management
- Specialized Mobile Mental Health Teams for
  - Seniors
  - Concurrent Chemical Dependency
  - HIV/AIDS

Chemical Dependency Services

- Chemical Dependency Treatment
- Community Education and Outreach
- School-Based Prevention

Rehabilitation Services

- Continuing Day Treatment
- Adult Case Management

Main Office: 1808 Route Six • Carmel, NY 10512
website: www.PFCSinc.org
Tel.: 845-225-2700 • Fax: 845-225-3207

A Home of Their Own

By Andrea Kocsis, LCSW
Executive Director
Human Development Services
of Westchester (HDSW)

There are families headed by a person with mental illness that are currently living in Westchester shelters. There are other similar families who are living in the homes of family members, often moving from couch to couch. Human Development Services of Westchester is a mental health agency that can help these families move into homes of their own with rent subsidies provided by the New York State Office of Mental Health Supported Housing Program or by the federal Department of Housing and Urban Development through its Shelter Plus Care Program.

All these families have young children who need the comfort and security of a home of their own, and the stability that comes when their parent is supported by the case management services that HDSW provides. We presently serve over 45 families, with over 125 children, in our Supported Housing Programs, but there are many families still waiting.

Each family we serve includes a parent, usually a mother, who is recovering from mental illness and who also may have issues with substance abuse. Many families face multiple problems and have already experienced several unsuccessful housing placements. These parents are in need of mental health as well as primary health care services; they are low-income, unemployed and usually have not achieved educationally.

Historically, the children in these families have been underserved. As a result of family crises, lack of resources, and frequent moves, the children have "fallen through the cracks" and have many needs

Andrea Kocsis, LCSW

that are unmet. For many of the children, the HDSW apartment is the first stable environment they have experienced. While the parent is HDSW's primary client, our staff evaluates the needs of each child in the family and provides support services, activities and equipment, and linkages to resources in Westchester's system of children's services. In the past few years, HDSW has experienced unprecedented growth in its Supported Housing Program. However, as our funding barely covers the needs of the parents in our program, we are frequently unable to provide for the costs of extremely important interventions for the health and well-being of the children and of the family as a whole.

HDSW has found that the children living in these households often need assistance with health care, schooling, social, recreational, and spiritual needs. The children are particularly disadvantaged and are at an environmental and genetic risk of developing a mental illness. Mental illness is reported to be afflicting children at an increasing rate. The rate of schizophrenia in the general population is 1%. If one has a parent or sibling with schizophrenia, the risk rises to about 10%. If both parents have schizophrenia, there is a 40% chance that their child will also have schizophrenia.[1] The average age of onset for persons with bipolar illness has fallen in a single generation from the early 30s to the late teens. Experts estimate that a million preteens and children in the U.S. may suffer from the early stages of bipolar disorder. "Experts believe that children are being tipped into bipolar disorder by family and school stress, recreational drug use, and a collection of genes that express themselves more aggressively in each generation…children with one bipolar parent have a 10% to 30% chance of developing the condition; a bipolar sibling means a 20% risk; if both parents are bipolar the danger rises as high as 75%," explain Cray and Ressner.[2]

Bipolar disorder, schizophrenia, depression, and certain anxiety conditions are powerfully influenced by surroundings. If a child is raised in a steady and stable home the odds of his developing a mental illness are reduced.[3] Healthy lifestyle management and family support are among the most important interventions to address mental illness in children and teens. Through the Supported Housing Family Program, HDSW strives to maintain the stability of the family unit and reduce the risk of mental illness' occurring among its children. In addition to assisting families to access housing, HDSW offers case management services to the parent. These include parenting training and stress reduction education, life skills training for successful reintegration into the community, and linkages to emotional, educational and recreational resources for the children.

After over 11 years of our Supported Housing Program operation, an impressive 88% of our families continue to live successfully in the community, a testimony to how seriously the parents work on their recovery. For the families and for our staff, this is one of the most exciting and gratifying outcomes that we have experienced in our agency's thirty-nine years of service.

Most importantly, however, this program succeeds because:

- There is as little disruption as possible for the families – they are able to move from the shelter directly into an apartment of their own without having to experience transitional housing.

- There is as much empowerment as possible – the families are able to select the area where they want to live, and can reject specific apartments until they see one in which they will feel comfortable living. And, if they find, with time, that they are not feeling safe or satisfied with this living arrangement, they can work with their housing case manager to choose and move to a more acceptable apartment. This degree of choice is extremely valuable to the families.

- The program operates with a "housing first" philosophy – families are admitted to and are able to remain in their housing whether or not they wish to engage in treatment for their psychiatric illness (or for substance abuse issues, if present). Our staff, of course,

see A Home on page 40

Community-Based Family Care for Adults

By Mary E. Barber, MD
Director, Community Services
Rockland Psychiatric Center

Family Care is the oldest form of housing for adults with mental illness in New York State, going back to 1931. Middletown Psychiatric Center, now part of the Rockland Psychiatric Center (RPC) System, was an early participant in Family Care, going back to the 1930's, and continues to run a large program today. For many years after its inception, Family Care homes provided the only option for discharge for patients leaving state hospitals who could not return to their family of origin. It also remains the least expensive form of mental health housing.

The Family Care program was modeled after the foster care system for children. Families in the community welcome adults with mental illness into their homes, and are reimbursed for room and board. The family is expected to integrate residents into their own household rather than simply giving them meals and a place to sleep. Each Family Care provider is screened and receives training by their local program. Case managers visit the family and residents to provide support, ongoing training, assistance, and monitoring. Residents are expected to be at work or in treatment services during the day. Individuals in Family Care homes may stay for as long as they need.

At the program's height in the 1980's there were about 2,400 Family Care residents in New York State. Today there are about 1,500 residents in 500 homes across the state. Rockland Psychiatric Center's Family Care program includes 155 residents in 31 homes in Orange and Sullivan Counties, and 20 residents in 6 homes in Rockland and Westchester Counties.

Mary Cuzo is the director of Family Care for Rockland Psych Center's program in Orange and Sullivan Counties. "We have a great group of families, and a great group of staff, and that's really what makes it work," she says. "Most of our referrals for new homes come from word of mouth, from providers referring other families they know through work, or through church." Cuzo supervises a staff of 3 case managers, 2 1/2 nurses and two account clerks to oversee the 155 Family Care residents in her program. Hedy Villanueva, who has been directing RPC's Family Care Program in Rockland and Westchester Counties for over 20 years, agrees with Ms. Cuzo. "Many of our families have been with us for a long time. They are very experienced with the work, and we know them well."

One Family Care provider in Otisville in Orange County, NY, is proud of the home and support she's given to different residents over the years. She regularly puts residents in front of a carved, full-length mirror sitting in the sunroom of her antique-filled home. "Look at yourself, you're a beautiful person!" she tells them. And the men and women, who may have never heard themselves described this way before, slowly begin to take pride in themselves. Another Family Care provider in Middletown, Orange County, NY, gets a lot of satisfaction out of watching the people sharing her home as they grow and work toward recovery from their mental illnesses. "I love doing this work," she asserts, sitting in her living room surrounded by photos of her children and husband.

In sum, Family Care has many advantages for individuals and for the system as a whole: a home-like setting, stability of housing, cost effectiveness, and individual choice in participation in programs to support recovery. Rockland Psychiatric Center is in the process of expanding its Family Care program in Rockland and Westchester Counties. If you know of an interested family, have them call (845) 326-8000 for more information. □

Mental Health News ~ Health and Wellness Forum

Preventing Alcohol Poisoning

By Colm James McCarthy
Emergency Medical Technician

Colm James McCarthy

The irresponsible consumption of alcohol is a serious problem that is not only dangerous, but can lead to death. This most frequently occurs during binge drinking. Drinking more than five drinks in a row for men and four drinks in a row for women is classified as binge drinking. In order to avoid irresponsible and binge drinking it is necessary to know how your body responds to alcohol, what constitutes a drink, and what personal factors can increase your risk of drinking dangerously.

There is no safe alcoholic drink. Beer, wine, and alcohol can all cause intoxication. Their ability to do so is related only to their alcohol content. While each drink is different, they can all be compared to each other based upon their alcohol content. Generally speaking, the alcoholic content of a 12 ounce beer is comparable to a 5 ounce glass of wine or a 1.5 ounce shot of hard alcohol. Chemically, each type of alcohol is equally dangerous. Hard liquor is the most dangerous because of how quickly and easily it is to consume a lethal amount since it is so concentrated. A shot of Bacardi 151, 75% alcohol by volume, is the equivalent of just under two drinks; half way to binge drinking.

While alcoholic drinks are easily comparable, people are not. Every person responds differently to alcohol based upon a wide variety of individual characteristics. How "drunk you are" is based upon your blood alcohol content, the ratio amount of alcohol to the amount of blood in your body. Rapid consumption of strong drinks on an empty stomach is the fastest way for anyone to get alcohol into the blood stream. Smaller people feel the affects of alcohol more so than larger people. Women, on an ounce to ounce basis of any drink, are more affected by alcohol then men. In addition, women are at a greater risk than men in contracting an alcohol related illnesses such as cirrhosis of the liver and brain damage. A woman's risk of breast cancer also increases linearly with increased alcohol consumption.

Medications never mix well with alcohol. Never drink alcohol if you are taking medications unless you are absolutely certain it is safe. This rule applies to both over the counter and prescribed medications. Tylenol and drugs containing acetaminophen are lethal when taken with alcohol. When in doubt about the interaction or risks of alcohol and any medication, prescribed or over the counter, consult your doctor. There are almost no medications used for treating mental health related illnesses that can be safely taken with alcohol.

The signs and symptoms of alcohol poisoning are easily identified and usually appear in a predictable order, unless the alcohol was consumed very quickly. In stage 1, when intoxication first becomes problematic, we find that there is difficulty with speech and fine motor movement, swaying from side to side and dropping small objects. Drinking should cease now and the individual should begin to sober up. Stage 2 occurs if drinking continues and results in impaired judgment, difficulty walking, stumbling, and the beginnings of nausea. If one continues to drink and enters stage 3 the body begins attempting to remove the alcohol by causing vomiting, dry heaving despite an empty stomach. In addition in severe cases there may be a complete loss of consciousness, choking risks, and possibly death.

Prevention is the best approach. Fortunately alcohol poisoning cannot happen if you are not drinking alcohol. This is an easy problem to prevent, don't drink. If you do decide to drink, do so slowly, never on an empty stomach and know your limits. Surprisingly, drinking alcohol leads to significant dehydration. When you, or those around you, begin to notice symptoms of intoxication switch to a non-alcoholic drink such as Gatorade, juice, or water which will help hydrate

see Alcohol Poisoning on page 37

What Else Works with Medications

By Richard H. McCarthy, MD, CM, PhD
Research Psychiatrist

Richard H. McCarthy, MD, CM, PhD

When I started this column years ago I picked the title, Working with Medications because it had two meanings. First of all it described part of what I do each day as a psychiatrist. Medications are tools that I use to help people solve problems. I think of medications in much the same way that I think of the tools that an orthopedic surgeon might use during an operation. The surgeon will use an osteotome to shape the bone as needed in an operation. An osteotome is a big name for a stainless steel chisel and it is not terribly different from a chisel that a carpenter might use. It is a fairly unsophisticated, possibly crude instrument, which can do a lot of good in the hands of a skilled practitioner. Medications are very much the same. As sophisticated as our medications are they are still somewhat crude. They are not magic bullets that speed directly to the site of the problem where they wipe it out. All medications circulate thorough the body and have multiple effects but, in general, do more good than harm. All drugs have been developed to be this way and psychiatric medications are no different than any other medicine. So when I am working with medication, I know that I am working with a tool and it is part of my job to use that tool properly.

The patient is in very much the same position. The patient's medications are tools that can help solve some but not all problems. The "some but not all" is the most important part of the previous sentence. Medications are necessary for most patients with serious illnesses to recover, but they are not sufficient. That is why the patient also must work with the medication and not against it. Recovery is very hard work, and medications will not make your life perfect without effort. No matter how good a medication might be, it is always possible to un-do or overwhelm the benefits that medications may offer. The easiest way to do this is through the use of drugs or alcohol. There is no such thing as a perfectly safe or benign drug. This includes "natural remedies", over the counter medications, prescribed medications from physicians and "street drugs", including marijuana. All medications have adverse effects: if something is powerful enough to help, it must also be powerful enough to harm. The use of drugs or alcohol work against medications, when one should be working with them instead.

There are other things that work with medications. There is growing evidence that some forms of psychotherapy can be very helpful for people with significant mental illnesses. These treatments, with the best evidence supporting their use, are the so-called "Cognitive Behavioral Therapies" (CBT). These treatments are all based on the proposition that our thoughts cause our feelings and behaviors much more than anything else. Therefore, in order to change our lives, we do not need to change the world we are in, we only need to change the way we think. CBT seeks to change the way we think so that we will feel and act better. This is a very direct approach and is very problem focused; much more directive than traditional therapies; almost always involves "homework", where the patient works on the newly learned ways of thinking between session. This treatment feels more like school than traditional psychotherapy. Another treatment that works well with medication is Cognitive Remediation. This treatment is relatively new, somewhat "school like" and tends to also focus on how people think. New York State published a good, publicly available handbook about Cognitive Remediation that is available on line at http://www.omh.state.ny.us/omhweb/cogdys%5Fmanual/cogdyshndbk.htm.

One reason we want to use whatever else we can in order to work with medications and avoid working against them is that we physicians, probably more than patients, want to use the lowest amount of medication necessary to help a person recover,. Working with medication, rather than against them allows us to achieve this goal. □

Mental Health News 2007 Campaign Raises Vital Funds

Many Thanks to All of Our Supporters

Individual Donors

Paula Barbag

Dr. Peter D. Beitchman

John F. Butler

Dr. Peter Campanelli

Georganne Chapin

Susan Clayton

Michael B. Friedman, LMSW

Steven J. Friedman

Mary Guardino

Mary E. Hanrahan, LCSW

Anne G. Katz

Andrea Kocsis, LCSW

Dr. and Mrs. Leo Leiderman

Dr. Bob Lichtman

David H. Minot, BA

Ira H. Minot, LMSW

Peg Moran, LMSW and Jim Bopp

Dr. Barry B. Perlman

Debra Del Toro-Phillips

Swami Deyananda Saraswati

Dr. Newton M. Schiller

Janet Z. Segal, LCSW, BCD

Dr. Alan B. Siskind

James L. Stone

Martha Adams Sullivan

Alan Trager

Dr. Sam Tsemberis

Eileen Wentz

Marlene H. Wertheim, LCSW

Vera E. Winskill

Many Anonymous Donors

Grant Support

Bristol-Myers Squibb

Nassau County Department of Mental Health, Chemical Dependency and Developmental Disabilities

New York City Department of Health and Mental Hygiene

Orange County Department of Mental Health

Westchester County Department of Mental Health

Advertising Support

Antonio Abad, MD

Baltic Street AEH

Bilingual-Bicultural Clinical Services

Bristol-Myers Squibb

Coalition of Behavioral Health Agencies

Columbia University

Eli Lilly and Company

Family & Children's Association

Federation of Organizations

FEGS Health and Human Services System

Four Winds Hospital

Garfunkel, Wild & Travis

Hall-Brooke Behavioral Health Services

Hispanic Counseling Center

Human Development Services of Westchester

The Guidance Center

Institute For Community Living

Jewish Board of Family & Children's Services

LIJ North Shore Hospital

Long Island University - Rockland

Mental Health Association of Nassau County

Mental Health Association of New York City

Mental Health Association of Putnam County

Mental Health Association of Rockland County

Mental Health Association of Westchester

Mount Sinai Medical Center

NAMI Westchester

New York City Department for The Aging

New York City Law Department

New York - Presbyterian Hospital

New York State Psychiatric Association

Norwalk Hospital

Peninsula Counseling Center

Psychiatric Society of Westchester

Putnam Family & Community Services

R.G. Psychological Services

Search For Change

SLS Health

South Shore Child Guidance Center

St. Vincent's Hospital Westchester

The Performance Institute

Westchester County Department of Mental Health

Westchester County Medical Center Behavioral Health Services

Westchester Jewish Community Services

Douglas K. Stern, Esq. and Carolyn Reinach Wolf, Esq.

If we left off your name from this list please let us know

We wish to thank our 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 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 will soon include providing our award winning format to the autism community with the upcoming premier of *Autism Spectrum News*.

Alcohol Poisoning from page 36

your body and aid in recovery. Don't drink coffee; it won't help you sober up and will cause increased dehydration. If stage 2 arrives, do not force or induce vomiting. Begin drinking fluids and stop drinking alcohol immediately. If you insist on drinking beyond stage 2 and towards stage 3 have a friend call for an ambulance as you ask the bartender for another drink. While you do not need the drink, you will need the ambulance. For individuals falling asleep or passing out or vomiting do not allow them to lie on their back. Vomiting in this situation could cause death by choking. Instead, place them on their side with the top leg's knee posted on the floor, head resting on the bottom arm angled down, and top arm on the floor in front of the hips. Don't leave them alone longer than it would take to call an ambulance. If someone has passed out from drinking and cannot stay awake they require constant observation or an ambulance. While they may be angry at you the later for calling the ambulance, at least they will be alive. The only real treatment for alcohol poisoning is the removal of alcohol; this is why your body vomits. The only real cure for alcohol poisoning is stopping the consumption and letting the body remove the alcohol from the system. Cold showers and other treatment of that nature don't do anything but increase risks of other problems like hypothermia.

Alcohol is only as dangerous as you let it become. Plan ahead; know how many drinks you can have responsibly and never drink and drive. Alcohol poisoning is simply the ignoring of the many signs your body provides. Listening to your responsible friends and your body makes avoiding alcohol poisoning easily accomplished. □

A Home from page 35

will consistently encourage and support any parent to access or return to treatment. Frequently, the very experience of attaining stability in their housing, the comfort of having a home again, enables parents to have hope for their future and to see treatment as a way to strengthen themselves and move forward.

- The housing case management services are comprehensive and available as needed – case managers work to engage residents in rehabilitation and healthcare services consistent with their desire, tolerance and need. Families may be seen every day or once a month, children's needs are assessed and addressed, employment potential is evaluated, and linkage to vocational and/or educational resources is provided, etc.

HDSW serves an additional 140 individuals in its supported housing programs, including 30 persons in WestCAREs, a mobile housing and clinical treatment program in collaboration with The Sharing Community and St. Vincent's Hospital. Some supported housing residents choose to have housemates, but most live in their own individual apartments in neighborhoods throughout Westchester County. HDSW serves another 66 residents in its Transitional Residential Program, and many of these persons eventually move on into supported housing with HDSW or with one of the several other housing providers in the County.

In order to sustain the highest degree of quality service, HDSW measures and evaluates its outcomes each year:

- Residents of our supported housing program (individuals and families) have maintained a 88% housing stability rate over the last 10 years,
- 70% of the residents have been involved in volunteer work, vocational activities, educational programs and/or competitive employment,
- 90% of the parents in the Family Program have participated in parenting education to help them provide a healthy home environment for their children,
- residents rate their satisfaction with program services at 91%, and hospitalization rates are negligible.

Supported housing is a win/win situation for all involved. For persons recovering from a psychiatric illness, stable housing is a proven support to recovery, and provides an opportunity for individuals to live in the community in surroundings that they can make their own, just like other folks. For the community, it is a form of housing that is most economical. It costs about $17,000 per year to provide the rent subsidy and case management services for an individual in supported housing, and somewhat more for a family, half the cost of shelters and transitional housing, and a fraction of the cost of hospital care. Most providers receive, on average, about $13,500 per individual per year, which doesn't cover the cost of the rent for most individuals and leaves nothing for case management services (fair market rents for the Westchester County area are $1,095 for an efficiency apartment; $1,306 for a one-bedroom; $1,519 for a two-bedroom; $1,832 for a three-bedroom; and $2,259 for a four-bedroom apartment). Throughout downstate New York, where the cost of housing stock has skyrocketed, this financial disparity has caused some providers to consider closing their programs. The Westchester County Department of Community Mental Health has recognized this crisis and has, when able, granted providers some additional funding for case management staffing. However, in New York City, on Long Island, and in Westchester and Rockland Counties, many agencies' programs are threatened by yearly deficits. HDSW will continue to seek resources to provide the crucial case management services to the parents and children of these families that will support their recovery and preserve their homes.

Understandably, supported housing for individuals and for families is one of the most highly desired resources for recipients of mental health services in Westchester County. The wait lists for such housing are long and continue to grow. Supported housing is truly a "best practice," but an endangered one. It is additionally threatened by the growing refusal of area landlords to rent to persons who receive rent subsidies from programs such as Section 8 and supported housing. Currently, the Westchester County Board of Legislators is considering a draft amendment to the Westchester County Human Rights Law that will make it illegal for landlords to refuse to rent an apartment to persons who have a lawful source of income. We hope that we advocates are successful in supporting the passage of this legislation and that Westchester County will join the many other states, counties and cities that already have source of income protection laws, including our neighboring states of Connecticut and New Jersey. □

Veterans from page 27

Despite significant efforts to address the stigma associated with mental illnesses, many people still believe that mental illnesses are character issues that an individual can overcome by 'toughing it out' or focusing on the future rather than on past events. Despite the military's best efforts to educate commanders to treat the issues of mental health professionally, many servicemen and women have reported inappropriate discipline and/or demotion when attempting to deal with mental health or substance abuse disorders following combat experiences. On the outside, returning Guardsmen have faced inappropriate actions by employers who became impatient with their returning employees' changes. Consequently, soldiers are reluctant to admit to having a mental health need and from seeking treatment.

Many veterans themselves self-stigmatize, feeling shame at not being able to return quickly to full functioning. The military culture emphasizes toughness under stress and 'not making excuses.' Some soldiers seeking mental health treatment have even been disciplined or discharged from the service for behaviors related to their illness. Even with the encouragement of family and friends to seek treatment, many veterans continue to deny the need until their situation becomes desperate and treatment becomes much more difficult.

I propose that we re-frame the need for psychiatric treatment to a term that is more acceptable to the public and the veterans themselves. That term is *psychological prosthetics*. A Prosthetic device is a support that permits the user to return to more complete functioning. After the initial shock of loss, a soldier who loses an arm or leg is highly receptive to replacing the limb. More important, no patriotic American would deny the funds necessary to assure that every soldier requiring a prosthetic device is properly equipped with the most sophisticated device available.

Psychological prosthetics functions in a similar manner without the mechanical devices. Proper treatment—which might include individual and group therapy, medication and/or family treatment—provides the supports necessary to return to full functioning. Why should a disorder of the brain resulting from combat be treated with less commitment and sophistication than a physical injury? We owe it to the men and women who risked everything on our behalf to have not only the best treatment but also a complete recovery. Three sessions with a VA social worker and then a discharge is unacceptable. Either we must fund and staff the VA to provide full and appropriate care or the federal government must contract with community providers to fill the gap.

One of the terrible lessons of the Vietnam War is the aftermath of broken lives of soldiers who were never properly treated for their combat-related mental injuries. Even today, a visit to any homeless program in the country will reveal veterans whose lives remain in ruin 35 years later. Veterans make up 26% of the homeless population. Besides the human tragedy that resulted from our failure to respond effectively to Vietnam-era vets, society has paid untold billions in mental health, physical health, domestic violence, substance abuse and welfare costs.

Let us not fail again to provide the *psychological prosthetics* necessary to assure a restoration of functioning to our many brave veterans. If we think of the brain as <u>at least</u> as important as an arm or leg, we cannot fail to provide the necessary therapy and supports to restore Iraq-era veterans to full community participation.

Steven Greenfield is the retired Exec. Director of the MHA of Nassau County and currently Coordinator of Special Projects for Family Residences and Essential Enterprises (FREE) on Long Island. □

Housing from page 18

"Until recently the NYS Housing Finance Agency (HFA) was at best a minor player in the development of low income housing outside of New York City. HFA was almost completely uninterested in supportive housing anywhere in the state," said Ald. "Since Governor Spitzer appointed Priscilla Almadovar to head HFA there has been a dramatic change. Now only DHCR rivals HFA in dedication to development of supportive housing for low income persons state wide and particularly in the upstate region," he added. "I believe it is the leadership of Priscilla Almadovar that has lead directly to this result. She is responsible for the many innovative steps taken by HFA to sweep away the former barriers to the development of both regular low-income housing upstate and supportive housing in particular," Ald continued.

Ald and Whitney are considered experts in funding and investments in the non-profit world. Both have spoken before several government agencies about the process and advantages of financing housing through the non-profit development channels. The results have been numerous successful funding applications and the development of many new projects. Currently under construction is a new Single Room Occupancy (SRO) Home to replace the Johnson Adult Home in Fredonia, NY and the Lakeview Mental Health Special Needs SRO in Ithaca, NY. STEL, Inc. has worked as a developer of other properties including several sites in the Buffalo and Rochester areas. The team uses low income housing tax credits to finance construction of licensed New York State Office of Mental Health (OMH) housing. Financing packages have included funds from the New York State Housing Trust Fund, the Federal HOME Program, Community Development Block Grant funds and the Federal Home Loan Bank. Project closings for STEL, Inc. have exceeded units for 265 persons with disabilities in the past five years.

The combination of landlord and provider of services is an area that STEL, Inc. handles well but one that many service providers do not want to venture into.

"We hire qualified people like Alex Parkman to run the affordable housing side and the issues in rental are handled fairly and with the best interests of tenants and landlord in mind at all times," said Whitney. Parkman is highly regarded by tenants. One in particular, Robert S., recently said he felt that Alex would be the person he would want contacted if he had an emergency. "Alex is a great guy and someone who I feel would help me out if I was in need of an ambulance or some other assistance," said Robert.

Independent apartment living was a goal of Robert and his family. Through STEL, Inc. programs Robert not only found an apartment that he could afford and feel safe living in but he also used the vocational program at STEL, Inc. to help him find a part-time job to supplement his social security income.

"The umbrella of services we provide to our tenants and consumers is all part of our approach to providing an improved quality of living for people with mental health disabilities," said Whitney.

The STEL, Inc. comprehensive services includes case management services, vocational counseling and assessment and Compeer, a program that matches trained volunteers with persons who have been diagnosed with mental illness and are looking for social interaction and friendship.

For more information about STEL, Inc. visit the website at www.stel.org., or contact Thomas Whitney at whitneyt@stel.org or 716-366-7792. □

Senator Morahan from 1

Community housing waiting list legislation is supported by leading mental health providers, consumers, family members, advocates, housing developers, social policy experts and legal rights organizations, many of whom rallied in Albany late last year to urge New York State officials to address the housing crisis for people with serious mental illnesses. The New York State Campaign for Mental Health Housing, a bipartisan coalition of over 50 organizations supports the establishment of community waiting lists within the NYS Office of Mental Health service system.

The NYS Campaign for Mental Health Housing has worked over the years to educate the public and government policy makers about the need for New York State to undertake a comprehensive plan to:

- Preserve approximately 30,000 existing units of supportive and licensed housing
- Reform existing models and programs to meet the complex needs of the clients being served; and
- Develop at least 35,000 new units of mental health housing statewide over the next ten years

Senator Morahan's legislation would require the establishment of community housing waiting lists with the New York State Office of Mental Health (OMH) service system. It would also direct each provider of housing services within the OMH system to provide:

- on a monthly basis a list of each person referred to housing
- a list of each person admitted to housing
- a list of each person applying for housing
- a list of each person withdrawing an application for housing
- a list of each person denied admission to housing provided by an OMH provider

The legislation requires community-based agencies performing assessments of person with a documented mental illness to provide OMH with the names of individuals who have been assessed, and who meet the eligibility criteria for funded and/or licensed housing programs. The bill also would require OMH to publish such waiting lists on a monthly basis.

BILL NUMBER: S568
SPONSOR: MORAHAN

TITLE OF BILL: An act to amend the mental hygiene law, in relation to the establishment of community housing waiting lists for adults within the office of mental health service system

PURPOSE: This legislation would enable the state to track the wait time for persons with psychiatric disabilities seeking supportive, supervised or congregate housing in the office of mental health system.

SUMMARY OF PROVISIONS:

- Amends section 7.15 of the mental hygiene law, providing for establishing waiting lists.
- Defines terms "provider of housing services" and "agency or institution".
- The agency shall forward for collection names of the applicants to the office of mental health.
- The Commissioner shall prepare a written report on the community housing waiting list. The report shall be submitted to the governor and the legislature.

JUSTIFICATION:

There is a great need for the establishment of a waiting list that would truly reflect the need for housing and related services for people in New York with mental disabilities, and also match those people up with appropriate housing, in the most integrated setting. This bill would help to bring the state in line with the already-existing obligations under the federal Americans with Disabilities Act, the Supreme Court's decision in Olmstead v. L.C., and New York State Executive Law sections 701-703.

Mental Health News wishes to thank Ron Levine, Director of Communications NEW YORK STATE SENATE, 38th District, for the Office of NYS Senator Thomas P. Morahan, Senate Majority Liaison to the Executive Branch, for his help in providing this article. □

House Proud from page 12

overcoming many obstacles and helping him stay hopeful about the future.

Joanna is one of the thousands of women who were considered by the shelter system as a "Long Time Stayer". She has been in and out of the shelter system since the early 1990's.

Joanna's upbringing was traumatic. Early in her childhood her biological father physically and sexually abused her. Joanna first became depressed at the age of 18, when her mother died. Her father died a year later. In 1993 alcohol and drug abuse prompted her first psychotic break and a period of repeated hospitalizations and homelessness. Joanna began to move from shelter to shelter and lived on the streets of New York City for years. Joanna's string of traumas made it difficult to develop coping skills to deal with life. When Joanne married, things did not turn around. Her husband abused her physically and psychologically. Despite her depressive condition, Joanna successfully raised three children.

Joanna always expressed interest in education. She graduated from High School, where she majored in cosmetology. She was employed by the V.A hospital as a home health aide.

When Joanna moved into F.E.G.S. Willow (a shelter based program) and later the Burnside CR/SRO, the staff noticed her potential to become a great advocate. She cared about other people and knew how to listen to her peers and explain to staff what was needed. The same instincts, attributes and skills that helped Joanna to be a good mother, despite her many problems, made her a great peer advocate. For Joanna, success led to more success. As her self esteem and confidence in her abilities grew she progressed.

At the age of 54, Joanna lives in her own apartment in the Washington Heights area of New York City and attends the ICD Business Training Program sponsored by VESID.

Housing is not a simple thing, as anyone who has lost their home due to fire, flood, illness, lose of employment, drug addition or mental illness knows. Housing seems simple but it is not to be taken for granted. Without safe, secure housing one cannot work on other recovery goals. The staff of successful housing programs for people with mental illness develops an understanding of mental illness, drug addiction, homelessness and trauma. To help residents move forward, staff also needs to be able to think outside the box, or in this case, "outside the house." Our staff offers a combination of protection and support along with an eye and an ear to what will make each person's journey to achievement possible.

For more information on F.E.G.S. Behavioral Health Residential Services you may contact our Central Intake Department at 212-831-7007 ext 203, 204. Actual consumer names are not used in this article. □

Governor Spitzer from page 1

Assemblyman Vito Lopez, Chair of the Assembly Housing Committee, said: "I would like to commend Governor Spitzer for proposing this Housing Opportunity Fund. This program is the first of its kind in New York State and will go a long way towards helping us get out of the affordable housing crisis we're currently in. I look forward to helping make the fund a reality."

Senator Liz Krueger said: "Few problems facing our state are more critical than New York's severe shortage of safe, decent, and affordable homes. In recent decades, homeowners and renters in cities, towns, suburbs, and rural areas across New York have seen the state's affordable housing problems become a full-blown crisis. There are more homeless families today in New York City than anytime since the Great Depression. Ensuring safe and affordable housing is not only a key responsibility of state government—it is also good economic and fiscal policy. I could not be more delighted that the Governor shares this commitment and placed it front and center on his agenda."

Assemblyman Joseph Lentol said: "The Governor understands that many working families and individuals are struggling with health or physical disabilities are extremely vulnerable to losing their homes. Others can not find ones they can afford. His State of the State message on housing is welcomed and hopeful news. I have always said that my constituents keep New York going and growing, but they need safe, affordable housing and that need has become a desperate one. I look forward to working with the Governor on his housing proposals."

Deborah VanAmerongen, Commissioner of the New York State Division of Housing and Community Renewal (DHCR) said: "Governor Spitzer's commitment to affordable housing is unprecedented in New York State. We are extremely fortunate to finally have a governor who understands the connection between ample affordable housing and the health of our economy—and who is willing to take bold steps to address New York's housing needs."

Priscilla Almodovar, President and Chief Executive Officer of the State Housing Finance Agency (HFA) said: "This fund will enable us to build on our success during the past year and work collaboratively with our partners in the private and nonprofit sector and in the Legislature to create much needed affordable housing. I am particularly proud that the Governor is creating a vehicle to promote and create supportive housing across New York State."

Joseph A. Agostine, Jr., Executive Director of the Neighborhood Preservation Coalition of NYS, Inc., said: "Governor Spitzer's commitment to expand affordable housing opportunities in New York State is terrific and exciting news. His proposed Housing Opportunity Fund will go a long way to make those housing opportunities a reality. We applaud the Governor for his efforts and look forward to working with him as we continue to address this state's housing crisis."

Bernie Carr, Executive Director of the New York State Association for Affordable Housing (NYSAFAH) said: "The Governor knows that economic vitality is impossible without sufficient affordable housing opportunities. This historic investment in affordable housing is good for Upstate cities in need of revitalization and good for Downstate communities that have been adversely affected by skyrocketing housing costs."

Martin Dunn, President of Dunn Development Corporation, said: "For the affordable and supportive housing development community, this is extremely welcomed news. These funds will enable New Yorkers with special needs, currently living in restrictive or substandard conditions, to live more independently and ensure a better quality of life for them. We applaud Governor Spitzer's leadership and vision on this groundbreaking initiative."

Richard Higgins, President of Norstar USA, an affordable housing developer said: "This extraordinary investment will help to create hundreds of jobs and revitalize entire communities. The impact of this announcement will reach far and wide."

Ted Houghton Executive Director of the Supportive Housing Network of New York (SHNNY) said: "Everyone who cares about making housing affordable should be excited by this historic announcement. We finally have a Governor who understands just how serious the housing crisis has become in all regions of the state. Building affordable housing is one of the most effective economic development strategies available to government. And the inclusion of substantial resources for supportive housing – permanent housing linked to social services for homeless people with special needs – demonstrates that the Spitzer administration recognizes that the countless millions spent each year on emergency shelter and services for homeless individuals and families are better spent on permanent housing and recovery-oriented services."

Michael D. Lappin, President of the Community Preservation Corporation (CPC) said: "Governor Spitzer's announcement will bring hope to families whose lives are being made more and more difficult by spiraling housing costs. And moreover, the economic stimulus produced from this activity will serve to help many communities emerge from hard fiscal times."

David Muchnick, Coordinator for Housing First!, a statewide housing advocacy organization, said: "This historic investment is a quantum leap forward in modernizing the state's affordable and supportive housing policies. Investment on this scale demonstrates the administration's recognition of affordable housing as a core component of the State's mainstream economic development, smart growth and infrastructure programs."

Shelly Nortz, Deputy Executive Director for policy at the Coalition for the Homeless, said: "The Spitzer Administration clearly understands the scale and dynamics of the affordable housing crisis in New York State. The Housing Opportunity Fund will embody smart investments of limited public resources to provide integrated housing opportunities for individuals and families - including those with various disabilities - and strengthen communities across New York State. This is what government is for."

Blair Sebastian, Executive Director of the NYS Rural Housing Coalition, said: "Governor Spitzer has already made great strides in bringing new life to Upstate New York's cities and rural communities. This extraordinary proposal is a clear signal that the Governor will continue to focus his attention on providing affordable housing, creating jobs and revitalizing Upstate New York."

Abby Jo Sigal, Vice President and Director of Enterprise New York, a leading nonprofit provider of affordable housing for low-income people, said: "Governor Spitzer recognizes the crucial link between affordable housing and economic empowerment and revitalization, and we applaud him for taking such a significant step to address this issue through the $400 million Housing Opportunity Fund. Enterprise is proud to be a key partner in working with the State to ensure that every New Yorker has a place to call home."

Carl Young, President of the New York Association of Homes & Services for the Aging, representing New York's not-for-profit and public providers, said: "New York's low-income seniors and seniors with disabilities face many challenges when it comes to affordable and supportive housing. We are pleased that Gov. Spitzer is making the needs of this important population a priority." □

Positive Outcomes from page 27

process. Being able to perform that function will surely promote the likelihood of a positive outcome.

As this episode in my life continued, it did not take long for the doctors to diagnose that I had an inflamed appendix and that it was on the verge of bursting. Therefore, surgery was scheduled for later that evening. About four hours elapsed from the point that I arrived in the ER until I was brought to the operating room. That fact brings me to another point; that being that the quality of care received is also related to whether or not a significant other is present and involved in the health care delivery process.

My wife came with me to the hospital and she stayed throughout the emergency treatment process, and it was apparent that without her involvement, the medications I was prescribed and the tests that were ordered would not have been received in a timely manner.

Clearly, the vast majority of health care practitioners are well meaning and competent; however, these individuals are also susceptible to becoming stressed and overworked. Therefore, matters can and do go awry; but this is less likely to occur if a significant other is involved. This is because it is an unfortunate fact that many practitioners are more likely to be mindful of their performance if they know that they are being monitored by someone who is actively concerned about the welfare of the patient.

That brings me to a public policy concern, that on the average, one categorized as seriously mentally ill, has a life expectancy that is 25 years less than that of the general population. This sad condition, I would trust, is due in part to the fact that often times the seriously mentally ill client is estranged from their family, therefore the involvement of a loved one in their physical health care is frequently lacking.

The social policy implication is that we should do more to support families in their role as partners in the service delivery process. In this regard, I trust that innovative programs that address the emotional, financial and time demands that are placed on families when a loved one is ill would have a positive impact on the physical health of our clientele.

In my situation, I was eventually brought to the operating room and before being rolled into that area the surgeon introduced himself to me. He also did a quick examination and then proceeded to inform me that, in 18 out of 20 cases, the appendectomy can be performed using a laparoscopic method. That was interesting information, and it elicited two reactions from me. One of which emanated from the statistician in me, thus I was prompted me to wonder why the doctor would say 18 out of 20? Why not state 9 of 10, or 90% of the time. His was clearly using an odd statistical reference, but it did not concern me, because I was more impressed by the fact that he could express, with confidence, how my course of treatment was likely to proceed.

This struck me because, in the mental health profession, we often resist making assertions about the type of outcome a client can expect from our intervention. I find this unacceptable, because we should be able to tell our clients what they can expect as a result of the service we offer. Our clients are entitled to ask, and have answered, questions such as, is it likely that my symptoms will be lessened if I accept your help, or, is the quality of my life likely to improve; or, if I participate in your job training program is it reasonable to assume that I will attain employment?

If we are unable to answer those type of questions, it raises the concern that perhaps we do not know what kind of effect our intervention will have; and if we do not know how we are effecting people, is it possible that we are doing more harm than good? I am sure that is not the case, but we must be able to prove that point, and in order to do so we must get better at measuring what it is that we do.

In Nassau County, initially many of our mental health agencies may have seen this as a daunting task; however, we have evolved to the point where many mental health providers are becoming adept at predicting the type of outcome a client can expect as a recipient of their services.

This has happened because agencies are required, as part of their contract with the county, to specify in numerical terms, the type of client centered outcomes that are expected to occur. In other words, an agency cannot satisfy the terms of their contract with the county by simply stating that they will deliver their service to a certain amount of individuals. Instead the provider must project that a particular number or percent of the program participants will achieve a desired life change. Later in the contract year, we in the county will then assess the agency's performance against their anticipated outcomes.

The result of this initiative is that we are finding that agencies are in fact helping great numbers of clients to achieve measurable improvements in their lives. This type of development not only validates that we have always been helping clients to make progress in their lives, but it serves to demonstrate to society at large that the work we do is making a tangible and measurable difference. The final and most important effect is that our consumers can know beforehand, the type of benefits they may achieve when they buy into the services offered by a particular program. □

Subscribe to MHNews

Yes! **I want to receive each Quarterly issue by Mail**

- ☐ Consumer/Survivor/Ex-Patient ($20/year)
- ☐ Student ($30/year) School/Program _____
- ☐ Individual/Family ($40/year)
- ☐ Group - 50 Copies Each Issue ($300/year)

Order a Gift Subscription for A Friend - Give a Gift of Hope
all subscribers receive both of our award-winning publications at no additional cost

Name & Title: _____

Address: _____

_____ Zip: _____

Phone: _____ E-mail: _____

Include your Check Payable to:
Mental Health News Education, Inc.

cut out this coupon and mail it with your check to:

Mental Health News
16 Cascade Drive, Effort, PA 18330

Phone: (570) 629-5960 E-mail: mhnmail@aol.com

Advertise in MHNews

*** 25% Savings - Book 3 Get 1 Free!!**

- ☐ Business Card - 4 issues ($320)
- ☐ Eighth Page (1 issue $300 - 4 issues* $900)
- ☐ Quarter Page (1 issue $500 - 4 issues* $1,500)
- ☐ Half Page (1 issue $750 - 4 issues* $2,250)
- ☐ Full Page (1 issue $1,000 - 4 issues* $3,000)
- ☐ Inside Covers & Back Page (please call)
- ☐ Special Multi-page Supplements (please call)
- ☐ Corporate Sponsorship (please call)

Name & Title: _____

Address: _____

_____ Zip: _____

Phone: _____ E-mail: _____

Include your Check Payable to:
Mental Health News Education, Inc.

cut out this coupon and mail it with your check to:

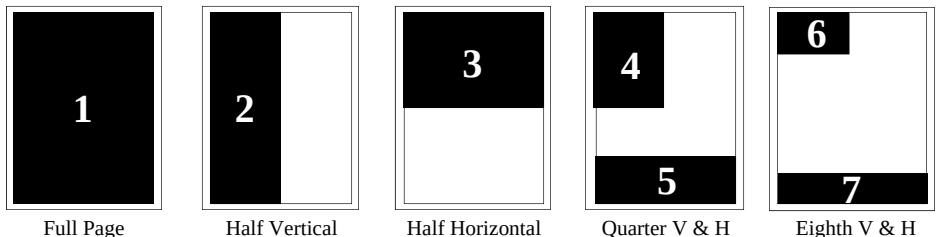
Mental Health News
16 Cascade Drive, Effort, PA 18330

Phone: (570) 629-5960 E-mail: mhnmail@aol.com

Promote Your Vital Programs and Services for the Mental Health Community
And Reach Our 120,000 Readers
Advertise in Both Mental Health News and Salud Mental and Save 38%

Deadline Calendar & Ad Size Specifications

Deadline	Release Date
May 1, 2008	July 2008 (summer issue)
August 1, 2008	October 2008 (fall issue)
November 1, 2008	January 2009 (winter issue)
February 1, 2009	April 2009 (spring issue)



Full Page $1,000 | Half Vertical $750 | Half Horizontal $750 | Quarter V & H $500 | Eighth V & H $300

Ad Sizes - In Inches

	Width	Height
Full Page (1)	10.375	12.9
Half Vertical (2)	5.088	12.9
Half Horizontal (3)	10.375	6.3
Quarter Vertical (4)	5.088	6.3
Quarter Horizontal (5)	10.375	3.05
Eighth Vertical (6)	5.088	3.05
Eighth Horizontal (7)	10.375	1.425

MENTAL HEALTH NEWS

recovery from mental illness is possible
but it takes a community of support

Mental Health News provides a vital link
to that community of support
and helps to open the door to recovery

learn how Mental Health News can help
provide mental health education to your
community...it's easy and affordable

call us today at: (570) 629-5960
visit our website at www.mhnews.org