

MENTAL HEALTH NEWS™

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SUMMER 2008

FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE

VOL. 10 NO. 3

Employment for People with Mental Illness

Having Faith and Trust in Consumers Breeds Success

By Ellen Stoller, ATR, LCAT, Gary Scannevin Jr., MPS, CPRP, and Minnie Berman LMHC, CRC, F.E.G.S. Health and Human Services System

Kitty was a consumer enrolled in the FECS Manhattan Intensive Psychiatric Rehabilitation Treatment Program (IPRT). It was there, that she got off methadone, learned how to manage the symptoms of her bi-polar disorder and got a job at the Calvin Klein store in SoHo. She was the highest earner in the store last year.

Betsey got a job at a doctor's office; she is now the office manager. Part of her recovery journey involved working on the IPRT warm-line, helping her peers and joining a choir at the YMHA which gave her a new community and a fulfilling way to use her voice.

Kara, who is 25, deaf, with a history of trauma, was helped to find work by the IPRT program in tandem with the F.E.G.S. Workservices program and VESID. She is now working in a women's clothing store. She periodically visits her friends and new members in her former IPRT to share her story.

All paths to employment are different. What do these mental health consumers have in common? They were all clients of a FECS rehab program where a culture of recovery and work pervade.



Gwen: Working at Wal-Mart

At first Gwen didn't want to tell anyone in the program that she was working, in case it didn't work out. She had experienced that before. Then she had a situation with a boss who was "too big for his britches", but with Mark Springer, her rehab worker in a FECS PROS program (one of the first on Long Island), she worked that out. Then she had a horrible

sinus infection, but hardly missed any work. Gwen doesn't make excuses any more, she works through it.

Gwen, a client in the PROS Possibilities program (Personalized Recovery Oriented Services) in Copiague Long Island, has a long history of mental illness and a long history of frustration in the work world.

Gwen began to actively participate in Intensive Rehabilitation Goal Acquisition groups; she developed skills to manage

her anxiety and depression and learned to effectively control her emotions and behavior around others.

There were just so many barriers, first the depression and anxiety that has been part of Gwen's life for most of her 47 years, then her interpersonal difficulties. Angry outbursts were not uncommon for Gwen—and then there was her weight. Although Gwen has tried to diet many times, she is morbidly obese. Gwen felt discriminated against but also realized she used her size too, to keep herself back.

Gwen did not have great hopes when she interviewed for her present job working in a fitting room at a local Wal-mart, but she role played her job interview, talked about her anxiety, and bolstered by the support of the PROS Possibilities program staff and her peers, she went on the interview. She was ready, looking and sounding her best, and she got the job. At her 90-day review she also got a raise for the first time in her life. Success breeds success. Mental Health programs were part of Gwen's culture, now work is also becoming a way she defines herself.

Gwen's recovery story is one of many. Each path to employment is different but all start with a program that has a culture of work and recovery and staff who help clients "unpack" their dreams.

see Faith and Trust on page 32

Hiring Consumers for the Mental Health Field: A Fresh Perspective

By Ron Kavanaugh, MS
Executive Director
Search for Change

The idea of hiring consumers to work in the mental health field is applauded, even though long overdue. Professional bias, liability fears, and plain old lack of confidence and faith in consumers delayed this practice. After all, many of the clinicians and administrators had been trained that "consumers needed fixing" and that they and only they had the knowledge and skill to do so.

In the late 1980's my residential and vocational agency began "the experiment" of hiring consumers as employees. After

discussing this policy change with the consumers in the respective programs, we began hiring consumers to do coverage. Gradually, we increased their responsibility as we witnessed their competency. Our regulatory agency, at the time, had questions about the legality of our employment practice and ordered us to cease operations. Consumers were reinstated to their positions following an appeal process that took sixty days.

A few years later Harlem Valley Psychiatric Center began training consumers to become case managers. Three of our employees were part of the first training class. Shortly thereafter several consumer case management positions were created at various agencies, employing the graduates of the HVPC program.

The consumer movement exploded, and over the next several years' consumer run programs were established. These programs were to be entirely consumer run and managed and were largely funded through reinvestment money. Consumer run programs were designed as drop in centers, social clubs and provided case management and outreach services.

A few years prior, I had a multiple year assignment training substance abuse staff on mental health issues. Consumers in the substance abuse area had a long-standing tradition of working in this field. In fact if you asked the recovering staff, they felt the professionals were less effective staff members, because they "had not been there." Likewise, professional staff felt the recovering staff lacked empathy

and understanding and were likely to relapse at any time. There was clearly an "us versus them" mentality operating. I couldn't help but wonder where the potential for an integrated mutually respecting treatment team went wrong. It appeared that each camp was separately entrenched, and were not respecting the other's experience or talents.

Our agency, Search for Change, located in White Plains, New York, was in its infancy of co-mingling our staff in the mental health field, and I saw the potential for this staff conflict in the offing. I remember the response from some professionals when we started our employment program. Several questioned our judgment,

see Hiring Consumers on page 33

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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

Summer 2009 Issue:
“Recovery and The Consumer Movement”
Deadline: May 1, 2009

From The Publisher

From Astronaut to Advocate: A Personal Journey

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

The year was 1997, and I had just been discharged from a month long inpatient stay at the hospital. I was now to attend their Vocational Rehabilitation Program (Voc Rehab). After many years in and out of the hospital I had finally received the right treatment, was on the road to recovery. I was now feeling well enough to think about finding my way back to the world of work. However, after ten years battling major depression, and now in my forties, my former professional career had long ago been left in a state of shambles.

Before becoming ill at the age of thirty eight I had studied psychology in college and had gone on to earn a Master's degree in Social Work. Following some years in the field, I became interested in fundraising, and spent twenty years helping non-profit organizations raise funds to provide vital services to the community.

After my prolonged and devastating illness, my resume now had more holes in it than Swiss cheese. My doctors advised me not to return to the social work or fundraising field because of the long hours and stress involved. I was at a loss to figure out what I wanted to do or what job would be most rewarding and beneficial to my fragile mental health.

My referral to the Voc Rehab program gave me hope that I would once again be able to return to the working world. It was like starting all over again, but the challenge seemed like a real opportunity to find a new and meaningful path.

The Voc Rehab program was designed to put attendees through an intensive course of vocational career testing. We had to show up promptly each morning and stay until the late afternoon to show our commitment and ability to hold down a job. Over the length of the program we were put through many written, computer based and physical thinking tests (fitting square pegs into round holes). I knew from my psychology background that many of the tests were personality tests and others were strictly vocational. I think every test in the book was given to us, so I imagined that the counselor's at the Voc Rehab program must know their stuff and would surely have some meaningful results to give me once I finished the course. Boy, was I wrong.

After many weeks of attending, the final evaluation day had come. I arrived promptly as I had every day and waited for my counselor to call me into her office. She held my folder which contained all of my test results. As she reviewed my test scores, performance skills and other numbers, I seemed to tune out, just waiting to hear what career they thought would be best for me. "Mr. Minot, your evaluations indicate that you are best qualified to become an Astronaut."



Ira Minot, LMSW

This is a true story. On the list of career choices she showed me, Astronaut was number one. I forget the other choices, but they all seemed pretty meaningless and not rooted in anything I could identify with, wrap my arms around or become passionate or excited about.

As I sat there, all my hopes and expectations about my Voc Rehab experience sank into my socks. The whole process had yielded nothing other than a categorized list of career choices that had little to do with my background, values, hopes and aspirations, or my future. I could have gone to the Library and found the same lists and exercises in finding a career in the many books available—none of which I ever had any use for.

The one thing that the Voc Rehab program experience had done for me was to open my eyes to the fact that I was going to have to find another way to discover what my destiny would be. It would take time and a great deal of thought and hard work. I would have to take a journey down The Yellow Brick Road of my new life to discover the answer.

Starting over again can be a scary experience. One needs a whole community of supports to make it. Thankfully, the hospital discharged me into the care of supportive housing—a place to live being one of the most basic of needs. I was also referred to a wonderful Psychologist who was seeing me in outpatient care following my discharge. Steve was a real hands-on therapist who didn't just sit there and listen as so many had done with me in the past. Steve was a great listener, but he also put me to work doing things that would help me each week. One thing he did was to suggest I purchase a book he thought I would enjoy reading that had to do with mindful meditation. This was a subject that I was not that familiar with. I still have this book that is by an author named Jon Kabat-Zinn, and is titled: "Wherever You Go, There You Are."

The book really helped me focus on the big picture—the little things in life that we often don't see or appreciate as much as we should. Things like living in the moment, breathing, and appreciating where you are in your life right now, even if you are not doing anything. I would recommend this book to anyone looking for answers in their life, whether you are in recovery or not.

The other thing Steve did was to introduce me to Don who he said was a Job Coach. I had never heard of a Job Coach, but the idea seemed sensible enough, especially since I was so confused about what I was going to do with my life. I needed all the coaching I could find.

Don became my Job Coach, and more. He was a consumer like me who had struggled with bipolar disorder. He was very educated, had a former career working in high levels of the Corporate sector for many years. He understood the recovery process having been there himself. He was a wiz at negotiating the government "benefits" maze, and even lived in supportive housing as I was now living in. He knew exactly what I was going through. I couldn't believe I had found someone I could really relate with. Finally !!

Don and I quickly became good friends, but he made me work hard. We would meet every Friday at Starbucks to brainstorm ideas relating to my recovery and career path. As a mentor and coach should, he let me find my own way, but with informed guidance and criticism. When I had a career idea we would discuss it, dissect it and then he would assign me things to do in order to accomplish the task. With this approach, I soon became one of Don's best protégés and looked forward to our meetings each week to report on my weeks accomplishments. It was during these meetings that I began to realize my vision to start a small newsletter to help others who were going through the same difficult journey through mental illness and into recovery.

Today, the little local newsletter I thought I would start has become the award-winning Mental Health News, now in its ninth year of publication.

In this issue, we are revisiting the topic of employment for people with mental illness. It is a theme we first addressed 5 years ago in our Summer 2003 issue. Back then, the picture was not very encouraging. However, many programs such as supportive employment, and a new Medicaid buy-in initiative were being launched that held a lot of promise for improving outcomes for getting people back into the workforce. It was also a time when the consumer movement was making great strides in establishing that self-help and recovery were of enormous value to the lives of people with mental illness. In addition to enhanced provider based programs, peer-run recovery based programs were proliferating and were helping to improve employment outcomes across New York state.

Unfortunately, we still have a great deal of work to accomplish to get people into meaningful employment. Many wonderful articles that are in this issue attest to the fact that the community is really trying to improve the situation, but many challenges lie ahead, and much more still needs to be done.

Dr. Michael Hogan, Commissioner of the NYS Office of Mental Health states the following in his article on page 5:

- people with mental illness have the lowest workforce participation of any disability group, with national data suggesting that a little less than one-third of all individuals with serious mental illness are employed
- ironically, and tragically, the employment rates of people who use/receive mental health care are even lower, where only about 15% of working age adults who rely on New York's mental health system are employed.

Dr. Hogan goes on to say: "When receiving mental health care cuts your chance of working by 50%, something is wrong. I consider this problem of unemployment the worst failure of the adult mental health system in the United States. It is time for a change. And, though much should be done at every level including federal and state governments, this is also a problem that everyone in mental health can address. For consumers, the goal of employment is both realistic and appropriate. For mental health providers, much more can be done."

I couldn't agree more, and think that people with mental illness do want to work (as I did). Still, barriers to employment such as stigma towards people with mental illness, fear of losing one's supplemental disability income and medical benefits, do exist. The notion that "you have to recover" before thinking about employment isn't true in all cases. For many, employment enhances the recovery process, and in addition to medications and therapy, should be built into treatment plans at the earliest possible opportunity.

The NYS Office of Mental Health needs more Federal and State revenues in order to continue to develop useful new initiatives and to fund supportive employment programs in the community.

Finally, we need to allow consumers to have their own hopes and dreams about what they want to become in life—not try to categorize people based on a tired list of obscure career choices. As the Good Witch explained to Dorothy in the Wizard of Oz, "You could have always returned to Kansas, but you had to find that out on your own," and as I found out *on my own* during my journey down The Yellow Brick Road from Astronaut to advocate.

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

Mental Health, Work, and Recovery: A Call to Action

By Michael Hogan, PhD
Commissioner
NYS Office of Mental Health

“What do you do?”

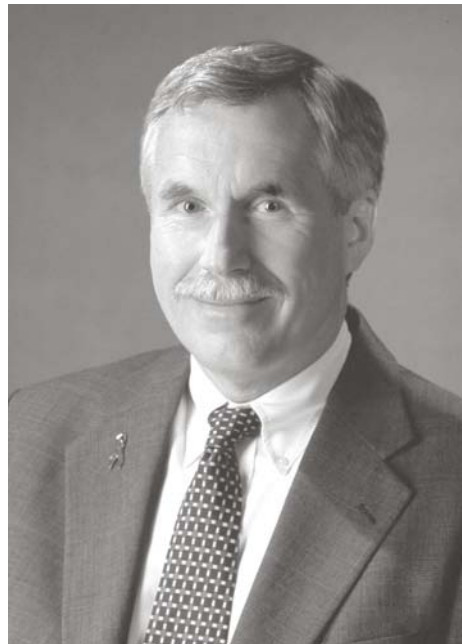
It is the quintessential question that Americans ask each other. In our culture, rightly or wrongly, our jobs help define us. And work is how we pay the bills, how we get health insurance, and where we connect for relationships and support.

Yet people with mental illness have the lowest workforce participation of any disability group. National data suggest that a little less than one-third of all individuals with serious mental illness are employed. Ironically, and tragically, the employment rates of people who use/receive mental health care are even lower. Only about 15% of the working age adults who rely on New York's mental health system are employed. When receiving mental health care cuts your chance of working by 50%, something is wrong. People with a mental illness related disability represent the largest and fastest-growing disability group receiving SSI and SSDI.

I consider this problem of unemployment the worst failure of the adult mental health system in the United States. It is time for a change. And, though much should be done at every level including federal and state governments, this is also a problem that everyone in mental health can address. For consumers, the goal of employment is both realistic and appropriate. For mental health providers, much more can be done.

There are many reasons why the mental illness unemployment problem is this bad. I'll get to some of this in a minute. But first, it is important to establish that the right job approached in the right way is a realistic goal of people who receive mental health care. Many surveys have asked people receiving mental health care about their employment goals. The results are consistent. In study after study, 55-70% of all consumers report that they would like to work. And, as noted by Judith Cook of the University of Illinois in Chicago, consumer expectations are realistic. Recognizing their illness/recovery status and in many cases their limited employment experience, consumers often talk about a goal of part time work, and recognize that they might need a little accommodation or support to sustain their employment.

Additionally, we now understand that ordinary community mental health systems can, but only with focus and persistence, help the majority of people with serious mental illness who want a job to



Michael Hogan, PhD

work — to get, choose, and keep one. State level efforts and large scale demonstration projects such as the Employment Intervention Demonstration Project have achieved sustained employment rates of over 40% among people with serious and persistent mental illness receiving care in public systems. Thus, we know that real world efforts to help people get work can roughly double the “mental health consumer employment rate,” achieving jobs for about two thirds of the people who want one.

It's important for us to be clear about the magnitude of the problem. First, unemployment for people with mental illness is unacceptable because employment is a cornerstone of American life. Unemployment perpetuates poverty, stigma, poor self esteem, and negative social roles. It contributes to poor health outcomes and housing problems. Second, the mental illness unemployment problem is unacceptable because getting a job is a reasonable goal of most people receiving care, and because proven methods exist to address the problem.

Let's acknowledge that there are many barriers to address in helping people get, choose, and keep a job. The nature and experience of mental illness creates barriers. Many people's lives are interrupted by their illness—and the care they get for it—in adolescence or early adulthood. Thus, they never have the early career experiences (learning what you like to do and are good at, how to behave in the workplace) that some research suggests is the single most important personal factor in job success.

The effects of mental illness can also be very disruptive if one is employed. Motivation can be depressed and perform-

ance affected. “Good days and bad days” can take on a whole new meaning. Mental illness is often an “invisible disability,” and the accommodations that an employer can easily understand with a physical problem may be more subtle or hard to justify. Stigma is a real barrier. And the fear of “losing benefits,” often reinforced by mental health providers, can be paralyzing. A national study of the impact and cost of mental illness in the workplace is expected to be published this summer in the American Journal of Psychiatry. Surely it will confirm that “underemployment” and “presenteeism” (being on the job, but not functioning at your best) are big economic problems. So we know the challenges are real. But surely we can do better to help people get into the workforce.

It's time to get real. We have to acknowledge the reality is that mental health care can be irrelevant at best and an actual barrier to employment at worst. And the vocational rehabilitation system—though useful for a good number of consumers because of its practical orientation—performs worse for people with a mental health disability than any other category of impairment. While respecting the very real challenges, we can start by a self-examination of what the mental health system actually does—and what we could do better—to help people achieve their employment goals.

This self-analysis has to start with reality. Here are some questions to ask and answer.

(1) Is employment an issue that we even consider in our programs? The evidence shows that treatment of mental illness has little to do with employment outcomes. This is logical; when our focus is managing symptoms, that's what we're helping with, not employment. The research suggests that major mental health interventions (medication treatment, counseling/psychotherapy, case management) have essentially zero impact on employment. There may be many reasons for this. Sometimes treatment goals actually compete with employment goals (“you really have to avoid stressful situations and concentrate on getting better”). And sometimes we may operate from the generally false impression that “recovery” has to precede employment—when the evidence suggests that often it is the other way around (people use their job as a way to organize their lives as well as a source of social support and stability). So a place to start is for every program to inquire about work and include it (getting, adjusting to and keeping a job) in every treatment plan.

(2) Once we decide to address employment, what can we do that will be effective?

The key part of every journey is the first step. But after we make a commitment, what is effective? In a word, the research says we have to focus. First, as we know from our own careers, building on what people want is more effective in getting there, than building skills (the “train and place” model). Starting with people's personal employment goals is a core feature of the “Choose, Get, Keep” sequence of Supported Employment. Second, we know that activities that are directly related to a specific goal are more effective than general interventions (e.g. classroom training). The key is “functional focus.” Finally, it is clear that the most effective way to get someone a job is to hire them. The mental health field has a recruitment and retention problem in what are often considered “entry level” jobs. But these same jobs can represent an exciting career for many consumers. Affirmative employment takes work and commitment. Many community agencies in New York and also the Office of Mental Health have learned much about the reasonable accommodations and supports that will allow qualified people with psychiatric disabilities to perform very well in our workforce.

(3) What about the fear of losing benefits? I am reminded of Franklin Roosevelt's famous admonition: “We have nothing to fear but fear itself.” This is very relevant when it comes to income benefits (SSI and SSDI) and especially Medicaid. Consumers, families, and providers are very fearful of losing these resources. However, the tools are available, in SSI's 1619 (b) provisions (an individual plan that allows continued Medicaid coverage up to an income of over \$40,000 in New York) and the Medicaid Buy-In option that is even more generous. The challenge is that people need help figuring out and applying for these protections, to have a reasonable peace of mind. Some experiences have shown that simply assisting people with understanding and managing their benefits can double employment rates of people with a mental illness.

Federal and state leadership is essential to fixing the problem. The narrow scope of what Vocational Rehabilitation and Medicaid will each reimburse makes financing of supported employment—the evidence based “gold standard” of mental health rehabilitation—very difficult. Mainstream employment programs and indeed employers must be more hospitable. And the labyrinth of benefits must be simplified. But there is much that we can do—at every level—to make a difference.

Let's get busy.

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Promoting Recovery Through Work

By Lauren B. Gates, PhD
and Sarah L. Gowtham, MS
Columbia University School of Social Work
and Douglas Ruderman, LCSW
New York State Office of Mental Health

Recovery from mental health conditions means many things to many people, but increasingly it includes meaningful work in the community. In recognition of this emerging viewpoint the New York State Office of Mental Health (NYS OMH) has launched the Personal Recovery Oriented Services Program (PROS) to provide rehabilitation services that promote recovery of people with mental health conditions. A major component of PROS is to support individuals who wish to obtain employment in the community and create lasting connections to the world of work.

Over the next year agencies statewide will be converting their Intensive Psychiatric Rehabilitation Teams (IPRTs), psycho-social clubs, some continuing day treatment programs and NYS OMH funded vocational services to PROS. The challenge for the new programs will be to translate employment-related best practices into PROS so that successful employment outcomes can be reached for the individuals being served. In response, NYS OMH has partnered with the Workplace Center at



Columbia University School of Social Work. The Workplace Center has expertise in research, program development and training around best practice approaches to supporting employment for people with mental health conditions. Drawing on its expertise and previous research, the Workplace Center has been asked by the NYS OMH to provide extensive training and consultation to agencies to help PROS staff set in place policies and operations that support individuals' employment goals. A

significant objective is to help agencies learn how to offer best practice employment-related services through PROS.

Employment-related support to individuals with mental health conditions can be offered through any of the three PROS components. Individuals receive employment support through the Community Rehabilitation Support (CRS) component when they are exploring career options or require job maintenance support while focusing intensively on other recovery

goals. Once individuals have identified their career path and are ready to seek employment, they are offered support through the PROS Intensive Rehabilitation (IR) component. Finally, those individuals who are sustaining employment in the community are supported through On-Going Rehabilitation Support (ORS).

Although the specific services provided vary depending upon where individuals are in the employment process (i.e., seeking, securing or sustaining employment), the steps to guide providers in service determination are similar in all three PROS components. The general steps include:

- Verify participant eligibility for services through one of the three components.
- Identify, with individuals, the requirements for the specific job or occupation of interest.
- Identify, with individuals, the strengths they have that promote reaching their employment goals and the barriers that may stand in the way. Once these strengths and barriers have been identified, work together to understand how the strengths and barriers may help or hinder meeting the occupation or job requirements.

see Promoting Recovery on page 35

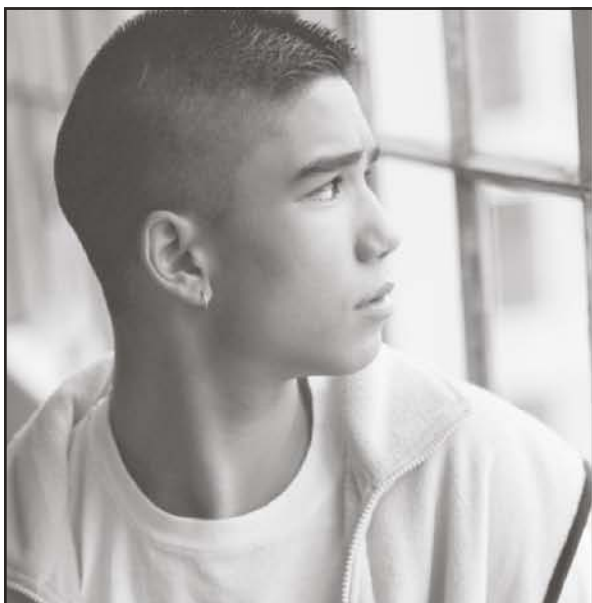
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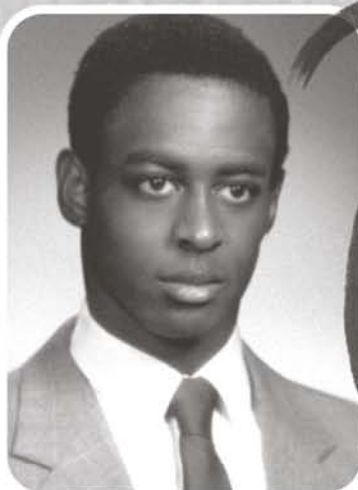
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Varsity Basketball Cheer Squad,
Homecoming Queen,
Diagnosed with
mental illness in 1995.



Todd Dunzello
Marching Band, Drama Club



Scott Durfee
National Honor Society,
Photography Club,
Diagnosed with
mental illness in 2001.



Katie Esteves
Senior Chorus, Varsity Softball,
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**SUPPORT OPEN ACCESS AND GIVE PROVIDERS THE FREEDOM TO FIND
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1. National Institute of Mental Health. Available at: <http://www.nimh.nih.gov/healthinformation/statisticsmenu.cfm>. Accessed August 7, 2006.

Career Development Initiative A Creative Approach to Employment Possibilities

By Carol Blessing, LMSW
Cornell University and
John Allegretti-Freeman, LCSW-R
New York State Office of Mental Health

How can we all work together and share responsibility to exceed the traditional employment outcomes that are really unacceptable? That is the question that is being asked by staff across the state who are involved in the Career Development Initiative.

In "Achieving the Promise" (July 2003) the President's New Freedom Commission reports that individuals with psychiatric disabilities are among the least likely to obtain employment opportunities. The national employment rate for these individuals tends to hover around 15% regardless of what services are provided despite the fact that about 70% of these individuals report a desire to work (Achieving the Promise, 2003). The barriers to employment are huge including financial disincentives, stigma, and perceived limitations.

Joe Marrone (Institute for Community Inclusion, MA), a leading advocate in the field, states that employment is an expectation of everyone in our society, except for those with mental illness. For some reason, a "pass" is given to this population, despite the fact that, when asked, they express a desire to participate in the community and share work responsibilities. Denise Bissonette, an employment



Carol Blessing, LMSW

services trainer from Canada, states that "any employer will hire any employee as long as the potential to increase revenue exists". The art is in assisting individuals in creating employment opportunities that match their skills and interests which also meet the needs of employers. Connie Ferrell (Integrated Services, Inc.), a pioneer in Supported Employment, has long stated that there is a unique job match for everyone.



John Allegretti-Freeman, LCSW-R

As New York State began looking more closely at evidence-based models of treatment, supported employment as a methodology gained more prominence. Supported Employment was one of the evidence based models that New York chose to highlight (Winds of Change, 2000). Furthermore, the evidence supports that evidence based models are best done in combination (Fallon).

The Career Development Initiative (CDI) is an approach that the New York State Office of Mental Health has undertaken within its 16 adult facilities to address the issue of poor employment outcomes. CDI was born out of a desire to focus on work as a major aspect of recovery. In 2002, OMH partnered with the Cornell University School of Industrial and Labor Relations' Employment and Disability Institute to design a new approach to assisting individuals achieve their employment goals.

The initial phases of CDI involved agreement on common language and terms as to what constituted integrated employment. Given that there were so many models in the field (sheltered work, enclaves, affirmative business, transitional employment, supported employment), there was little consistency or agreement as to what a real job was.

Agreeing to utilize the national standard definitions allowed the project to move forward on common ground.

Traditional approaches to addressing the "employment problem" have been to train vocational staff in job development and to send them out to develop "job slots". Although the development of job placement skills along with other technical vocational rehabilitation skills is a part of the supported employment approach, we fail to consider the individual when we look for "job slots" alone. Traditional approaches

see Creative Approach on page 32

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THE MENTAL HEALTH LAWYER



Employer Discrimination Against People with Mental Illness: The ADA

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

After the much celebrated sweep of civil rights legislation in the 1960's surrounding race, ethnicity and sex, Congress, in that same anti-discrimination tone, enacted the much less known Rehabilitation Act in 1973. The Rehabilitation Act is widely regarded as the first of its kind in America that demands equal treatment for individuals with disabilities. The legislation outlaws discrimination against the disabled that results in the denial of any program or benefit provided by an entity that receives funds from the federal government. This includes not only government agencies but essentially all colleges, airports, hospitals and many other public bodies as most of them receive some sort of federal funding. It was the Rehabilitation Act that paved the way for the passage of the much more widely known Americans with Disabilities Act ("ADA") in 1990, which prohibits discrimination against the disabled by public as well as wholly private entities with 15 or more employees.

In enacting the ADA Congress observed over 43 million Americans suffer from some sort of disability whether it be physical or mental. Moreover, that society has tended to isolate people with disabilities and that the Nation's proper goal should be to assure equality for the disabled in all facets of daily living.

This article will focus on Title I of the ADA, the portion of the legislation that bars discrimination against the disabled in employment. Specifically, the article will address the ADA as it relates to people with a mental illness, the rights held by the mentally ill under the ADA in employment situations and finally, what to do if you think you have suffered employment discrimination because of your mental illness.

Who is Covered Under the ADA

Not all disabilities or illnesses are covered by the ADA. Only those illnesses that substantially limit one or more major life activities is considered a disability for the purposes of the ADA. What exactly satisfies the major life activity requirement has been much debated in the Courts and there is no definitive list. Although, the life activities that are most commonly affected in those suffering from a mental illness, the ability to sleep, deal with high stress situations, or concentrating at work, do qualify as major life activities for purposes of the ADA.

In addition to impacting a major life activity, the disability in question must be of a permanent or long term nature. Therefore, while someone may, in a very real sense, suffer from clinical depression over the loss of a loved one or post traumatic stress disorder from experiencing some horrific event, if the disability is transitory the person will not qualify for the benefits of the ADA.



Douglas K. Stern, Esq.

Specific to Title I and employment, in order to qualify for the protection of the ADA, a person must also show that they are able to perform the essential functions of the job they are either applying for or currently employed in. Of course, one of the major rights granted under the ADA is the right to request a reasonable accommodation (reasonable accommodations will be discussed more thoroughly in the foregoing paragraphs of this article) and if the person can perform the essential functions of the job with the help of a reasonable accommodation they are a qualified individual for purposes of the ADA.

When considering mental illness there are two particular areas that tend to, more frequently, affect a person's ability to perform the essential functions of the job. The first is attendance. Many people with a mental illness often find themselves unable to work at all during times of decompensation in their mental status. Whether or not this would disqualify them from the protections of the ADA depends greatly on the length and frequency of absenteeism as well as the nature of the position.

A second area that those with a mental illness are sometimes affected by is potential dangerousness. An employer is not required to hire or continue to employ someone that poses a threat to co-workers. However, this only applies where the employer concludes that the individual in question is an actual danger to others, supported by objective evidence, and cannot be based upon stereotypical views of those with a mental illness.

Rights Granted Under the ADA

If someone meets the requirements outlined above, the rights granted are quite substantial. As a basic principle, the ADA bars outright discrimination based

upon prejudice against, or fears of, those suffering from a mental illness. More subtly and important, the ADA mandates that employers provide employees with a qualifying disability reasonable accommodations so that the affected individual can perform their job. For people with a mental illness the most common accommodations are often a flexible work schedule to mitigate the effects of prescription medication, time off to attend appointments with mental health providers, leave from work during periods of acute decompensation, self paced workloads and a modification of non-essential job responsibilities.

The ADA only requires an employer to grant "reasonable" modifications. In other words, the employer is not required to grant any and all modification that an employee may need. First, the employee must request an accommodation from the employer in order to receive it. Employers are not under an affirmative duty to provide accommodations without prompting. Although, once the employee has requested the accommodation the employer is required to engage in an interactive process with the employee in order to reach an accommodation that is reasonable and effective. Modifications that pose an undue financial burden or that alter the nature and character of the job function is not considered reasonable and

therefore an employer can refuse any such requested modification.

Another area of great importance to those with mental illness is an employer's right to inquire about the nature and character of an illness, or whether one suffers from one at all. In general, the ADA prohibits an employer from asking about one's mental health. Although, where an employee requests an accommodation that opens the door for the employer to ask limited questions regarding one's illness. For instance, employers will often submit the requirements of the job of the individual seeking an accommodation to his treating mental health professional in order to determine if the person has the ability to meet the essential requirements of the job.

Remedies if Your Rights are Violated

If an employer fails to provide a reasonable accommodation or flagrantly discriminates against someone with a disability then the ADA defines the following process for redress. The first step one must take is reporting the action to their local Equal Employment Opportunity Commission ("EEOC") office within 180 days after the discriminatory action. The EEOC will either decide to pursue the action on its own,

see The ADA on page 34

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

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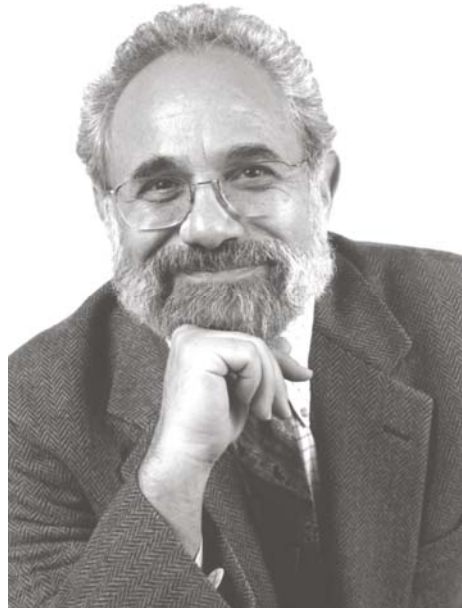
POINT OF VIEW

Mental Health is The Essence of Aging Well

By Michael B. Friedman, LMSW

In discussions of the needs of old people, mental health is generally an afterthought. Will there be enough money in private pensions and the Social Security system to support them? Will Medicare be fiscally viable and adequate health care available? Will they be able to remain at home if they become disabled or will they have to go to a nursing home? Will they end up isolated and lonely? These are the first questions on the minds of people as they age and of the policy makers who are charged with meeting their needs.

Mental health is not a concern. A stunning omission because you cannot live well in old age without mental—as well as physical—health.



Michael B. Friedman, LMSW

- Imagine that you are driving your car one day and cannot remember where you were going and that over time your memory gets worse and worse until you ultimately cannot recognize family and old friends.
- Imagine that almost nothing interests you or gives you pleasure. You could care less whether your grandchildren come to visit or who the next President will be.
- Imagine that you live with the pain of unrelenting depression, hating your worthless past, hopeless about your future, and contemplating suicide much of the time.
- Imagine that you are constantly angry, that you over-react to minor slights, and that you are abusive to your family, friends, and caregivers.
- Imagine that you worry all the time. Did you turn the stove off? Did you insult your friend? Is your daughter mad at you? Is it safe to go outside?
- Imagine that you believe that your home health aide is robbing you blind or a spy from the CIA.
- Imagine that you surround yourself with all the material things of your life, old newspapers, unwashed dishes, and clothes that wore out long ago because without them you feel you have no life.
- Imagine that you feel your life is meaningless because there's nothing productive you can do.
- Imagine that your friends are gone and that you feel there's no one left who cares about you or who you care about.

- Imagine that you find solace and sleep in alcohol or that you become addicted to painkillers because you just cannot stand the constant pain in your hands or shoulder or knee.
- Imagine that you are responsible for your mother or father or aunt or uncle, who is failing and can no longer take care of him or herself. Imagine that for years you have had to be there in the morning to get them washed, dressed, and fed; that you have had to be there in the evening for dinner and for bedtime, that you have had to be there in the middle of the night when there is a crisis. Imagine that you are abused for your efforts, that nothing is ever good enough, that no one can fill in for you. How does it feel? Do you wear down? Does sending your loved one to a nursing home come to seem more and more necessary?

Isn't it obvious when you imagine these things that mental health is not just part of living well as you age but that it is of its essence? Isn't it obvious that the public policy agenda for older adults must address mental health opportunities and needs?

Here are key elements of a mental health agenda to help people live well in old age:

- **Positive Aging:** Contrary to the ageist assumptions of Western society, most older adults can retain their mental health. Public mental health, health, and aging policy should focus on opportunities for aging well—for remaining engaged, for productive work, for civic engagement, for creative activity, for physical activity, etc.

- **Integration of Medical and Mental Health Care:** Mental illness increases risks of disability and premature mortality in people with chronic illnesses such as diabetes, heart disease, and neuromuscular disorders. It also increases the costs of medical care. It is very important, therefore, to build the identification and treatment of mental illness into both primary and specialty medical practice.
- **Caregiver Support:** Mental illness and behavioral problems also increase the likelihood that an older adult will end their lives in nursing homes, usually—but not always—contrary to what they want for themselves. To hold the need for nursing homes to a minimum, it is essential to provide support and education for formal and informal (usually family) caregivers in the community so as to help them to care effectively for people with mental and behavioral problems.
- **Access to Care:** Access to treatment is quite limited for older adults with mental and/or substance use disorders. There are too few geriatric mental health professionals and too few programs. There is a particular shortage of culturally competent/bilingual services. Lack of transportation and home-based services are also barriers. And cost can be a significant problem, particularly since Medicare requires a 50% co-pay for most services. To make mental health services accessible in the community, all of these issues need to be addressed.
- **Outreach and Public Education:** Because of stigma, ageism, and just plain ignorance about mental and substance use disorders and their treatment, most older adults do not seek care from mental health providers. To engage them, it is necessary to reach out into community settings such as aging service programs, primary health care practices, houses of worship, and the like. It is also necessary to provide education about mental and substance use disorders.
- **Quality of Care:** Those older adults who do seek and get treatment often get poor quality care. Most get care from primary care physicians who are not adequately trained regarding mental and substance use disorders. And even those who go to mental health professionals often get inadequate treatment because few professionals get the training they need regarding older adults. In addition, many older people with mental and behavioral problems are served out-

side the mental health system via home health, day care, adult protective services, and nursing homes where it is unusual for staff to be competent regarding mental health and/or substance use issues. Major efforts are needed to increase clinical, generational, and cultural competence among those who serve this population.

- **Workforce Development:** Given the vast shortage of adequately trained providers and the vast growth of the elderly population that will take place over the next 25 years, it is clear that a massive workforce development effort is needed, including training of current personnel and the building of a much larger workforce for the future. Seniors, themselves, can be part of the workforce of the future if we go beyond traditional ways of providing services and develop appropriate roles for older adults.
- **Funding:** Success at all of the above will cost more money than we are now spending. Yes, some cost savings are possible by averting institutionalization and by re-structuring finance models. But, as the population of older adults grows from 13% to 20%, increased costs are unavoidable.

And that's the rub; almost no one in power these days wants to spend more money on humane services, let alone on mental health or substance abuse services for older adults. To them our message has to be, mental health is not a minor issue for older adults. Mental health is of the essence of aging well and should be a major public policy concern.

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. 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.

The Geriatric Mental Health Alliance of New York is an advocacy organization dedicated to improving practice and policy regarding older adults with mental and/or substance use disorders and disabilities. It provides information, policy analyses, and policy proposals for advocates and policy makers. It also provides a broad range of educational activities.

For more information about the Alliance, visit www.mhwestcher.org/advocates/geriatrichome.asp. To join the Alliance (there is no charge), send your contact information to the Alliance at center@mhaofnyc.org.

The NYSPA Report: Our 2008 Agenda

By Barry B. Perlman, MD
Richard Gallo, and Seth Stein

A central aspect of NYSPA's mission is to advocate on behalf of persons with mental illness. It does so by advocating in relation to both budgetary, programmatic and regulatory issues. As we write this NYSPA Report, the NYS legislature has just completed work on the state's Budget for 2008 – 2009. The budgetary outcome for issues related to mental health has been a good one. With this in mind, we wish to share with the readership of MHN highlights of NYSPA's agenda for the current legislative session.

Timothy's Law

NYSPA, together with our coalition partners, continues to work on insurance parity issues involving both the implementation of Timothy's Law and new legislation augmenting it.

On the legislative front, the Timothy's Law Campaign is fighting for passage of two initiatives:

1) S.6818 by Senator Morahan (R-Orange; Rockland)/ A.10078 by Assemblyman Rivera (D-Bronx) – adds post traumatic stress disorder (PTSD) to the list of biologically based mental illnesses requiring full parity coverage under Chapter 748 of the Laws of 2006 (Timothy's Law);

2) Requiring (as part of the 2008-2009 budget) parity coverage for mental health and substance abuse services be included in the State's Child Health and Family Health Plus programs. The Assembly advanced the measure in their budget recommendations but it fell victim to the three way negotiations leading to the budget accord. Parity advocates will pursue the passage legislation separate from the budget but the outlook is bleak given the, State's economic woes.

The PTSD bill (S.6818) has been favorably reported from committee and has advanced to the Senate floor. On the Assembly side, Assemblyman Peter Rivera (D-Bronx), Chair of the Assembly Mental Health Committee has agreed to carry the "Same As" bill in his house but, as of this writing, has not yet introduced it.

Timothy's Law has been in effect for over sixteen months. Nevertheless, NYSPA, TLC coalition partners and the State Insurance Department continue to receive questions and complaints about the implementation tactics of some insurers and HMOs. Representatives of the Timothy's Law Campaign meet regularly with State Insurance Department (SID) officials to sort through the questions and complaints in an effort to distinguish non-compliance from misinterpretation.

Some of the technical issues being pursued which have important clinical implications for coverage and care under the law include:

1) Clarify the full range of DSM IV diagnoses accorded full parity coverage under

Timothy's Law. To accomplish this goal, there has been a need to cross-walk and convert the DSM-IV definitions of "biologically based mental illness" and "serious emotional disturbances" used by the authors of Timothy's Law to ICD-9 diagnosis codes used by insurers to pay claims pursuant to the law. In that regard, the State Office of Mental Health, in consultation with NYSPA, has supplied the Insurance Department with a DSM IV to ICD-9 conversion document, which, when circulated, should clarify any ambiguities arising out of the definitional-coding differences between ICD-9 and DSM-IV.

2) Clarify whether, in conformity with Chapter 551 of the laws of 2006 as well as with Timothy's Law, psychiatrists may utilize all CPT (current procedural terminology) codes to describe the work they do with patients. Psychiatrists assert that being able to use all applicable CPT codes, including what are referred to as E&M (Evaluation & Management) codes enables them to better serve their individual needs of patients.

3) Clarify whether under Timothy's Law the 20 visit limitations in the base include psychopharmacological medication management visits (CPT code 90862). Clearly, the inclusion of a medication management visit as a full visit subtracted from the base would dramatically reduce the benefit package available under Timothy's Law.

Privacy

NYSPA is seeking to have legislation introduced in the legislature which would provide for punitive damages when health insurance companies lose control of protected health information. While reading about the loss of credit card or social security data has become commonplace, learning of the loss of medical records such as occurred when Wellpoint had to notify 75000 members of its Empire Blue Cross and Blue Shield unit in New York that their medical and other personal information disappeared was startling. It was even more upsetting to learn that the lost compact disc contained unencrypted data sent to Magellan Behavioral Services, a company specializing in managing mental health and substance abuse treatments for health insurance companies. Legislation is needed because currently when such a loss occurs there are often delays in notification of the affected parties and the remedy offered is often a year long credit watch. In essence, despite the potential for far greater damage to the affected persons, the health insurance industry treats the loss of such protected material as though it were no worse than the loss of credit card information. NYSPA is proposing a small payment, perhaps \$50 to each person whose records are lost. Such payments would represent only a gesture to individuals whose records were lost but a significant penalty to the company when the records of thousands are lost as has occurred many times when unencrypted data discs or computers are lost.

Mental Hygiene Law

NYSPA recently noted that section 9.05 of the Mental Hygiene Law effectively keeps psychiatric leaders from fully participating as organizational leaders in the hospitals in which they work. Working within institutions, it is important that psychiatric leaders to educate colleagues about mental illness and its treatment and advocate for adequate budgets and quality behavioral health and psychiatric programs within those organizations. Section 9.05 states, "(a) A person is disqualified from acting as an examining physician in the following cases:" "2. if he is a manager, trustee, visitor, proprietor, officer of the hospital in which the patient is hospitalized or to which it is proposed to admit such person" In other words, if a psychiatrist were an hospital trustee they could not serve as an examining physician for purposes of involuntary commitment, an important function of the hospital psychiatrist. While unlikely to undermine the functioning of large departments, department directors perform this task frequently in smaller community hospitals where the number of available psychiatrists may be limited. Directors of clinical departments, including psychiatry, often serve ex officio on the Medical Board of their hospital. Often the President of the Medical Board in turn serves ex officio as a trustee of the

hospital. By prohibiting their functioning as examining physicians, Section 9.05 of necessity prevents psychiatrists from assuming leadership roles which would place them on the hospital's board and thus limits their ability to advocate on behalf of the persons with mental illness served by their hospitals. NYSPA urges a reform of Section 9.05 in order that psychiatric leaders be able to serve as trustees of Article 28 voluntary hospitals without limiting their ability to function as examining physicians. We believe such a change on balance will have a beneficial effect on the care of patients with mental illness at those institutions without creating inappropriate conflicts of interest when deliberating about involuntary commitment.

NYSPA is pleased to be able to share our legislative and regulatory goals with the readers of Mental Health News, and would welcome their comment on our agenda. Beyond comment, we would welcome collaboration with other groups sharing our mission of advocacy on behalf of persons with mental illness in advancing these items.

Barry B. Perlman, M.D. is the Legislative Chair and Immediate Past President, Richard Gallo is the Government Relations Advocate, Seth P. Stein is the Executive Director & General Counsel of the New York State Psychiatric Association.



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The Economics of Recovery: How Business Tools Can Help

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

In late April, NYS Governor David A. Paterson sent a memo to all eleven State Agency Commissioners asking them to submit their plans for reducing their agencies projected 2009-10 spending by 3.5 percent. This would slow the growth of the states' annual budget of one hundred twenty two billion dollars from an average of seven percent, to just one percent.

DOB's projected 08-09 Mental Hygiene Budget of 8.9 billion contains a number of budget saving initiatives including deinstitutionalization, community housing, managed care of High-Cost Beneficiaries, eliminating unnecessary use of inpatient, nursing home & emergency rooms, minimizing overtime, consolidation and/or closure of state run facilities, improved coordination among OMH, OSAS, OMRDD, and DOH, holistic health care and other plans to prompt cost-effectiveness. (budget.state.ny.us/mentalhygiene/allfunds)

The Governors' memo also suggested the Commissioners "rethink their hiring practices, leave nonessential positions vacant and fundamentally reevaluate your agency's operations from top to bottom".

You often hear taxpayers asking "why can't governments operate as efficiently as business"? Before we can address this question, we need to better understand the world of corporate America. While their tools are effective, there is a price government and non-profits might not be willing to pay.

The World of Business

The core mission of business is to make money. As the chart below illustrates, for-profit corporations are organized to provide a product or service to



Donald M. Fitch, MS

their customers in return for payment. Collectively, the consumer has the power to determine which companies will be successful and which ones will fail. If the consumer is satisfied, they will continue to purchase the product or service. If they are not satisfied, they will take their business elsewhere. Competition ensures continuous product innovation and maintains the price/value ratio.

In business, success or failure is always defined quantitatively in terms of sales, profits, stock, market share, etc. If you make your numbers, you're rewarded. If you don't, you will be demoted, transferred or fired. The sword cuts both ways. (Jack Welch, former CEO of GE reportedly had a policy of letting go five percent of the least productive people in each department, each year, to raise employee performance!)

In addition to the competition both inside and outside the organization, for-profit employees must cope with layoffs, mergers, budget cuts and sixty hour work

weeks. There is no job security; you can be fired at will without due process.

The preferred communications style is like a PowerPoint chart presentation; the maximum amount of information transmitted with a minimum of words in the shortest time; tables, graphs and bullets.

There is an addiction to information; all kinds, all forms, all the time. Knowledge is power – but only if you act upon it. Since the consumer is king, their opinions count the most, especially the "hard core loyal users", the twenty percent of the customers that account for eighty percent of your sales.

Companies spend millions to identify and quantify the consumers' knowledge, attitudes, usage, shopping patterns, lifestyle, psychographics, demographics, etc. Any and every measure that would yield a competitive advantage. CEO's would never risk millions launching a new product or service on the opinions of a few focus groups or "expert" consumers. Every opportunity and risk is quantified. (Just ask your pharmaceutical representative)

The distribution of resources in business is based on proven performance and investment in exceptional opportunity. To do otherwise would be to risk ones company and career.

"Too often, failing government agencies get bigger budgets, while successful agencies have their budgets cut – because government caters to those screaming the loudest, regardless of what they are screaming about. In business it's exactly the opposite. You invest more in the most successful departments and less in those that aren't performing." (mikebloomberg.com)

For-Profit Solutions

What if a President of a major corporation had received Governor Paterson's memo? How would they respond? How would they decide where to cut? In sum; they would follow the money.

For example, with OMH's inpatient

care running at about \$200,000, per person, per year, the cost for four-thousand consumers is about eight hundred million dollars. Transferring just five percent of this population to community housing and supportive services, at a cost of 50k/yr, would save taxpayers thirty-million dollars (\$150k x 200) (plus the cost of union contractual buyouts and retraining, less the sale of the property and contribution to the tax rolls, etc.)

Second, the CEO would zero in on the "High-Cost Beneficiaries"--- the fifteen percent of the consumers that account for almost two-thirds of OMH's budget. The CEO would ask; "What are the expense components"? "Which holistic care configuration would reduce the number of inpatient days"? "Ambulance trips to the ER"? "Crisis team interventions? etc." The daily savings for inpatient diversion is about fourteen hundred dollars.

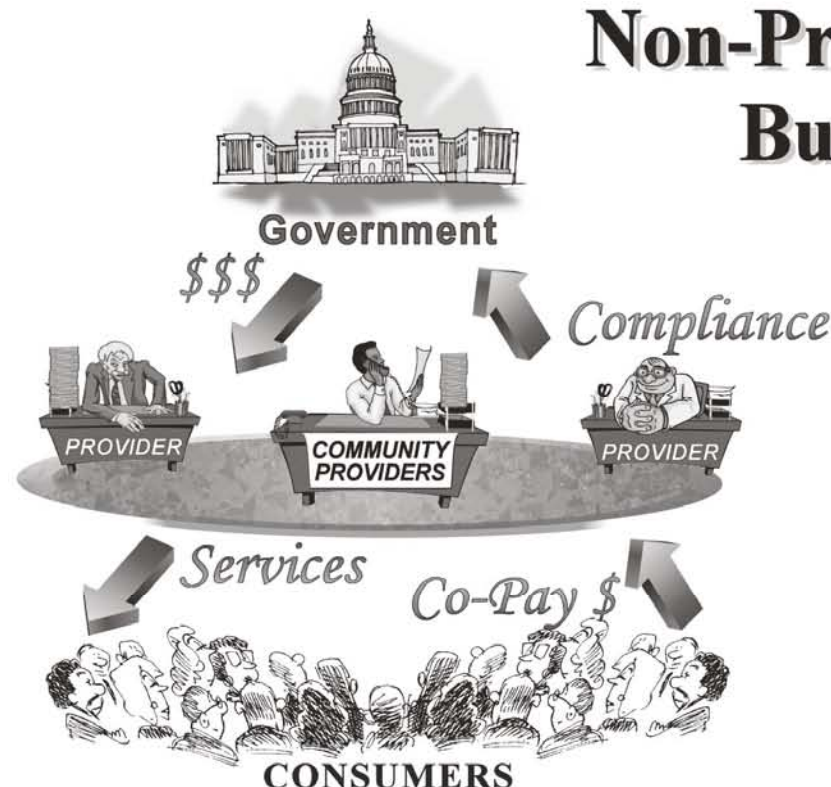
The traditional Govt/Non-Profit approach is to first build consensus through committees, stakeholders, and testimony from "expert consumers". Then, conduct informational/training/sell-in sessions and finally, to enact the program.

By contrast, the business/for profit approach is to start with the consumer; to identify and quantify their needs. How effective are the current services? What works? What does not? How do consumers respond to the new service? etc. The program is then tested & refined through a series of pilot tests before rolling-out.

Business asks: "Where are we? Where can we go? What is the best way to get there"? It's like building a roadmap; without it, we can & do wander for years.

Until Government and non-profits accept that the ultimate success or failure of any program lies with the consumer, they will continue to waste time, money and lives.

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The Mental Health News New York City Section

The Medicaid Buy-In Program for Working People with Disabilities: One Solution to Supporting the Employment Goals of Consumers

By Alysia Pascaris, Director
Center for Rehabilitation and Recovery
Coalition of Behavioral Health Agencies

Work is about much more than a pay check at the end of the week: it is about who we are and how we feel about ourselves. It is about identity, self-esteem, social responsibility and personal growth. It also has much to do with how we are perceived and the way we are evaluated by others. Our worth as individuals and our well-being as a society is measured by the product of our work. Work is a core value in American life.

The fundamental value of work for people with mental illness is beyond debate. We have learned from consumers that work is central to health and recovery for both psychological and economic reasons. Work helps people feel good about themselves by engendering a sense of identity and purpose, it allows individuals to contribute to their communities in both financial and personal terms, and work helps consumers combat the complex social consequences of a mental illness: pervasive poverty, homelessness and loneliness. Work and the opportunity to



Alysia Pascaris

earn a living wage is inextricably linked to overcoming poverty and homelessness.

Unfortunately, numerous barriers and fears stifle peoples' desires and attempts to get and keep a regular job. Among the most significant barriers to work, consumers have long recognized the threatening effect of earned income on the dependable and secure attainment of cash and health

benefits. Many people with disabling conditions and serious or long-term impairments require access to a variety of health and wellness-related services and supports. Because of the critical nature of these supports, access to health coverage figures heavily on the employment decisions of persons with psychiatric disabilities. Although people receiving Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) have access to health insurance through Medicare and Medicaid, eligibility rules require that earnings are below a low threshold – meaning – the potential exists for employment to result in the loss of health benefits. Many SSDI and SSI beneficiaries perceive this risk of losing Medicaid through work as an equal or greater work disincentive than the risk of losing cash benefits. The fear of losing Medicaid is one of the greatest barriers keeping consumers from maximizing their employment, their earnings, their independence, and their recovery!

Over the years, key legislation has helped to alleviate some concerns about health coverage among working people who are disabled or those who are considering returning to the workplace. Since the 1619(b) Medicaid provisions became

permanent in 1987, SSI beneficiaries have been able to keep Medicaid even when they lose cash benefits due to wages. For persons receiving SSDI, without an SSI supplement, the Medicaid Buy-In for Working People with Disabilities (MBIWP) program allows them to work, or work more, and still keep Medicaid coverage. In existence since 2003 in New York State, the MBIWP Program offers Medicaid coverage to people with disabilities who are working full-time or part-time and earning more than the allowable limits for regular Medicaid (\$53,028 maximum for a single person, \$71,028 for married couples). Even though SSDI beneficiaries who work remain eligible for extended Medicare coverage, Medicare typically does not provide the scope of coverage available through Medicaid.

At the Coalition of Behavioral Health Agencies' Center for Rehabilitation and Recovery we strive to reduce the barriers consumers face in achieving meaningful life goals, such as employment, through education, training, consultation and systems change efforts. We establish strategic alliances with providers, consumers

see Medicaid Program on page 36

Promoting Rehabilitation and Recovery: Expanding Employment Opportunities For Consumers at The New York City Health and Hospitals Corporation

By Jonathan P. Edwards, MSW
Consumer Affairs Coordinator and
Marylee Burns, MEd, MA, LMHC, CRC
Senior Director, Mental Health Services
NYC Health and Hospitals Corporation

The majority of unemployed persons with psychiatric disabilities desire work (Rogers, Anthony, Toole, & Brown, 1991). Work is more than a job – it provides an essential role in society which translates into a sense of usefulness. Employment gives meaning and structure to our lives. Although work puts bread on the table, and pays for a roof over our head, it also puts us in touch with other human beings; some of whom become important parts of our lives. Having a disability does not preclude employment as a goal. Most consumers of mental health services say that meaningful work, not just “non-stressful” busy work, is what keeps them healthy.

Work can also be a means of self-empowerment in that it is a way of building self-efficacy and motivation to improve and sustain wellness, and a way in

which to feel good about oneself (Provencher, Gregg, Mead & Mueser, 2002). Analogous to the role that medication plays in treatment, working is a way in which to achieve and sustain recovery. “Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential” (Consensus statement from U.S. Department of Health and Human Services, SAMHSA, 2006).

In recent years, the mental health consumer movement has advanced the paradigm of self-help and recovery, broadening the spectrum beyond traditional, medically-oriented treatment approaches. Several studies have shown that clients who receive peer provided services experience fewer hospitalizations, use fewer crisis services, reduce their substance abuse, and improve their employment outcomes, social functioning and quality of life when compared to those who only receive professional services (Armstrong et al., 1995; Besio & Mahler, 1993). Evidence has also shown that peer support can stabilize participation in treatment by

helping to counter the sense of frustration, hopelessness and isolation that individuals experience when dealing with the complicated, often fragmented mental health care system (Deegan, 1992; Markowitz, 2001; Solomon, 2004). The peer role can have a significant positive effect on the recovery of the peers themselves (Anthony, 2000; Schiff, 2004; Solomon, 2004). Through the connection to work, peers can experience an increased sense of self-efficacy, empowerment and healing (Akabas & Gates, 2000; Markowitz, 2001; McGrath & Jarrett, 2004). Integrating individuals with psychiatric histories—who possess a desire to help others as part of their ongoing recovery—into mental health service delivery has an impact on the organization and contributes to enriching the diversity throughout the service structure and service delivery.

The New York City Health and Hospitals Corporation (HHC) has taken an active role in responding to mental health consumers' rehabilitation and employment needs and is changing its culture to become more focused on strengths-based treatment and on the notion of recovery. The Corporation has infused person-centered values

throughout its behavioral health services, making outcomes transparent, utilizing evidence-based and emerging best practices and involving consumers in planning and decision-making.

HHC, the largest municipal hospital system in the country, provides healthcare to one out of every six New Yorkers, and is also a major provider of mental health and substance abuse services. Since 1999, HHC has generated employment opportunities for persons with histories of mental illness (including those with co-occurring mental illness and substance abuse problems) by creating a Corporate job title of “Peer Counselor.” As of April 1, 2008, there were approximately 30 Peer Counselors working in an array of settings within HHC mental health programs, as members of psychiatric inpatient and outpatient treatment teams, on Assertive Community Treatment (ACT) teams, and in Assisted Outpatient Treatment (AOT, known commonly in New York State as Kendra's Law) teams. In order to qualify to work as a Peer Counselor at HHC, applicants must have a four-year high school

see NYC-HHC on page 37

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Brooklyn REAL Helps Clients Learn Job Skills

By JBFCS
Staff Writer

For the last three years, Ephrayim Levine, 43, has attended the Brooklyn REAL Continuing Day Treatment Program and for the last seven months worked successfully at the West Brooklyn Copy Center making copies and assisting customers. Brooklyn REAL, which stands for Rehabilitation and Education in the Art of Living, is a program of the Jewish Board of Family and Children's Services for adults who are living with mental illness.

Through the help of his social worker Cristina Caroli, LMSW, Mr. Levine prepared for the interview and took the steps needed to qualify for the job, including having a medical examination.

After his second interview with John Campitelli, the manager of the copy center, Mr. Levine was hired and has worked two hours a day three days a week for the past seven months.

And that's in addition to attending Brooklyn College where Mr. Levine takes one course a semester toward an undergraduate degree in history. Beginning in 1993, he has now completed 90 credits with 30 more credits remaining for graduation which Mr. Levine expects to do within the next few years.

Mr. Levine's attitude toward college reflects the work ethic he shows on the job. His credo? "You have to be diligent, disciplined, optimistic, cooperative with people, ask specific questions if you need help, and be courteous and polite—always say please and thank you."

When Mr. Levine learned about the job opening in the fall he was interested because it meant extra money for incidentals. "That comes in handy when I want to go out on a date," he explains. "Also I haven't worked in many years, so this help fills the gap in my resume."

Brooklyn REAL has an ongoing relationship with the copy center and other clients have worked there as well.

"Our clients usually work there on a temporary basis for six to nine months to try out the working world," explains Ms. Caroli. "We have a waiting list. Usually by nine months the assignment ends so another client can have a turn."

The Brooklyn REAL Program offers a "Getting a Job, Going Back to School" group to help clients who are interested in working. Additional groups allow clients to socialize among themselves which is good preparation for working with others in a work situation. The program also encourages clients to volunteer at the Brooklyn REAL kitchen with the daily lunch program, to see what it's like to be part of a team.



Ephrayim Levine, JBFCS Brooklyn REAL client enjoys a moment with Cristina Caroli, LMSW Social Worker at the program

"Ephrayim functions at an independent level, taking college courses, and living on his own in an apartment. He showed motivation to work, so he seemed like he'd make a good employee for the copy center," notes Ms. Caroli.

Mr. Levine clearly fulfilled her expectations. He has never missed work or been unable to complete his job responsibilities. "I like my job. I'm busy and productive," Mr. Levine says about the benefits of working. He has continued to attend groups at Brooklyn REAL during the hours he's not at his job or in classes.

As Mr. Levine nears the end of his term at the copy center, he and Ms. Caroli meet to figure out what his next steps will be and to make that part of his treatment plan.

Mr. Levine's long-term goals are to complete his B. A. in history and go on to graduate school for social work or further studies in history.

As for his immediate plans, this summer you can find him taking art classes at the school of Visual Arts in Manhattan. For the past five years, Mr. Levine has enrolled in drawing classes there.

"He's a very good artist. That's another one of his talents," Ms. Caroli says with a smile. "I'd encourage anyone living with a mental illness who is interested in working or going back to school to get support from a program or their social worker to pursue their goal. It can be an attainable goal for many people."

Brooklyn REAL is designed for clients who are 18-years-old and older who are living with mental illness and have a range of functional levels. For more information about the program, contact Svetlana Gritsko, LCSW, Director, at (718) 676-4260.



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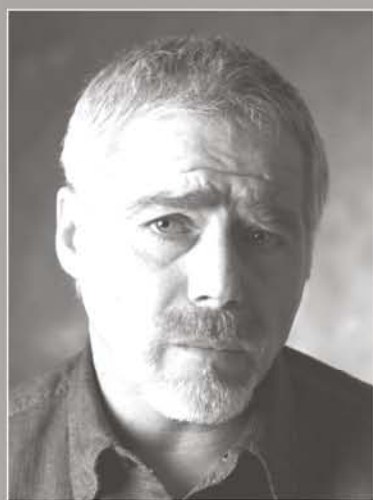
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The Role of the Provider in Employment For those Individuals Recovering from Mental Illness

By Larry Hochwald, Joseph DeVivo
and Raymond Pape
St. Vincent's Hospital Residential Services

Whenever providers get together and the talk turns to employment for consumers, particularly those challenged by mental illness, two things always come up: "work is great therapy but most of our clients aren't ready for it." The second is, "There's too much to worry about when our clients earn money, it causes issues with their benefits!"

We work in the Behavioral Health Services division of St. Vincent's Hospital, specifically in the Residential Services program. Our goal is to manage and grow Rainbow Environmental Services, which was developed in 1991 to provide meaningful and gainful employment for individuals who have been unable to attain or maintain employment due to their psychiatric disabilities. It has won many accolades, including the American Psychiatric Association's 1995 Significant Achievement award and the New York City Department of Mental Health, Mental Retardation and Alcoholism Services 1999 Mental Hygiene Business award. The program currently employs 40 people.

One of the founders of Staten Island NAMI, once said: "One of the worst things that the mentally ill suffer from is low expectations." Of course, some clients cannot handle working, but we need to think of these more as the exceptions

than as the rule. As some of our long-time Rainbow employees have said, "...after I finish work every day I feel good about myself" and "working for Rainbow, your time is filled with friendship and the fact that you are a productive human being." We have found that for our clients and our organization, embracing employment and taking a part in it, have been beneficial, therapeutic and rewarding.

Here at Rainbow we have grown to offer many services to all types and sizes of businesses. We started with Rainbow Brite Cleaning and Rainbow Recycling. Rainbow Brite offers cleaning services to offices and businesses primarily in Staten Island. Rainbow recycling offers paper, cardboard and bottle recycling throughout Staten Island as well. Rainbow Shredding offers comprehensive document destruction to businesses all over the city for all their sensitive data, a very valuable service in these HIPPA times! Rainbow later added the management and operations of company mailrooms to our clientele. Our newest business is Rainbow Toner and Ink Cartridges. We offer ink and toner for any printer, copier and fax machine to individuals and businesses throughout the metropolitan area. We are excited about the opportunities for our employees with this new business because, beyond the labor-intensive duties of the other businesses, it gives them the opportunity to develop skills in inventory management, shipping, customer service and sales.

As we have grown over the years, awards and employee satisfaction are

great. However, to be a self-supporting business you need satisfied customers that want to refer more business. Here are what some of our customers have to say about us over the years:

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"We have been a satisfied customer of Rainbow Shredding...since 2003. The confidentiality of medical records and professional service extended is compliant with Hippa regulations and criteria...The cost of this services is cost effective...."

One of our newest Rainbow Laser and Print Cartridge customers recently had this to say about our prices and quality:

"When you contacted our organization about the new Toner and Print Cartridge business, we could see that your prices and guarantees were excellent, but the quality of the printing was still the most important thing for us. We are pleased to say it is superb."

Steve Scher, Executive Director
Staten Island Behavioral Network.

Running a business to provide employment for your clients gives your organization the opportunity to work on community relations issues from a different per-

spective. This can be very helpful when you are dealing with a suspicious community regarding your placing new housing or outpatient clinical services in their environs. At least, it gives you the opportunity to get out into the community and talk about the positive impact your clients and organization are having on the local economy. It is also a good way for you to remind the community that your clients are living and working with them every day already. From a community relations and anti-stigma perspective this can be invaluable. It is difficult for even the most skeptical communities to argue with an increased tax base and lower entitlement costs.

Understanding and having to deal with the effects of client earnings on their entitlements does not have to be distressing. You need to work with someone who gets to know the ins and outs of entitlements. Your agency probably already deals with entitlements so this should not be difficult. Remember, too, that clients can work a substantial amount of hours and earn a reasonable sum of money before it becomes a major issue. In a best case scenario, as is the case here at Rainbow, we have a number of full-time employees that came from the ranks of the psychiatrically disabled, who now receive the same benefits as all other employees of our hospital.

To run a successful business that is self-supporting as Rainbow is, you need financial discipline that may, at times, have been lacking in the social services, but is

see *The Role* on page 32

Beyond Fast Food and Filing: Helping the College-Educated Client Find Work

By Rita L. Liegner, M.S.Ed., LMHC
Director of Vocational Services
Riverdale Mental Health Association

Mental illness most often strikes individuals after they have reached adulthood and have made at least tentative career plans. At the time of diagnosis, many mentally ill adults have completed their educations, including perhaps specialized technical training, college or graduate school. Many have embarked on promising careers. Certainly, it is not uncommon to see adults in their 30's, 40's and 50's who have devoted ten or more years to building their careers only to find their progress thwarted, their careers interrupted by worsening symptoms of schizophrenia, or the onset of major depressive disorder.

The Riverdale Mental Health Association has been providing vocational services to adults with mental health disorders since 1996. Our VESID-OMH funded employment programs serve people of all educational backgrounds from those without high school diplomas to those with doctorates. As it happens, our client base has always included a high proportion of people with at least some



Rita L. Liegner, M.S.Ed., LMHC

college education, including a significant number with graduate and professional degrees. Of the 117 clients currently enrolled, sixty-five (65%) of our 57 job-seeking clients, and 52% of our 60 employed clients have attended college.

Although college education correlates positively with lower unemployment in the general population, the existence of this relationship for those with mental illness is questionable. In her 2003 study on evidence-based supported employment for individuals with psychiatric illness, Judith Cook did not find level of education to be among the characteristics predictive of better employment outcomes among participants. In fact, according to a 2003 report of the President's New Freedom Commission on Mental Health, about 70% of mentally ill adults with college degrees were earning \$10.00 per hour or less. And as 75% of all documented job placements for people with mental illness are in entry level jobs, it follows that the majority of college educated consumers are undoubtedly employed in jobs that do not require a college education.

Underemployment among college educated individuals with serious mental illness may in some cases be a function of the individual's inability to sustain continuous employment, or to major impairments in certain areas of functioning. But in a majority of cases, causes may be environmental. Historically, there's been a sense in the clinical and vocational rehabilitation communities that higher level

work just isn't possible for those with serious mental illness. "People with psychiatric conditions often discuss being told that they ...must resign themselves to the simplest, least rewarding, and lowest paying work. Even professionals in the psychiatric rehabilitation field have developed work entry systems that peg their clients into low wage and menial work, the three f's 'food, filth, and filing,' " so stated Boston University's Center for Psychiatric Rehabilitation in a 1999 report of a national survey of professionals and managers diagnosed with mental illness.

Well-intentioned employment service providers generally strive to help clients find jobs quickly. Entry-level jobs are in greater supply and more accessible to job developers. Finding jobs with higher levels of responsibility for educated consumers often takes time and involves dealing with the complex issue of disclosure. As one employer recently pointed out to me "people don't understand that if you can't send your own email and cover letter, you can't be seriously considered for a higher level job." The college educated client is often better served by a strong "behind the scenes" approach in which the client is the

see *Beyond* on page 36

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Treatment is Working at MHA of NYC

By Michelle Des Roches, LMSW
Director of Adult Services
Mental Health Association of NYC

Posters declaring “Treatment is Working” can still be seen in agencies throughout New York City, despite having been created by the Mental Health Association of New York City, Inc. (MHA) many years ago. When MHA pioneered our work in supported employment eighteen years ago, we began with an internship model, but we soon realized that community-based competitive employment was not only possible but an important aspect of recovery for people with serious and persistent mental illness.

Our belief that working is an integral part of psychiatric treatment grew out of our early observations that people who secured employment had increased hope, self-esteem and quality of life; they seemed happier overall, and they even experienced fewer psychiatric symptoms.

In the past 10 years, multiple research studies have shown that our observations were both replicated and significant, and supported employment is now considered an Evidence-Based Practice. MHA currently operates programs geared toward providing a variety of vocational options based on consumer preference and need. Our latest undertaking has been in collaboration with the Bronx Mental Health Court, where we are providing vocational assessment, referral and follow-up services to consumers in their alternative-to-incarceration program.

MHA continues to provide a range of employment services including a Clubhouse Program, Internships, and an Enclave, which allows consumers of mental health services to work alongside their peers in a company while earning competitive wages. Our most successful programs, however, have been part of our Fast Track to Employment’s Assisted Competitive Employment (ACE) programs, which are based on the Individual Placement and Support (IPS) model. In adhering to this model, our programs do the following:

- admit people based on their motivation to work, not on “job readiness”;
- focus on getting people into competitive positions as quickly as possible, based on current skills, without pre-vocational training or extensive “work readiness” preparation;
- base the job search on the consumer’s interest;
- provide support services for an indefinite amount of time once the person is employed;
- coordinate all services with the mental health treatment team, and
- provide individualized benefits and long-term career counseling.



Michelle Des Roches, LMSW

The success of our IPS model programs, which emphasize quick placement and de-emphasize “job readiness”, is not surprising. A recent summary of study outcomes was undertaken by Bond, Drake and Becker (2008), who compiled and compared study results between IPS programs and other types of vocational programs for people with mental illness. Their results show that as many as 63% of program participants in IPS model programs are able to obtain employment, as opposed to 23% for other types of vocational programs, and that IPS program participants generally become employed more quickly.

Applicants to all of our programs are assessed primarily based on motivation to work. Fast Track admits people who may not be considered “work ready” by other programs because they are experiencing symptoms of mental illness or have limited skills, either job-related or “soft” skills such as social or organizational abilities. Although it may take a bit longer to help them find a job placement that will work, staff provide support and encouragement throughout the process. All services are individualized, and all program participants work closely with an Employment Specialist to develop a goal based on their interests and strengths.

In cases where a career goal may be unrealistic for the person at the time, we also integrate some of the “Choose, Get, Keep” philosophy of Boston University’s Center for Psychiatric Rehabilitation. Staff members assist in exploring options and developing long- and short-term goals; however, the focus remains on helping consumers find an acceptable place to work while embarking on a longer-term career path. Those who are unable to develop an employment goal within a reasonable period of time may be referred to a more appropriate type of service such as an internship, clubhouse or Intensive Psychiatric Rehabilitation Treatment (IPRT) program.

Employment goals generally take into consideration the field of interest, position, salary range, preferred location, hours and work environment and any necessary accommodations. Once a vocational goal is established, focus is placed on what will be needed to find employment as quickly as possible – resume writing, interview skills practice, and job search – and staff does not spend extensive amounts of time helping a person develop skills. Program participants are fully engaged in all aspects of the process including the job search, and staff provides support and job development as needed.

Because each person has a different interest and set of skills, individualized job development is imperative. Fast Track does not utilize a job bank which often caters more to the interests of employers than job-seekers. To empower consumers, staff teach them the skills needed to find employment and expect them to engage as fully as possible in doing their own job search. Generally, if a person is able to find a job independently, it is much more satisfying and esteem-building than if a job is handed to him or her. Of course, staff do provide job development services and are able to work with companies to creatively “carve out” jobs that might best utilize a consumer’s strengths, while taking into consideration accommodations that may be needed for their disability.

Although this can take some time, finding the best fit has resulted in job retention rates that are well above average for supported employment programs. The average job retention rate for people in supported employment programs is six months (Huff, Rapp & Campbell, 2008), whereas 55% of those in our Fast Track programs tend to maintain employment for at least one year.

The pros and cons of disclosure of mental illness are also thoroughly discussed with each of the job-seekers, and they are able to make their own decisions regarding whether or not to tell their employer about their disability. Consumers are educated about the Americans with Disabilities Act, and the primary reason people choose to disclose is that they need an accommodation. Accommodations can include: job coaching; extra breaks to enhance concentration or cope with symptoms, stress or medication side effects; scheduling of doctor visits; creating a work space free from distractions, and even negotiating salaries to maximize income, while maintaining the security of benefits.

Once a person is employed or in an internship, staff provides support to assist in development of skills that are needed to sustain employment. This is done on an individual basis through job coaching (either on- or off-site), counseling, crisis intervention, and advocacy with employers and other treatment providers if needed. Services continue for as long as the person wants and needs them. People are also free to leave the program and return if they experience difficulties, wish to find different employment, or change career goals.

The latest addition to our Fast Track to Employment program has been the provision of vocational counseling to the consumers at the Bronx Mental Health Court. In addition to having mental health issues, a vast majority of people seen have substance abuse issues, and all have recent criminal convictions, which makes finding appropriate job placements difficult but critical. One of the challenges of keeping people out of prison and engaged in treatment is helping them to connect to the community, developing a sense of purpose, and having a livable income. A recent preliminary finding by MDRC, a not-for-profit organization doing a study on Enhanced Services for the Hard to Employ, indicates that, for the general population returning to the community from prison, those who are assisted in finding supported employment within three months of release are “significantly less likely to have their parole revoked, to be convicted of a felony, and to be reincarcerated” (Bloom, Redcross, Zweig & Azurdia, 2007). This finding is very similar to the supported employment philosophy that guides our work with the forensic mental health population.

Although we have only been working with the Court for the past eight months, our vocational counselor has screened 110 individuals and worked intensively with 77 people to help them establish vocational goals and become involved in the programs to help them reach these goals. Referrals have been made to educational programs, vocational training programs, clubhouses and supported employment programs, and some directly to jobs. At this point, 17 people have secured competitive employment through this service, and only five of those who were engaged in vocational planning were reincarcerated or relapsed with substance abuse. These outcomes make us optimistic that the community reintegration and esteem-building that comes with developing and working toward vocational/educational goals, and ultimately becoming employed in a competitive job, will make a difference by giving people a reason to remain in the community and not re-offend.

Through our work, we have seen, repeatedly, the impact that working has on the lives of people who previously identified primarily as mental health consumers. Work gives them a new way to define themselves, self-confidence, improved quality of life, and a real sense of accomplishment. And nothing is more rewarding than the smile on the face of someone who has just started a new job.

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Promoting Vocational Development in a School-Based Mental Health Program: The Intensive Support Program (ISP) Experience

By Andrew Malekoff, LCSW, CASAC
and Brian Eck, CRC
North Shore Child and Family
Guidance Center

Let's look at an innovative rehabilitation service for high school students. The Intensive Support Program (ISP) is a school-based mental health partnership with North Shore Child and Family Guidance Center (NSC&FGC) and Nassau BOCES Department of Special Education (BOCES). The ISP program started in 1996 and has grown from a static capacity of 8 high school students to almost 150 high school, middle school and elementary school students ages 5-22. Education staff, mental health, and vocational staff are co-located at three Nassau BOCES schools. Family advocates from NSC&FGC are a part of the "extended-staff" available to students and their families.

A special feature of the ISP is the Innovative Vocational Rehabilitation Program (funded by the New York State Office of Mental Health) that aims to help high school students makes a successful transition beyond their high school years. Following is: (1) an illustration of a successful outcome of this coordinated approach of an academic program and community-based mental health and vocational service provider; (2) a discussion of obstacles to successful transitions including implications for addressing stigma and (3) the importance of tracking vocational progress post-graduation.

Carla is a high school student of Hispanic heritage who is suffering from major depression. She was referred by her school district to ISP. In addition to her classroom and mental health program involvement, Carla participated in ISP's Innovative Vocational Program, where she attended weekly career counseling meetings, individually and in group. Carla's focus was on long-term goals in the business field.

Initially, Carla requested assistance in obtaining competitive employment. IN a short time she was employed at a local restaurant where college reimbursement is



available for seasoned employees. Although it was available if she needed it, Carla did not require job coaching services.

Carla's job supervisor reported great satisfaction with her performance and work values. She was described as reliable and personable. Her fluency in Spanish was an asset that made her invaluable to her employer since the business is located in an ethnically diverse community. In less than one year Carla returned to her local district high school. She continued to work at her job and received bimonthly telephone support from her vocational counselor at the ISP program. The ongoing support enabled her to make a good transition. She has also made a good transition to North Shore Child and Family Guidance Center's outpatient mental health program where she has received uninterrupted and ongoing mental health services.

In a short time after the transition from the ISP program to her local district high school, Carla was promoted to crew trainer and she received a pay increase. Her employer informed Carla that she was the youngest person ever to be promoted in such a short period of time. Carla's hard work, family support, professional attitude, work ethic and willingness to accept support from outside resources has enabled her to thrive.

Carla is one example of a high school student who was able to overcome signifi-

cant obstacles represented by several trends specific to employment in Nassau County that have affected students' success in obtaining jobs.

Addressing Obstacles I: Unfair Standardized Testing "The Integrity Test"

In Nassau County, production and manufacturing jobs have steadily decreased. In contrast, service jobs, specifically in retail, have remained strong. Retail jobs can provide opportunities for entry-level workers, however many students with emotional difficulties are at a disadvantage, particularly when they have difficulty interacting with the public. If a student is suitable to work in retail, they may be asked by employers to take an integrity test, as part of the application process. Unfortunately, these tests are becoming policy for many employers. Our students tend to perform poorly on them. The tests are often quite lengthy and require a great deal of patience to complete. A basic level of computer skill is required, which many of our students do not have. These tests are generated to identify specific characteristics in a candidate. Our students sometimes do not fully understand what the employer is looking for, so they answer in ways that negatively affect their score. In most cases,

employers request that candidates take the tests without assistance and are not willing to make accommodations such as having the test waived or to having other components such as an interview have a greater impact on the application process. In an attempt to prepare our students for these tests, we have set up a computer station where they will have the opportunity to take a simulated integrity test that is similar in design to tests that local retailers use. This tool will identify students that need individual instruction so they can be instructed on how to improve their scores on this type of test.

Addressing Obstacles II: The Stigma of Mental Illness in the Workplace

An additional barrier to the success of our students who are employed pertains to the nature of their disabilities. The cyclical symptoms of their disabilities, the failure to comply with medication regimens and the side effects of medications make it difficult for our students to remain consistent in their efforts on a job. Unfortunately, many of their jobs can end in failure when problems occur at work and they choose not to involve their vocational counselors.

Many students feel that involving a counselor would force them to disclose that they have a disability in an attempt to avoid any stigma associated with making their disability known. In these circumstances, vocational counselors are prevented from stepping in to advocate for the student when needed, so vocational counseling can only be provided from outside the work environment.

Vocational counseling groups are critical in helping students to overcome the feelings associated with stigma. In a well developed group, students have an opportunity to share experiences and concerns, to learn about mental illness and stigma through a psycho-educational approach, and to role play various workplace scenarios that enable them to practice effective ways of handling difficult situations in the

see ISP on page 35

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Is Iatrogenic Stigma Keeping Your Clients From Working?

By Carolyn Beauchamp, ACSW
President & CEO
Mental Health Association in New Jersey

In his 1963 book *Stigma*, the renowned Canadian sociologist and author, Erving Goffman defined stigma as “an attribute that is deeply discrediting.” According to Goffman, it diminishes a person “from a whole and usual person to a tainted, discounted one.” Even now, in the twenty first century, the impact of stigma on the lives of people with mental illness has not diminished. It manifests in many forms - labeling, stereotyping, discrimination, limitation of choices, and isolation. Those with mental illness experience this stigma not only from the general public, but often from the very people who have made the commitment to help them -- mental health professionals. Iatrogenic stigma is the term used to describe this stigmatization by providers.

The unemployment rate of people with mental illness has been commonly reported to range from 70 to 90%. Despite the numerous factors that have been cited as barriers to employment – fear of losing entitlements, poor social skills, lack of transportation, and so on --studies show that people with mental illness say that they want to work (Rogers, Anthony, Toole & Brown, 1991). While the barriers



Carolyn Beauchamp, ACSW

just mentioned are often identified, the one that is often overlooked is the attitude of mental health professionals.

The sad news is that this is a worldwide problem. To address the issue, in 1996 the World Psychiatric Association launched a long term program to reduce stigma and discrimination experienced by people with mental illness (www.bmj.com/cgi/content/full/324/7352/1470). The United States is one of twenty countries currently participating in this project. Information

gathered as part of the project is being analyzed and some interesting findings are emerging. One finding is that stigmatization by professionals has a major impact on people with mental illness. In fact, a number of other studies have shown that “as group, mental health professionals are no less susceptible to stigmatizing beliefs than the general public.” (<http://ap.psychiatryonline.org/cgi/content/full/32/2/70>)

Most of us, as mental health providers, do not deliberately attempt to stigmatize people with mental illness, but in an effort to protect them we sometimes do it unconsciously. How often have you heard someone, or even yourself say, that an individual with mental illness cannot work because he/she will “decompensate” or is too “low functioning”? Another common feeling among professionals is that individuals with mental illness have “unrealistic work expectations”. Labeling, stereotyping, and limitation of choices are all at work (no pun intended) here. As a result, the attempts of people with mental illness to improve their quality of life by seeking employment are sometimes encroached upon and their recovery journey impeded by the very people who want to and are expected to help them.

Stigma exhibited by mental health professionals can often be the most debilitating because those we serve often hold our opinions as truths. Individuals with men-

tal illness who want to work and who are capable of doing so repeatedly say that they can't work because their case manager, psychiatrist or some other mental health professional has told them that they are not ready to so. However, there is much empirical data that substantiates that people with mental illness can be successfully employed with the support of evidenced based programs like Supported Employment (SE).

Supported Employment assists persons with the most severe disabilities to access, choose, get, and keep employment. SE not only helps persons with mental illness and other disabilities to obtain employment, it also helps them to acquire one of our most culturally prestigious roles; that of a “worker/employee”. When we meet someone for the first time, one of the first questions that we tend to ask is, “What do you do?” Many people with mental illness cannot answer this question with confidence because they are unemployed and spend most of their time isolated at home or in programs such as partial care.

What can be done to reduce or eradicate iatrogenic stigma? The first step is to make a conscious effort to examine our attitudes and beliefs as mental health professionals. Here are some questions to gauge your level on the stigma barometer. Using a 5 point scale (a. Definitely Not, b.

see Stigma on page 33

Vocational Rehabilitation Facilitates Recovery

Joseph Galasso, MA, PsyD
Hudson County Meadowview Psychiatric Hospital and Nicole Okragly, BA
William Paterson University

Sigmund Freud wrote that work is the individual's link to reality. To work, in our western society, is to exist. For many, our self-esteem, self-concept, and identity are hinged on just that, our ability to work. However, employment rates for people affected by serious and persistent mental illness are staggeringly low. In fact, SAMHSA research has estimated that approximately 90% of people with a serious mental illness are unemployed. This is also reflected in a study conducted by Grsenz and Sturm (2004), which indicates that unemployment rates are three to five times higher in populations with mental health disorders. Vocational rehabilitation should be considered as a viable adjunctive treatment option in the mid-to-late stages of recovery as it has many implications for one's psychological well-being. Recovery from mental illness is a widely personal process measured by objective and subjective ebbs and flows through periods of stability and relapse; recovery is not a linear process. One of the key indicators of recovery, which has been detailed in quantitative research and anecdotal report, is the focus on other interests and activities. As such, for adults recovering from mental illness, the stakes become

greater; successes are not only measured by objective remission of symptoms but also subjective, and often existential, challenges to attain (or in some cases, re-attain) a place as a productive member of society. While employment has not been found to be an essential ingredient for recovery, it helps to both facilitate and maintain recovery.

In this article, we will focus on three factors related to the role that vocational rehabilitation plays in the process and maintenance of recovery from mental illness. These three factors include: (a) Improving Overall Quality of Life; (b) Social Connectivity; and (c) the Recovery and Reformulation of a Positive Identity.

Improving Overall Quality of Life

According to Harris-Bowlsbey and Niles (2005), “our choice of work colors the perceptual lens through which others often view us and through which we often view ourselves.” Individuals with a severe mental illness experience recurrent disruptions in everyday routines, including occupational routines, which can negatively affect the possibility of job development. Therefore, it is important to consider how employment can impact a person's quality of life. To understand how employment affects quality of life it is important to mention Abraham Maslow's theory of self-actualization, or the desire for self-fulfillment. Having a job helps satisfy

many of the requirements necessary to achieve self-actualization, including: (a) meeting one's needs for survival, (b) providing him or her with security as well as social acceptance, and (c) ultimately building self-esteem. Holzner, Kemmler, and Meise (1998) conducted research showing that participants' diagnosed with schizophrenia expressed greater satisfaction with work, income, physical capability, independence, recognition, social support, relationships built outside the family, and free time. In fact, the authors surmised that the participant's overall quality of life was “almost to the level experienced by healthy persons.” Ruesch, Graf, Meyer, Rossler, and Hell (2004) conducted research using individuals diagnosed with schizophrenia or an affective disorder and showed a similar correlation between quality of life and occupation. In fact, a positive work experience was correlated with areas such as physical health, social health, and environment.

Social Connectivity

Continued focus on enhancing vocational rehabilitation will not only improve someone's quality of life but also build their social network, thereby providing individuals with a bigger support system. Social support can be defined as “a network of family, friends, colleagues and other acquaintances you can turn to, whether in times of crisis or simply for fun and entertainment” (MayoClinic,

2005). Ruesch, Graf, Meyer, Rossler, and Hell's (2004) research also concluded that participants with competitive work reported building a larger and stronger social support system. The participants rated their colleagues at work to be as significant in their social support system as family members and close friends. This was due primarily to the amount of emotional support they received from colleagues at work. Therefore, work can be an environment where men and women can begin to create and sustain influential and intimate interpersonal relationships that cannot be easily replicated in other environments.

Socializing with friends or families is necessary to maintain good overall health. Social supports help you get through difficult times and are often a positive source of encouragement to maintain healthy habits, which can prevent a relapse. Friends and family provide the feeling of belongingness, builds self-esteem, and comfort knowing that there is always someone to rely on.

Recovery & Reformulation of a Positive Identity

Identity development is a process which begins with the identification of self in infancy and evolves throughout childhood and adolescence where, as Erik Erikson (1959) and James Marcia (1991) theorized, our main task is to solidify a

see Recovery on page 35

Pathways' Housing First: A Paradigm Shift in Homeless Services

By Sam Tsemberis, PhD
Executive Director
Pathways to Housing

Here's the main thing about Housing First that most people don't see right off the bat. The program is not really about housing! It's really about listening to people and honoring their choices. Don't get me wrong, I do not mean to say that providing people who have been diagnosed with severe psychiatric disabilities and an active substance abuse addiction a furnished apartment of their own without requiring treatment or sobriety is not the most effective way to end their homelessness. It is! It is just that the program did not start out with that as its goal. The purpose of this program back when it was a drop-in center called 'Choices Unlimited' was to include consumers' voices in the planning and implementation of all services. It just so happened that all of our consumers were homeless and the first service that they wanted was housing. Hence, Housing First began fifteen years ago and over time has fostered a paradigm shift in homelessness interventions. By offering consumers an apartment of their own as a direct exit from homelessness, we were able to fuse several program-



Sam Tsemberis, PhD

matic steps—outreach, engagement, and housing—into a single powerful and desirable invitation, one that is consistent with consumer priorities for an independent apartment of their own without re-

quirements for psychiatric treatment or sobriety as a condition for housing entry or retention.

The Pathways to Housing model emerged from an ongoing dialogue among consumers, staff, and researchers who had developed an outreach and drop-in center program as an NIMH research demonstration project. Training staff in consumer-centered clinical approaches such as psychiatric rehabilitation reinforced that the program operated with an ethos of respect for consumers and their wishes. In addition, several staff members were consumers themselves, and consumers shared responsibility for policy and program decisions. Howie the Harp, an early consultant, brought to the program a commitment to consumer choice and consumer rights that fostered a political atmosphere of social justice and stirred among all of us a revolutionary fervor to change the mental health system.

In the drop-in center, neither status nor salary distinguished consumer staff from non-consumer staff, thus blurring the boundary between 'provider' and 'consumer' and fostering collaboration on the critical problem of access to housing. Staff and consumers witnessed how existing housing providers used the need for housing to leverage consumer acquiescence to unwanted treatment and absti-

nence requirements. After our repeated failures to secure housing for consumers, the group began a trial and error process to design a housing program that would be desirable to consumers and manageable to staff. Collectively, we determined that the scattered-site supported housing model met consumers' requirements for normal housing, tenancy rights, privacy, and an affordable rent contribution of 30% of their income. Consumers and staff collaboratively worked out operational details, occupancy policies, and program and consumer fiscal responsibilities, including a program account that required both staff and consumer signatures for checks to be cashed. This collaborative venture between consumers and providers evolved into the Pathways Housing First model, which focuses on ending homelessness by offering permanent, independent housing and comprehensive, consumer-driven supports without contingencies for treatment or sobriety.

Does it really work? Experimental and longitudinal studies of the effectiveness of the Housing First program found that 80 percent of Housing First participants were living in stable housing compared to only 25 percent of participants in the control (treatment plus sobriety -- then housing) group.

see Pathways on page 37

Finding Post-Hospitalization Housing to Facilitate Recovery

By Joseph Galasso, MA, PsyD
Staff Psychologist, Hudson County
Meadowview Psychiatric Hospital

According to the National Institute of Mental Health (NIMH, 2008), approximately 6 percent, or 1 in 17 people in the United States suffer from a serious mental illness. As such, the course of treatment varies greatly between individuals; however, for those who require hospitalization, discharge to the appropriate level of care is of the utmost importance as it has significant personal, professional, societal, and economic implications. Discharge planning, as a treatment intervention, also very much influences the person's prognosis as it relates to his or her subsequent recovery.

Recovery from mental illness is affected by many social, behavioral, and environmental factors. One of the most basic, and often most difficult to attain, is appropriate housing. In fact, there is a great deal of empirical evidence linking inappropriate housing and homelessness to repeated relapse and rehospitalization (Rosenfield, 2006). Homelessness can cause pre-existing mental illnesses to worsen, leading to expensive treatment and medical services. According to the National Alliance to End Homelessness (NAEH, 2007), finding appropriate housing for people with mental illness, physical and mental health can be improved, which reduces the need for hospitalization.



Joseph Galasso, MA, PsyD

Housing: A Basic Human Need

Housing and shelter are universally viewed as one of the most basic needs. Housing fulfills both physiological and safety needs (see Maslow, 1954). Without housing and shelter, we are forced to rely on our most basic and primitive drive for survival. With our physical and psychological energies focused on finding a means to this end, it stands to reason that an individual's focus on recovery will diminish. In other words, it is difficult to focus on getting other needs met (i.e., go to the doctor or find a job) if you do not

have a safe place to live.

Safe and supportive post-hospitalization housing is an integral element in helping people with a mental illness maintain their focus on achieving a higher level of functioning. This is true whether the placement is in a private residence or structured placement because it will encourage access to treatment services, intensive case management services, and, in most cases, continuation of medication distribution and monitoring.

Rehabilitation

Recent trends in the treatment of mental illness have focused on recovery and rehabilitation models. The focus of rehabilitation is congruence; by finding services that match the individual's needs, recovery can be achieved at higher levels. These models place increased emphasis on the environment as a critical factor for successful recovery and subsequent adjustment to living in the community. In short, the environment must be altered to accommodate people's disabilities, thereby supporting the person's best possible level of functioning.

Empowerment

The attainment of a consistent lifestyle in the wake of chaos is very empowering. Hospitalization for behavioral health type issues can be very infantilizing, touching the person at the core of their self-esteem and identity. Discharge is a very real and

palpable success, however, it often creates a large amount of worry and anxiety. People think, "Am I going to make it this time?" or "Is this really the right place for me to go?"

Much of this anxiety can be addressed during hospitalization by encouraging the patient to participate as much as possible in the treatment planning and discharge process. This will take the form of psychoeducation, psychological/psychiatric intervention, group process to discuss housing options, and discharge specific meetings. In doing so, the patient gains a sense of empowerment and importance to be involved in the decision making process, thereby facilitating discharge to the setting that can best fit their needs.

Promotion of Healing

Finding and maintaining appropriate housing after discharge from the hospital promotes psychological healing and growth during the recovery process. If the housing is truly safe and supportive it will promote growth within these varied domains: (a) it focuses on strengths; (b) people are treated with respect; (c) it promotes the resourcefulness of consumers; (d) it can foster trusting, equal relationships and partnerships; (e) it can help to moderate the objective and subjective feelings of discrimination and stigma; (f) it can be sensitive to cultural differences and the ways these differences may

see Housing on page 37

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MHA of Westchester Announces New Appointees

Doris Schwartz is New Associate Executive Director

The Mental Health Association of Westchester County, Inc. (MHA) is pleased to announce that Doris Schwartz, LCSW, a dynamic mental health professional, has taken the post of the Associate Executive Director.

Ms. Schwartz, a longtime advocate for families in crisis and champion of abused children, comes to MHA from Hedge Funds Care, where she served as Executive Director since 2001. Under her leadership, the charity has grown to include branches in New York, San Francisco, Chicago, Atlanta, Boston, Denver, Canada, the Cayman Islands and the United Kingdom.

A Westchester native, Schwartz, who from 1982 to 2000 helped the Guidance Center in New Rochelle develop Supported Housing, Supported Education and Intensive Psychiatric Rehabilitation programs, is segueing back into the mental health field.

"After being absent from the community-based mental health system for 6+ years, I am eager to return to my professional roots. I was lucky enough to have worked in Westchester when the recovery-based movement was blossoming, and I'm proud to have had the opportunity to participate in the development of supported housing, supported education and other consumer-driven activities. I am excited to have joined MHA, a wonderful agency with an ar-



Doris Schwartz, LCSW

ray of excellent services that strengthen families, promote recovery and expanded opportunities for all people," Ms. Schwartz states.

"We are thrilled to have her aboard," says Dr. Amy Kohn, MHA's CEO/Executive Director. "Doris' passion, experience and dedication to being an advocate to serve those in need, as well as her professionalism, complements MHA's endeavor toward achievement and innovation."

Shareen Kneeshaw is New NWCC Program Director

The Mental Health Association of Westchester (MHA) is pleased to welcome Shareen Kneeshaw, Ph.D. as the new Program Director of the Northern Westchester Counseling Center (NWCC), located in Mt. Kisco, NY.

Dr. Kneeshaw comes to MHA directly from Four Winds Hospital in Katonah, NY, where she served as Program Director of the Gatehouse Unit for eight years. Prior to that, she was the Program Director for the Child's Partial Hospitalization Program at Four Winds. Dr. Kneeshaw earned her Ph.D. in Clinical Psychology from Fairleigh Dickinson University in New Jersey.

"I am honored to be a part of MHA of Westchester. This organization has built a solid system for the delivery of a variety of services that meet the many needs in its host community. MHA continues to reach out into the mental health community to develop partnerships to facilitate advocacy and support for the underserved as well as to promote early intervention to improve developmental success for our children. I hope to be a vehicle for keeping this tradition of quality service moving forward by ensuring that our providers are given the opportunities to continue their education in specialized and cutting edge evidence based treatments, supporting advocacy for mental health, and



Shareen Kneeshaw, PhD

expanding our Child Clinic Plus, the Office of Mental Health (OMH) initiative," Dr. Kneeshaw states.

"We are delighted," says Carla Quail, LCSW, Assistant Executive Director at MHA, "that Dr. Kneeshaw has become a member of the MHA family. There is no doubt that Shareen's extensive experience, credentials and dedication will serve the Northern Westchester Counseling Center and MHA's mission well."

Hanrahan Honored for Grassroots Advocacy

By The National Association of Psychiatric Health Systems (NAPHS)

The National Association of Psychiatric Health Systems (NAPHS) presented the its 2008 NAPHS Grassroots Leadership Award to Mary Hanrahan, C.S.W. Ms. Hanrahan is government relations specialist at NewYork-Presbyterian Hospital, New York, NY. The award recognizes an individual whose actions demonstrate strong commitment to improving the lives of individuals who face mental and substance use disorders. The award was presented at the NAPHS Annual Meeting in Washington, D.C.

In announcing the award, NAPHS Executive Director Mark Covall noted that successful advocates are active in their communities and work to develop relationships with all key stakeholders. "These relationships are not built overnight, but take time and effort to foster. That is exactly what Mary Hanrahan has done. Change happens because of the action of individuals."

Ms. Hanrahan was recognized for her efforts to elevate the importance of grassroots advocacy within the association and

for taking direct, personal action to educate members of Congress about issues – such as mental health parity and emergency psychiatric care – that have a direct impact on whether people have access, coverage, and fair funding when they need mental health services. Ms. Hanrahan is currently the chair of the NAPHS Grassroots Steering Committee.

The National Association of Psychiatric Health Systems (NAPHS) advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Its members are behavioral healthcare provider organizations that own or manage more than 600 specialty psychiatric hospitals, general hospital psychiatric and addiction treatment units and behavioral healthcare divisions, residential treatment facilities, youth services organizations, and extensive outpatient networks. Founded in 1933, the association is headquartered in Washington, DC.

Mary Hanrahan is a member of the Mental Health News Board of Directors.

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The Big Picture

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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
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VNSW Mental Health Home Care Program: Supporting Successful Employment

Staff Writer
Mental Health News

It is becoming increasingly understood and appreciated just how much healing and comfort extend beyond the physical. There is a decided mental well-being component as well, recognized by Visiting Nurse Services in Westchester (VNSW). The White Plains based home health care agency created a program of psychiatric healthcare several years ago – in the patient's home, for maximized comfort and effect. Under this unique program, VNSW's registered nurses, with advanced psychiatric training, conduct home visits to develop a plan to treat mental health issues in conjunction with medical/surgical needs, and to support community integration for its patients. Adjunct services complementing the mental health component include home health aides, medical/surgical nurses, social workers and relevant rehabilitation therapies.

VNSW's mental health nurses monitor psychiatric symptoms and medication compliance. They teach skills needed to help individuals manage psychiatric needs consistent with each individual's level of functioning, empowering patients to obtain their optimal level of independent functioning / living. The agency's nurses also provide support during transitional periods related to new employment and undergoing vocational training. Times of transition are stressful and patients who are at risk benefit significantly from increased support and monitoring to ensure success.

Often an important component in the patient's assimilation into the community is the desire for employment. There are many job-training programs in the community that assist individuals, including those with disabilities, in learning a variety of job skills. Some individuals already have the assistance they need to acquire skills and education; others need to receive training and support so that they have the skills needed to obtain employment.

Coordinating all this at VNSW is Lisa Sioufas, LCSW-R, ACSW, manager of VNSW's Mental Health Program. A Licensed Clinical Social Worker with strong psychiatric education/experience, Lisa lives in Westchester with her husband and two children. Lisa's mental health team is comprised at any given time of about 15 nurses, full and part time, covering all of Westchester County. As the team receives referrals from other professional caregivers – those seeing the patient for medical-surgical diagnoses, from the community, from programs, from physicians, etc. – a nurse from the team is assigned to do an evaluation, and a plan of care is developed.

"Building a life in the community is part of the patient's recovery process," says Lisa. "A primary goal of VNSW's program is for individuals to be active members of the community. It is important to identify a person's strengths, capacities, preferences and needs, as well as their knowledge of their local community, its opportunities, resources and potential barriers. This enables each individual to find his or her niche in their home community."



Lisa Sioufas, LCSW-R, ACSW

VNSW In-Home Mental Health Program Features

- Facilitate psychiatric care from in-patient to home & community
- Prevent expensive in-patient psychiatric hospitalization
- Decrease symptoms & improve functional ability
- Improve knowledge base about medications, illness, coping & staying well
- Improve medication compliance
- Access community services and provide support for community integration

For some patients, this is more difficult than for others; for Barbara Varela, of Mamaroneck, NY, it was not at all easy. Explains Barbara, "I've had mental illness since I was a kid, an emotional, bipolar type of thing. I was over-sensitive to my environment, I had a lot of behavior problems, and, as I grew older, the bipolar really took over." From age 13, when she "could not adjust to the community," through her early 30s, Barbara was in and out of several institutions, "bobbing from one place to another." During this period she gained a great deal of weight, at one point approaching 300 pounds. On June 22, 2006, at age 32, Barbara had gastric bypass surgery and reduced her weight to the 160s. "With a new body and a new life," Barbara opted out of institutional life to take on the world

tle, because that kind of disclosure is not required, it was very hard to get around it. After awhile, I gave up hope and applied at a major supermarket. I didn't really want this – I really wanted to be with kids, make them happy and fulfill my passion – but I wanted to do something. But I didn't even get that."

Barbara's fortunes turned when she was offered a part-time position at the Childcare Center at the Westchester County Courthouse, minding children while their parents or caregivers are attending to court business. "We do activities with the kids, from 6 weeks to 12 years old," says Barbara, "we give them TLC, and provide them with comfort. Courtrooms are no place for children – that's adult business that often turns violent." At first she encountered the same obstacles she did elsewhere, and wasn't hired. But, she explains, "I went back and pushed, not my disabilities, but my positive attributes, my skills and what benefit I would be, what the Center would be losing out on, since most of the other staff are older volunteers."

This employer listened and engaged her. Barbara today is very happy with her new position, and feels that her superiors and co-volunteers are extremely supportive of her journey. Barbara also credits Pat, her VNSW nurse, who "kept encouraging me, pushing me positively, was responsible for the referral and the accompanying letter that got me the position. While Pat was assisting me with management of my psychiatric medications, diabetes, hypertension and weight, she kept pushing positively, encouraging me not to give up my search for meaningful work, providing support that was not available with my regular programs. This in-home contact was so important to my success."

It has been quite a different experience for 54-year-old Yonkers resident and VNSW patient Kathleen Joyce, who, since a disabling swimming accident in 1984, has led an extremely meaningful, productive life. Kathy has very limited use of her body, with some motion only in her shoulders, arms and wrists, but not her hands, typical of a C5/6 quadriplegic. While such a condition naturally led to depression, Kathy by sheer will and moxie, and abundant support from family, friends and home care personnel, overcame this and her physical challenges to learn how to drive a (specially-built) van, attend law school, receive her degree, and, as a single mother, raise two children to very successful adulthood. Kathy tutors needy children in her immediate community and counsels disabled adults who need legal advice. She also often ventures out into the world to serve the community at large.

"For example," Kathy relates, "last summer I was invited to join the Long Term Care Committee for Westchester County, a state-sponsored program, where they have mandated each county to address their long term care issues, and access to them. They have developed a phone number where anyone can call with any kind of question about long term care,

"People with mental illness generally seek decreased stigmatization; empowerment; in fact the exact same things in life that all people want – not just to survive, but to thrive."

with a schedule of programmatic assistance interspersed with volunteer work. She had a "self-realization" that the "morbidly-obese, old person was gone, along with that whole psychotic lifestyle," and "all that craziness I was living in hospitals."

In December of 2007, Barbara decided that she wanted to do something more with her life than go to day programs, and set out to find a job. At age 23, she had briefly worked as a camp counselor, had enjoyed working with children, and wanted now to do so again. Her financial needs had been covered, at first by SSI (Social Supplemental Income) and later by SSD (Social Security Disability), so she could "afford" to be a volunteer. She urgently wanted to "give back" to society, "to put on clothes, have somewhere to go every day in addition to my therapy," to be together with people who go to work, to be accountable and feel that she is needed. But, she found, the process of obtaining employment in her situation – even uncompensated volunteer work – was laced with speed bumps.

According to Barbara, "Given that I had last worked 10 to 11 years ago, with children, I encountered many obstacles. When I went to different employment agencies, they wanted to know where I had been – why I hadn't worked in all those years – and they wouldn't consider me. It's ironic – if instead I had a drug addiction, and said I was in recovery, that would have been more acceptable to an employer! They would not believe or accept that I could be 'in recovery from craziness.' Even though I disclosed very lit-

see VNSW on page 34



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Mental Health News ~ Health and Wellness

Everyone Should Have a Health Care Proxy

By Colm James McCarthy
Emergency Medical Technician

If you were to become so ill that you could not make a decision what might happen to you? What if you were unconscious or in a coma and could not tell your Doctor's what you wanted? What if you were so depressed, or psychotic that you could not actively work with your Doctors to help yourself get better; who would decide what to do and how would they know what you wanted? What if your parent, spouse or child becomes ill and can not make decisions, who will make the decisions for them?

Most states have some kind of a law that establishes a legal mechanism for someone to make health care decisions for you in the event that you are unable to do so for yourself. In New York State we have a Health Care Proxy Law. This allows any competent person to choose another individual to make health care decisions for the sick person if they are unable to do so for themselves. The designated decision maker on your behalf acts as your proxy and informs the Doctors what they may do, or not do, based on your wishes. If you do not have a designated Health Care Proxy, your physicians may be required to provide treatment that you may not have wanted to receive. In severe medical cases this would be something like putting you on a respirator even if you are in a coma with no hope of recovery. In psychiatry, the doctors could prescribe you medication that you might not want because they may not know what medications or treatments you do want.

The steps to setting up a health care proxy are easy, but they need to be done when you are able to make a decision (that is what competent means) and that means when you are healthy. The first step is to complete a standard health care proxy form. This is available for free on the internet from the New York State Attorney General's office at: www.oag.state.ny.us/health/proxy/hc_proxy_complete.pdf. You can fill this out online and print it out. The instructions for filling this form



Colm James McCarthy

out can be found at: www.oag.state.ny.us/health/proxy_instructions.html. You will need to decide who you want designated to make your decisions for you in the event that you are unable to do so. You can also indicate what kinds of decisions that you want the person to make. After that, all you have to do is to sign the form in front of two witnesses.

The Health Care Proxy is such an important Document that most hospitals ask if you have one when you are admitted. However, as long as you are able to make your own decisions, it has no effect. It only comes into effect when you can no longer make your own decisions. You can revoke your health care proxy at any time and sign a new one whenever you wish. As long as you are able to do so, you remain in charge of your treatment.

Health care proxies are most important when there is an emergency situation and you need someone to make important decisions for you. There are no negatives to these Proxies. Do not leave this your health decisions to chance. You can control your health care and that of your loved ones, but only if you take the time to fill out the forms

Medical and Psychiatric Problems

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

In the past 20 years, we have seen a remarkable turnaround in the medical treatment of severe psychiatric illnesses. In the late 1980s, it was taught that one could not and did not recover from schizophrenia. If a person recovered, then they must have had some other illness. Today, psychiatrists are trying to develop criteria so that we can say a severe mental illness is in remission. No one spoke about such things twenty years ago. A part of this improvement has had something to do with the development of newer and more effective medications. More effective medications are useful in two ways. We can treat illnesses that are so severe that they were not able to be treated in the past. Secondly, we can treat illnesses that are less severe which were not medication responsive in the past but have become so with the development of newer agents. This increase in the range of action for medications is based on their efficacy. What will limit the range of use are the negative things that medications do, their adverse effects. If a medication is very effective with minimal adverse effects we can use it with a wide range of illnesses with varying severity. If a medication is very effective but has severe adverse effects, we will need to limit its use. Typically, we will not use the medication for the less severe illnesses, but we may continue to use it with the more severe illnesses. This is particularly the case when we have fewer and fewer alternatives to treat the underlying illness. This leads to the problem alluded to in the title of today's article. Psychiatrists use medications to treat psychiatric problems, but the adverse effects of these medications cause what are typically thought of as medical problems. Who should treat these problems and what should guide their decisions?

Who should treat?

Basically there are 2 options. The prescribing psychiatrist should treat all of the



Richard H. McCarthy, MD, CM, PhD

problems that arise with the medication. This has several benefits. Presumably the psychiatrist knows the patient well and has a good picture of all of the patient's psychiatric and medical problems. This should allow the psychiatrist to most efficiently weigh the issues of benefit (effectiveness of the medication) and risk (the adverse effects of the medication). Psychiatrists are comfortable with talking with the mentally ill while many internists are not. This allows the patient to have one physician instead of several. This would decrease problems in communication between physicians, getting patients to their appointments at various sites and monitoring patient progress. Sounds great. However, we already have too few psychiatrists and filling their schedules with more work will make the shortage worse and not better. Another problem is that expecting psychiatrists to function as both an internist and a psychiatrist may be asking more than they can reasonably do. Both Internal Medicine and psychiatry are specialties that are advancing rapidly. Keeping up in either of

see Medical Problems on page 34



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Creative Approach from page 9

approaches yield traditional results.

In order to achieve the CDI goal, it is important to remember that evidence – based practices are enhanced when used in combination. CDI choose a theme of “Work: It’s Everybody’s Business” in 2006 to support this fact and to encourage everyone’s involvement in the process. In choosing this theme, we were identifying the value and contribution of everyone toward employment goals. The clinician, psychiatric nurse, psychiatrist, family member, and individual receiving services, along with the vocational counselor all have an important role in helping an individual realize his/her goal of employment.

Each facility was asked to identify barriers that they faced in making sure that work was considered a part of everyone’s recovery process. Barriers such as lack of administrative buy-in, clinical skepticism of the role of work might play in the recovery process, and the level of job development and coaching skills of staff who were to provide these services were identified. From this, each facility was challenged to target an area of intervention which would help place them in strategic positions to begin to achieve more positive employment outcomes.

Learning communities were established to bring staff involved in the project together to discuss issues they were facing, to be exposed to new ideas and approaches and to develop a network of support among facilities. This forum allowed the staff to identify the supports that were needed for them to move their goals forward and to learn from one another’s experiences. These communities have met quarterly since the program started.

In order to address staff skill needs, “Foundations to Recovery”, a catalogue of specific training and technical assistance programs designed to meet specific competency objectives offers support to facilities as they address their identified targeted CDI goal areas. These training opportunities are offered to facilities based on the connection to their specific facility goals. Programs are not offered as training for training sake. CDI representatives are encouraged to think beyond traditional participants and invite staff from other areas of the facility as well as their community partners to attend the quarterly meetings; participate in the annual conference; and/or attend CDI-sponsored training sessions.

The team’s next challenge was to “Shake It Up”, across the facility in ways that would expand the existing acceptance of typical approaches used to achieve vocational goals. Facility staff were encouraged to identify alternative methods to helping people using recovery-oriented services think about and move

toward employment. This requires looking at employment in different ways. It involved challenging treatment teams to consider the role of employment in recovery and to look beyond traditional job development in assisting individuals secure work

In response, facilities began to advocate for the role of employment in recovery with their administration as well as with the clinical teams. Employment fairs were held in various locations to increase the visibility of work, newsletters were started, and some vocational service programs changed course to secure more competitive employment opportunities rather than relying solely on traditional non-integrated forms of work. Some facilities began exploring the world of self-employment with individuals desiring to start their own businesses. Small start-up grants were offered to individuals with sound business plans. Employment proposals, rather than traditional resumes, have been popping up to market the unique skills of the individuals we serve.

Currently, the CDI is focused on “Extending the Table”, reaching out within and outside the traditional walls to discuss employment and share approaches with clinical staff as well as our community partners who share this journey with us. At the last annual conference in March, many community partners joined the CDI teams to look more closely at the work we are embarking on and to return to the soul of our work. Returning to the reasons we, as providers, got into this work in the first place is a key to genuinely connecting with the spirit of each individual we work with to get at their passion and how to connect that passion to the world of work. In the end, it is not only about money that can be poured into developing work outcomes, but it is really the relationship to the individual and his/her dream that is essential to achieving employment success.

Standing side-by-side an individual, understanding the personal reasons for work and maintaining a positive perspective are essential in helping get and keep employment. We believe the inclusive approach of the CDI is a positive step toward achieving success.

For more information, you are welcome to contact your local state facility CDI representative in their Rehabilitation Department to see how you can connect to what has become an exciting and dynamic process.

Carol Blessing, LMSW is a member of the faculty of the Employment Disability Institute of Cornell University. John Allegretti-Freeman, LCSW-R is Director of Community and Rehabilitation Services, State Facility Operations at the New York State Office of Mental Health.

Some of the issues you will come across, you may not have needed to deal with as a nonprofit. With our new toner and ink business, we have had to deal with the potential issue of sales tax collection when dealing with for-profit organizations. Also, unlike our other service oriented businesses, there are much greater expenses associated with stocking and selling our printing products than

see adjacent column

Faith and Trust from page 1

Greg: Working as a Housing Counselor

After a life riddled with psychological and physical abuse, mental illness, substance abuse and homelessness, Greg got his life back together. Episodes of psychotic behavior in his teen years, two attempted bank robberies, incarceration, a failed relationship and subsequent homelessness triggered a breakdown. In a court hearing a judge referred Greg to FEGS for mental health and rehabilitation services.

When he started the Manhattan Psychiatric Rehabilitation program he was guarded, demanding, had frequent angry outbursts, and expressed skepticism as to whether the program would help him get out of the shelter into permanent housing. After the program helped him get his own apartment he began to trust that the “system” would help him.

Greg gained control of his anger through his participation in Anger Management and DBT (Dialectical Behavior Therapy) groups and individual psychotherapy. He began to co-lead substance abuse groups in the program and gained a sense of self-efficacy as he was helped to see his strengths and abilities. He maintained his own apartment, and was elected Board President of his tenant association. After a few months of adjusting to his new living environment he was ready to start a career goal and chose to become a Forensic Peer Specialist as he felt a strong need to give back to peers, who like himself had mental illness and incarceration histories. Greg successfully graduated from the FEGS Manhattan Psychiatric Rehabilitation program and went on to receive training at Howie the Harp Forensic Peer Specialist Training program. He works fulltime as a housing counselor at Pathways to Housing, received a promotion and is earning competitive wages. He still attends FEGS Manhattan Counseling Center for psychotherapy and medication monitoring. “The staff are like a family to me” says Greg. “My psychiatrist, therapist, parole officer and the IPRT team have worked together. They’re on my side.”

Marie: Working in
a Skilled Nursing Facility

“I love my job,” said Marie when Gary Scannevin, Program Coordinator from the PROS Possibilities Program met her at the Babylon train station for a scheduled support session after her shift.

The Role continued

there were when we just needed to buy inexpensive cleaning supplies, or make one-time capital expenditures for recycling bins or shredding machines.

All of these issues are manageable. The results are well worth it. You ensure esteem building, meaningful and financially rewarding work to a population that can, and deserve, to do it. All too often, people cannot look past the illness, to the competent individual inside. Providing these jobs and getting the disabled back to work in the community brings great personal and therapeutic benefit to your consumers. It is also one of the most effective ways to enhance your own com-

Marie is 35 and has been in and out of programs and the hospital since she was 21, substance abuse and bipolar disorder defined her life for many years. One thing motivating Marie right now is gaining custody of her one year old daughter.

Marie commutes over an hour to her job as a patient aid at a skilled nursing facility in Southampton. She is working 3 to 4 days a week.

Marie, Gwen and Greg have also learned that there are many components to work life. For instance, Marie had never thought about the environment as a factor in how she would feel about work. The Hamptons Center, where she is employed, is a beautiful building with beautiful grounds. She feels good just walking into the building every day.

Gwen too has realized that although there may be people at work she doesn’t always like there are many people she looks forward to seeing every day. She has learned to respect her co-workers and has noticed that when she is nice to people they are nice to her.

Marie, Gwen and Greg all still receive help from mental health professionals but receiving a service does not define them.

FEGS is proud of Psychiatric Rehabilitation programs such as IPRT (Intensive Psychiatric Rehabilitation Treatment) and PROS (Personalized Recovery Oriented Services), which help people transform their lives and achieve greater independence. Work readiness activities are designed to help people with mental illness take down the interpersonal, cognitive and emotional barriers that have impeded their progress over many years.

No recovery journey is the same as any other. But each of these mental health consumers was motivated and spurred on by staff members’ faith and trust that they could achieve their personal employment goal. Different is part of the point. What makes the process work is a non-judgmental approach, belief in recovery, and following the client’s lead.

Ellen Stoller, ATR, LCAT, is the Assistant Vice President of Community Services, Training and Consumer Affairs, Gary Scannevin Jr., M.P.S., CPRP, is Program Coordinator of the PROS Possibilities Program, and Minnie Berman LMHC, CRC, is Program Manager, of Focus: Manhattan IPRT, at F.E.G.S. Health and Human Services System.

All consumer names in this article were changed to respect confidentiality.

community relations and reduce the stigma of the mentally ill in your service area.

Here at Rainbow we look to the future with eagerness and excitement. We will continue to expand our clientele and the products and services we offer. We hope everyone who hears about Rainbow Environmental Services will become a customer. We will continue to offer assistance to other organizations to get into business as we did. Most importantly, the future is bright for our employees. One of them said it best: “*With Rainbow I have a good reason to get up get out of my house every day, even on days I don’t feel like moving. It makes me feel just like everybody else.*”

The Role from page 19

critical in today’s environment. Some of us involved in Rainbow come from a business background as well as behavioral health, and this can be beneficial when there is a need for sales skills. Knowledge of technology, taxation and business practices are also helpful. We have developed our own business operations tools from commonly available business software.

Hiring Consumers from page 1

the legality of our actions, and some even filed complaints with our regulatory agency. That isn't to say that support wasn't forthcoming from the professional community, however it paled in comparison to the outcry. I recall how consumers of our program thought it was a great idea, but several said they would prefer non-consumer counselors. Some of our own staff, in units not yet employing consumers, consistently brought up potential problem areas. It was obvious that all the resistance to this new practice wasn't outside our agency.

In order to expand our employment practice beyond the two units, where staff had developed and embraced this practice, we had to address our bias from within. We embarked on a series of agency trainings where staff and consumer employees told their stories to the other staff. Videos of the employed consumers were viewed. We essentially had to sell the efficacy of our actions to the total agency. Employees were told how clearly this employment action had become part of our overall mission and was highly valued by the agency. The benefits to staff and consumers were detailed but we were very clear that this employment practice would be a core practice in our agency mission. Actions that rejected, impeded, or obstructed this practice would not be tolerated. To staffs' credit and to optimism and persuasiveness of the converted staff, the consumer employee program grew, with minimal resistance.

The early 1990's was an exciting time, as the consumer employees and I embarked on a series of presentations throughout the Northeast. I would present the structure and implementation procedure and the consumer employees would detail their job duties and work experiences. We always ran over our allotted time trying to answer the multitude of audience questions. When we explained that nineteen consumers were working at



Ron Kavanaugh, MS

our agency, at that time, some audience members suggested we could open a "consumer run unit." Some mental health officials had also suggested this idea. I explained that we saw the "consumers only" idea counterproductive. The benefit to having consumers on payroll was that we were working side by side, together, each reaping the benefit of the other's experience.

Some of the key principles of our employment program we presented were: consumers were hired into existing agency positions were paid at that job rate, position titles were not preceded by the label consumer or peer, and expectations of performance were the same for everyone. Labeling the position consumer or peer takes away the employees' choice of disclosure. Not all the consumers I hired wanted their mental health histories to be known by the individuals they were working with. Disclosure of the employee's history was left up to the employee.

Meanwhile, outside of our agency, the consumer movement was catching fire. Peer advocates positions were created in some agencies followed by talks of consumer run programs. The state and county mental health officials looked to use reinvestment money to fund these programs. What I had feared was coming to fruition. The funding developers and program designers, following I'm sure multiple meetings with consumer advisory groups, was setting up what I viewed as a separate but equal provider network. Why had they decided on this model? Was there resistance from traditional treatment providers to embrace a joint process? Were the consumer advisory representatives so dismayed by past experiences with professionals they wanted to separate? Didn't they see the advantages of working together, or did they view the bias on both sides as insurmountable? I have attended several meetings in the tri-state area where hospitals and other facilities speak of the consumers they have working at their facilities. However further inquiry reveals that often they are not paid by the facility but rather by a grant supported consumer program. Do they really work for you, if they are not on your payroll? If you really believed in the value of their contribution, why aren't they on your payroll?

Why were they called consumer case managers, peer advocates, and not just case managers and advocates? Why the need to distinguish, differentiate and label? Do the consumer case managers and case managers have different pay rates? How do their job tasks differ? Are the performance expectations different? I'm not aware of any differentiation of titles in the substance abuse field. Licensed professional or unlicensed recovering staff can earn CSAC certification. Where is that mirror degree in the mental health system?

Our vocational counselors don't place our clients into jobs labeled mentally ill cashier, salesperson, or truck driver. Then why do we identify our hires in mental health as consumer/peer etc., labeling then once again.

The PROS period is upon us. One of the central concerns of affected agencies is the staff credential and experience requirement. This rehabilitation model calls for predominantly professionally licensed staff. The PROS model seems to overvalue the professional certification and undervalue the consumer experience and talents. Many professionals work in clinical not rehabilitation programs. Where is the recognition value of non-licensed consumers/ non-consumer staff that has 2-5 years experience working in a rehabilitation setting? Many consumer run programs are in danger of having their existing staff not meeting the staff requirements. Will existing employees lose their positions? I'm not placing a positive or negative value on the PROS model, as regulations are still not formalized. What I do see is the opportunity to blend consumer and professional staff. The opportunity to eliminate the separate but equal, us versus them, and consumers only labels. PROS may provide us a chance to develop a program model that brings consumers and professionals together. I hope the PROS planners use the strength-based concept in developing their staffing model, recognizing the strengths of both camps and develop a blended staffing model. The major obstacle to the blended idea remains a bias left over from the 1980's.

A few weeks ago I had a conversation with an employee of our agency, who has a consumer history. This employee has a master's degree and professional license. The employee in applying for case management positions in the area also decided to share their consumer history. Immediately the individual was steered toward the consumer labeled position. The employee told me "I didn't get my degree and professional license so I could have the label consumer or peer precede my job title."

Currently, Search for Change employs twenty former residents in full, part time and relief counselor positions.



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Since 1975

Stigma from page 24

Probably Not, c. Possibly, d. Probably Would, e. Definitely Would), answer as truthfully as you can. The only person who will see your responses is you!

- 1) Do you believe that people can recover from mental illness?
- 2) Would your relationship with your best friend remain the same after he/she was diagnosed with a mental health disorder?
- 3) Would you oppose the opening of a psychiatric rehabilitation group home next door to your home?
- 4) Would you allow your child to have a sleepover at the home of a child who has a mentally ill relative or parent living with her?

5) Would you choose a doctor with a known history of mental illness as your primary care physician?

6) Would you employ someone with a history of mental illness for a key position in your organization, such as the director of your partial care program?

7) Would you marry someone with who has a mental illness or a known family history?

8) Do you believe that you can tell that someone has a mental illness?

9) Do you believe that all persons with mental illness who want to work can do so with the proper support?

Remember, when using the following key to interpret your score, that this exer-

cise is designed to help you assess your belief system and how biases could be impeding the work that you do.

- If you answered 'Definitely not or probably not' to 4 or more questions, you may need to think whether your beliefs (stigma) may be impeding your work. Consider researching information about wellness and recovery.
- If you answered 'Possibly or probably would' to 4 or more of the questions, you are well on your way to embracing the concept that recovery is possible for people with mental illness. Think about exploring additional information and resources that can help you further expand opportu-

nities for the individuals you serve, allowing them to take on more valued roles – worker, tenant, homeowner, student, and so forth – in their communities.

- If you answered 'Definitely would' to 6 or more of the questions, keep doing what you are doing! Share your experience with others in the field.

In an effort to address the stigma associated with mental illness in the employment arena, the Mental Health Association in New Jersey, private non-profit advocacy, education, training, and services organization, hosts an annual

see Stigma on page 35

Medical Problems from page 31

these fields is difficult; keeping up to date with the most effective treatments in both fields is probably beyond the capacity of most physicians. Since two heads are better than one, perhaps the treatment should be split between two or more physicians.

Split treatments offer the advantage of up to date treatment in multiple fields, medicine, endocrinology, gynecology to name a few. However, split treatment requires that the patient and information about the patient (such as a chart or a note) move from one physician to another and then back again. Getting patients to move around is relatively easy, getting the information to move around is a bit harder, getting them to both be in the same place at the same time with the physician is very hard and getting the information back again often feels impossible. Of course, many of these difficulties are what psychiatric rehabilitation is all about, viz., teaching people how to get around in the community to get their needs addressed in a reasonable way. This fosters independence, self awareness and personal responsibility and directly confronts passivity, a correlate of most major mental illnesses. Sounds great. However, the real burden in split treatment is that the staff is supposed to be both efficient and foster all of these recovery values at the same time such that no errors of omission or commission ever occur. This is utterly impossible. Perfection does not exist in the world as we know it. The way most organizations respond is that they try to "simplify" the institution's problem (getting good treat-

ment and information flow) over the recovery or rehabilitation task. Minimizing errors is a value for both the patients and those that treat patients but it is important to remember that it is not the only value.

The clash of values that can occur is not limited to physicians, patients and organizations. It also occurs between the various physicians that are treating the patient. We are seeing more of this as we work with medications that at the very least contribute to and sometimes cause potentially serious medical problems for patients. The best example of this is the problem of diabetes in patients taking the newer antipsychotics. While the FDA has warned that all of these medications may cause this, there is general agreement that the problem can be worse with a very effective medication clozapine, the only medication indicated for treatment refractory schizophrenia. What should physicians do if the only medication that works to alleviate schizophrenia is also causing a potentially life shortening illness? I will discuss this dilemma in my column in the next issue.

Footnote: I prefer the use of the term adverse effect to the term side effect. "Side effects" are things that medications do that we do not like, but they are built into the medication in the same way that the positive effects are. Calling them side effects make them seem accidental, the patient's problem alone and easy for physicians to ignore. They should not be ignored; they are important and must be directly addressed. Calling them "adverse effects" is both accurate and emphasizes their importance to both the patient and the physician.

The ADA from page 10

or if it does not, issue a "right to sue letter" granting the aggrieved individual the right to sue her employer in court.

If the EEOC pursues the claim they will either conduct a full investigation and if they find the employer at fault issue the appropriate sanctions, or they will conduct some sort of Alternative Dispute Resolution ("ADR"). ADR can include such things as fact-finding a neutral evaluation, settlement conferences, and most commonly mediation. Mediation is where the employee and the employer submit their cases to a neutral mediator who reaches a decision regarding whether or not the employer has violated the ADA, and if they have, what damages the employee should receive in compensation. It is important to note that the ADR process is non-binding, hence if either the employee or employer is dissatisfied with the result they are not bound by it. Many people prefer the ADR process because it is quicker and many times less expensive than engaging in full litigation.

A "right to sue" letter may be requested even if the EEOC decides to conduct its own investigation or if ADR is chosen at an earlier point. It is important to reiterate though that if an individual wishes to seek judicial resolution of the matter they must follow the reporting requirements to the EEOC as a prerequisite to filing suit.

Where one chooses to go the lawsuit route the employee may seek injunctive relief in the form of the grant of the accommodation requested or a particular employment post. In most cases though, where an employee has been forced to resort to suing his employer the relationship has deteriorated to such a point that the individual is no longer in the employ of the employer. In those situations, the employee may sue for back pay, prospective pay as well as other compensatory damages. Like other civil rights statutes the ADA allows for fee-shifting if a plaintiff wins her case. In other words, if you sue your employer and win in court your employer must pay your attorney's fees.

Conclusion

The ADA is landmark piece of legislation granting a wide swath of rights to the mentally ill. Prior to its passage those suffering from a mental illness were vulnerable to prejudice and discrimination in the work force often requiring people to hide their illness from their employers without the ability to request an accommodation. Because of the potential for liability most employers are open and willing to work with employees suffering from a mental illness in order to provide them the accommodation they require. Accordingly, it is important to notify your employer as quickly as practicable when you think you need a workplace accommodation.

VNSW from page 29

whether for a disabled baby, or a child with a learning disability, in fact anybody of any age facing long term care, and for family members and health care providers. We meet periodically at the County Office Building, to discuss the objectives of this program, how to access it, and how to get it integrated into the commu-

nity and the institutions that deliver health care. And, because of my work there, I was contacted to join the downstate committee as well, in Manhattan, and have been going there since January '08."

"Bottom line," explains Lisa, "people with mental illnesses generally seek decreased stigmatization; empowerment; in fact the exact same things in life that all people want – not just to survive, but to thrive."

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Mental Health Awards Luncheon

**RECRUITMENT OF
PHYSICIAN EDUCATOR****MEDICATION BEST PRACTICES DIALOGUE PROJECT**

HHC is seeking a psychiatrist to work with the Corporation's "Medication Dialogue Project." Dialogues use a team of consumers and a psychiatrist as trainers. They are intended to help improve the relationship between providers and consumers who are being prescribed medication and to foster a better understanding of the place of medication in a person's recovery. The Medication Dialogue Project uses a curriculum that engages staff to address some of the reasons for medication non-adherence.

Dialogues take approximately one hour and are scheduled for inpatient and outpatient groups, and on evening and weekend tours. Dialogues are targeted to psychiatrists, residents, and those in the position of helping consumers increase adherence to medication.

Compensation: \$175 per dialogue training session.

Contact:

Jonathan P. Edwards at (212) 788-3524
or by e-mail: jonathan.edwards@nychhc.org



Promoting Recovery from page 7

- Determine the services that support individuals in overcoming the barriers to reach their employment goals.
- Support individuals in activating their strengths and natural supports to meet specific occupation or job requirements.
- Select the PROS services that will help individuals achieve their employment objectives.
- Assess if the identified services meet the criteria for reimbursement through PROS (a program funded with a combination of state aid and Medicaid).

The foundation of recovery oriented employment supports are the Supported Employment (SE) best practices. SE focuses on creating lasting connections to the world of work through integrated competitive employment. To a great extent, SE principles translate into PROS. Like SE, PROS is defined by:

- Zero exclusion: No one is excluded from employment-related support based on his or her diagnosis or symptoms. Anyone who wants to work is supported in achieving that goal.
- Rapid placement: Research shows that successful employment outcomes are more likely when individuals are encouraged in job placement as soon as they indicate an interest in work. In PROS individuals are offered in-

tensive services through the IR component to support them in reaching their employment goals as soon as they express the desire to work.

- Individualized services: Research also documents that individuals who work in areas related to their own interest tend to have higher levels of job satisfaction and job retention than those for whom counselors select job options. As a result, PROS supports individual preferences through individualized recovery planning which allows for self-determination in both the type of employment pursued and the supports offered.
- Integrated services: The integration of services ensures that all members of the treatment team are supporting individuals in their life goal of obtaining meaningful employment. It also allows for individuals to receive support for both the employment-related issues that arise (such as symptoms or side effects of treatment that interfere with the ability to work) and the nonemployment-related issues that can also derail employment efforts (such as unstable housing, concerns about benefits, and a forensic history, among others). PROS requires clinical and rehabilitation services to be co-located at the agency to ensure coordinated services.
- Comprehensive and continuous assessment: Assessment determines the com-

ponent through which individuals will receive services and informs the types of services selected to ensure that a good match is made between individuals and their jobs of interest. The assessment allows for services that best meet the needs of individuals based on their strengths, abilities, and challenges. PROS supports comprehensive and continuous assessment both on-site, at the agency, and in the community once individuals are employed.

- On-going, unlimited post placement support: The need for support does not stop once individuals are placed on a job. SE research reinforces the experience of many that on-going post-placement support is essential to job retention. This is incorporated into PROS through the ORS component which provides the opportunity for on-going support including workplace interventions that help individuals obtain accommodations that will best enable them to meet job requirements.

To facilitate a smooth transition to PROS, the Workplace Center joins with agency staff to help them review key policies and set in place practices that affect the provision of employment-related support. Of particular importance are formalizing employment-related assessment tools, developing curricula for groups that provide employment-related information and support, ensuring benefits counseling to individuals with employment goals, helping

individuals develop disclosure plans, establishing a system for coordination between the PROS staff and the world of work, determining PROS staffing patterns that best support individuals' employment goals and setting in place systems for identifying needed services and documenting service eligibility for reimbursement. PROS staff are also encouraged to review policies related to informed consent, work-readiness of individuals with mental health conditions, and the provision of employment-related support in a harm reduction environment. Finally, the Workplace Center helps agencies inventory their current service menu and evaluate the extent to which their existing range of services meet the needs of individuals at all stages of employment from first exploring career options through career development and advancement.

The New York State Office of Mental Health's Personal Recovery Oriented Services represents a powerful expression of the recovery perspective. It creates enormous opportunity to meet the priority of finding jobs in the community and supporting the self-determination of individuals in gaining access to full participation in everyday life, including employment.

Lauren B. Gates, PhD is Research Director and Sarah L. Gowtham, MS is Program Coordinator at the Workplace Center of Columbia University School of Social Work. Douglas Ruderman, LCSW, is Director of the Bureau of Program Coordination and Support at the New York State Office of Mental Health.

ISP from page 23

workplace. Spontaneity and mutual aid are keys to building a good group that offer its members support, strength and hope and, the knowledge that they are not alone in their struggle.

Tracking Vocational Progress Post- Graduation

Early on in the development of Innovative Vocational Program, there was no adequate tracking system to monitor the vocational progress of our students once they leave the school. There was always an assumption that our graduates could benefit solely from services such as placement, soft skills training and career counseling. We decided that this was not enough.

We now have established a system for students who have accessed vocational services. Before graduation, students complete a questionnaire that identifies the type of services they choose to receive, once they

leave school. These services are provided on a consultation basis. Contact is made at regular intervals to monitor progress if they do not reach out themselves. The knowledge gained by continued contact with our graduates will help us to adjust the content of the program, so that our current students will be better prepared for the workforce upon graduation.

Transitional services are critical for students with mental illness. Successfully overcoming the obstacles such as stigma and so-called "integrity testing" and offering students consistent support beyond graduation are key elements to ensuring that increasing numbers of students will experience success, like Carla, beyond high school.

Andrew Malekoff, LCSW, CASAC is Executive Director and CEO and Brian Eck, CRC, is Senior Vocational Counselor at North Shore Child and Family Guidance Center, located in Roslyn Heights, New York.

Stigma from page 33

Employment Works: Excellence in Employment Awards Luncheon. This will be the 4th year of celebrating individuals with mental illness who have taken the step of becoming employed, as well as the providers involved in helping them. This event brings together key players in supported employment and other mental health services, along with employers, government leaders and individuals with mental illness to celebrate their successes, and demonstrate that employment is a strong and growing component of the

mental health wellness and recovery movement in New Jersey. Primarily though, the luncheon's purpose is to showcase the idea that people with mental illness can and do work and succeed at all levels of employment. "The Mental Health Association in New Jersey hopes that by celebrating these successes, the general public, as well as the mental health community, will see that work is a viable option for people with mental illness, and that it is a part of the recovery process, not the end result of it" said MHANJ's

continued in adjacent column

Recovery from page 24

coherent ego identity. Experiences with severe and persistent mental illness often cause or create confusion in regards to the ways in which we evaluate who we are and how we fit in our society. Anecdotal accounts of people recovering from mental illness document the negative self-perception, which becomes internalized and forms the basis for self-representation. Self-statements, once including positive affirmations become consumed by diagnostic jargon, "I am schizophrenic, bipolar, or depressed."

This process can abruptly erode one's self-concept, the cornerstone of the more all-encompassing construct of identity, or the way by which one views and un-

derstands his or her self. It is to this end, that vocational rehabilitation becomes a highly effective and viable treatment planning option: helping people regain a sense of control over their environment by entering or re-entering the workforce and thereby stimulating the growth of a positive identity.

This article was written using the information disseminated through the Family Education Group. The FEG is designed for individuals who have a family member or loved one struggling with a mental illness. We meet the second Wednesday of every month.

For more information about the Family Education Group or Meadowview Hospital, please contact Meghan Farrell at (201) 319-3660.

Stigma Continued

President and CEO, Carolyn Beauchamp, when asked about the luncheon.

In addition to the annual luncheon, the Career Connection Employment Resource Institute (CCERI), a program of MHANJ, provides employment related technical assistance and training to providers who work with people with mental illness. Attitude awareness about how of people with mental illness are viewed by providers is a topic that is continuously addressed. Since its inception seven years ago, CCERI has provided training and technical assistance to almost 3,000 of New Jersey's mental health providers, resulting in a system wide increase in the belief of the capacity of people with mental illness to choose, get and keep em-

ployment. CCERI's goal is to create a paradigm shift in New Jersey's mental health system that will encourage and support individuals to consider employment despite having a mental health disability.

Forty years after deinstitutionalization, we are still addressing the issue of stigma. It continues to impede the recovery and wellness of millions of persons with mental illness. As professionals in the field, we must make an effort to eradicate it. But before this can happen, we have to take a serious and honest look at ourselves. Without this introspection, we will continue to be a barrier to the recovery of those we are committed to serve, resulting in their continued high levels of unemployment and underemployment.

Beyond from page 19

point person in dealing with employers. This approach removes the stigma of being represented to employers by a rehabilitation service provider, and boosts clients' self-confidence.

The stress factor associated with higher levels of work is frequently cited by clients as a reason to target jobs with lower levels of responsibility. However, we point out to clients that stress may be more likely in the face of a mismatch between the client's work identity and either the "culture" of the organization or the job duties performed. Stress can be manageable given an accepting and supportive environment, the consistent early support of an employment specialist, and job duties that draw upon the client's strengths, while minimizing the client's particular areas of vulnerability.

In an October 1994 Journal of Rehabilitation article on supported employment, Marrone and Gold pointed out that perceived lack of motivation to work among the educated mentally ill may in fact be due to the "need for high status employment or strong specific vocational interests." Certainly, there is evidence that mental illness, and responsible, higher level work are not mutually exclusive. The 1999 Boston University survey of 500 individuals cited earlier demonstrated that people with serious mental illness including schizophrenia are able to sustain professional or managerial jobs given various supports. Most frequently cited (75%) by the 500 participants as supportive of job tenure was job satisfaction and interest in their job duties. Use of medications, therapy, and social support systems were other important retention contributors, as were employment accommodations, most of which were informal and not specifically tied to the psychiatric condition.

At one of our recent Career Club meetings, college educated clients voiced

"Going from \$98,000 a year to \$7.00 an hour doesn't pay for anything. All the education I have, all the training that went into me...you're telling me to work at McDonalds? That's not going to cut it. I can't see taking a mop and mopping up the place."

Bill, physician assistant

"My depression got worse when I took a \$6 an hour job. In the past 4 years I've taken menial jobs. If I do a menial job, I see myself doing that job and the image kills me."

Emily, legal word processor

"When people are trained and educated in an area, the greatest effort should be made to keep people in that area...something related. It doesn't have to be the ideal job, but something more telling of what we've done in our lives."

Stephanie, academic research assistant

"I saw a guy in Barnes and Noble. I said if they could hire him, I could work there too. But I decided it would water down my search. If a service provider started suggesting I take very low paying jobs, I wouldn't stay with that person very long."

David, social worker

strong feelings on the topic of underemployment. Some of their comments are reflected in this article's introductory quotes. Our group was on average, middle-aged. Their advice to younger consumers was to "go back to what they were doing" after a mental health setback. One good reason is to avoid the gap in work history and the difficulty in providing references. As one client put it "people who are continually in the workforce can always dig up references." If taking a job

at a level comparable to the person's prior work is not possible, then a related job in the same or similar industry or field may be the next best option. There is bound to be greater familiarity with the work culture.

In our experience, with good psychiatric care, a support system, and perhaps basic work accommodations, clients with serious mental health conditions can be successful in higher level jobs. Since 1996, we've helped many college-educated clients return to their former occupations. By following the practices described below, we've placed teachers as teachers, engineers as engineers, pharmacists as pharmacists, paralegals as paralegals, retail managers as retail managers, and so forth:

Give consistent person-centered service that focuses on career development: Each client works one-on-one with an employment specialist to assess transferable skills, work values, interests, and preferred work environment, identify the job objective, prepare an effective resume, market the client's qualifications to potential employers, plan for work incentive benefits such as the SSDI trial work period, ticket-to-work, Medicaid buy-in, etc., develop interview skills. Once a job is found, the same employment specialist provides ongoing coaching and support (almost always away from the worksite) helping the client make adjustments and solve problems.

Provide peer support: Job Clubs for job-seekers and Career Clubs for employed clients are held regularly and facilitated by staff. Clubs foster self-help in dealing with the emotional and behavioral issues of returning to work. Problem-solving, social skills, and interpersonal communication are most often the topics addressed. Since social isolation is frequently a barrier, these groups provide natural supports and feedback. Often clients who have been away from the workplace misinterpret their own normal anxieties and fears, attributing these to their illness.

Team up with the client's mental health treatment provider: The therapist and psychiatrist are critical supports for clients. With client's consent, our employment specialists establish connections in order to create a support team. This helps when there is a need to discuss medication effects, identify potential adjustment problems or interpersonal conflicts, and symptom management. Evidence shows that integration of vocational and clinical services produces the best employment outcomes. RMHA's Life-Works program, for example, teams clinicians and employment specialists to offer clients with substance abuse histories a coordinated approach toward goals of recovery and employment.

Teach coping skills for job retention before the client starts work: To help clients handle the anxiety of returning to work, we discuss possible problems and solutions before a job offer is even in hand. Part of this is the decision to disclose the mental illness to the employer. Many college educated clients choose to wait until after they begin work to do so, fearing stigma and discrimination. In our experience, once employers are aware they are usually supportive.

Build self-esteem and self-efficacy: Clients unemployed for a long time frequently fear not being able to perform adequately if hired. We encourage clients to talk about their past accomplishments and overcoming of past challenges. We focus on strengths, positive thoughts, cognitive reframing of negative beliefs. For example, it is common for clients to feel ashamed of their mental illness, and to feel somehow undeserving of higher level jobs. These negative beliefs when successfully challenged are replaced by a sense of being entitled to work in one's chosen field.

For more information on how RMHA Vocational Services can help with employment please call 718-5300 ext 109.

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Medicaid Program from page 15

and governmental agencies, and we work with programs and staff to promote the integration of rehabilitation and recovery-oriented practices into service provision. Within New York City's community mental health sector, we help staff acquire the competencies to better assist consumers get and keep jobs of choice, navigate the complex world of federal disability benefits, and learn how to use existing work incentives to promote the career goals of individuals with mental illness. Understanding that the MBIWPD Program could serve to promote employment outcomes for individuals with psychiatric disabilities, the Center began to look closely at how the Program is operating, especially in New York City.

Between 2003 and 2007, the MBIWPD has helped 4,624 New Yorkers with disabilities retain their Medicaid health benefits while working (New York State Independent Living Council statistics). Of this group, we were both surprised and disappointed to learn that only 288 individuals with disabilities (all disability groups included) - or 6% - are residents of

New York City. Underutilized, underpublicized, and misunderstood, it appears that the Buy-In Program is not being accessed, to the extent possibly, by New York City consumers who could gain from it. The Program has not come close to meeting projected enrollment rates. Confusion around eligibility and the enrollment process persists.

In an effort to address this situation and increase enrollment, in collaboration with the New York State Office of Mental Health (NYSOMH) and in consultation with key stakeholders including the New York City Department of Health and Mental Hygiene (NYCDOHMH), New York City Human Resources Administration (NYCHRA), New York State Department of Health (NYSDOH), mental health providers, and consumer advocates, The Coalition's Center is facilitating a work group tasked with identifying the barriers to MBI enrollment in New York City and developing collaborative ways to overcome them. To augment our understanding of the Program's perception and rate of utilization, we are gathering information from community-based programs on the characteristics of their program participants includ-

ing disability benefit status and interest in employment. We are grateful to all of the program directors who have helped us to compile this information.

Working closely with our partners, we hope to determine, or facilitate the development if needed, of administrative protocols that can help facilitate the application and enrollment process in ways that are more efficient and effective. Our involvement spearheading this work group has been informed by first-hand knowledge, acquired through the personal experience of one of our staff who was among the first mental health consumers in New York State to apply for the MBIWPD. At that time, the application process proved highly challenging to her and clearly reflected a lack of knowledge among Medicaid staff about the Buy-In and what distinguished it from other Medicaid programs. Once enrolled in the program, still with a moratorium on premiums, our colleague has saved as much as \$1200 per month in prescription drug costs.

Questions abound for our work group's consideration: how difficult are the MBIWPD rules to interpret? Is the program well understood by HRA's eligibility workers? How are staff trained on

the Buy-In? How can providers in different programs support consumers in making informed decisions about benefits? How can we reach out directly to SSI and SSDI beneficiaries to lessen fears about loss of health benefits and support acquisition of work goals? How can peers help one another to take advantage of work incentives? In depth discussions are underway regarding training needs in New York City and the most effective means to market and promote the MBIWPD. Work group members are considering the role of web-based technologies for application processes, and steps have been taken to create materials that are consumer-friendly and easy to use.

To encourage people to resume or attempt employment, all of us - all individuals supporting consumers - must understand that the fear of losing health and other benefits is pervasive and credible. In response, we all must be prepared with information and proven ways to help individuals try employment without jeopardizing their benefit status. The Medicaid Buy-In Program for Working People with Disabilities is one such way to address these concerns.

NYC-HHC from page 15

school diploma (or its equivalent) and received training from a formalized peer counselor training program approved by New York State Office of Mental Health or one year of full-time satisfactory experience working with consumers of mental health services as a Peer Counselor/Advocate. They provide case management services, facilitate groups and foster a sense of hope and empowerment for other mental health consumers through their role modeling. Integrating this specialized workforce in HHC's behavioral health programs underscores a new model of treatment and rehabilitation characterized by individuals making a transition from a patient to a helper. This phenomenon is a source of encouragement to individuals currently being served in HHC's mental health programs, and an impetus for systems' transformation in behavioral health services.

One of the first steps that HHC's Office of Behavioral Health took in response to the research and the expressed needs of consumers was to hire a "Consumer Affairs Coordinator." This person provides technical assistance and training around rehabilitation and recovery to both HHC staff and mental health consumers.

In 1998, another opportunity to employ consumers was created through the "Consumer Empowerment Dialogue" Project. This project consisted of a series of specialized trainings to HHC consumers, to encourage their active participation in treatment.

As some consumers said after their dialogues: "Recovery means taking steps day by day to improve my mental, physical and spiritual well being," and, "Recovery means getting stable on meds and treatments and able to work towards being independent."

Dialogue trainings were then expanded to be given not only to consumers, but also separately to staff. These groups were led by a team consisting of a few consumers of mental health services along with staff from the Corporate Office of Behavioral Health. The Project sought to change attitudes of clinical professionals and consumers, by providing education about rehabilitation and recovery and

about the possibilities and opportunities for people with mental illness. Between 1999 and 2005, over 250 dialogue sessions were conducted - 1,100 consumers and 1,600 staff participated.

The Empowerment Project later became more focused on medication non-adherence, a problem identified in the literature as the number one issue for psychiatric inpatient admissions. This current project, known as "Medication Dialogues," promotes recovery-focused partnerships between consumers and providers and fosters greater awareness about the risks, benefits and side effects of taking medication, from both the consumer and provider perspective; explores how people feel about taking medication and reasons for non-adherence; and helps consumers understand the role of medication as a recovery tool that ideally supports them in achieving meaningful goals.

Medication Dialogues are conducted using a curriculum developed by HHC in collaboration with a national expert in psychopharmacology, and are led by a team of mental health consumers and a psychiatrist or nurse practitioner as trainers and consultants. Since the implementation of this project in 2006, 785 staff and 810 consumers have participated in these specialized "Medication Dialogues." The Dialogues generate data through the use of pre and post tests which are intended to measure participants' attitudes about medication. Thus far the data shows that after attending just one dialogue, there was a significant increase in the number of psychiatrists who said they would "tend to change a medication based on the consumer's feedback."

Although employment of mental health consumers was not the driving purpose of the dialogue projects, they have in fact provided part-time employment opportunities to over 40 consumers over the years.

To support HHC's peer counselor workforce, the Office of Behavioral Health conducted a conference in 2004 entitled, "Consumer Employment: HHC Empowerment" for behavioral health, and human resources staff that included the Office of Labor Relations. The conference provided clarification about the roles of peers working in the hospitals and created interest in further learning about how

to effectively incorporate Peer Counselors on staff.

In 2005, with the assistance of staff from New York State Office of Mental Health (OMH) and Howie-T-Harp Peer Advocacy Center in New York City, focus groups were conducted at HHC with Peer Counselors, and with managers and supervisors, to address concerns about boundaries between supervision and therapy, the challenges consumers face in re-entering the workplace, and training needs for both peers and supervisory staff. HHC Consumers have expressed many concerns about incentives and disincentives to working, especially in regard to Social Security and insurance benefits. The Consumer Affairs Coordinator, along with HHC's facilities' Human Resources Department, helps navigate the benefits' terrain.

Beginning in 2006, HHC also launched an ongoing series of Educational Events known as the "Consumer to Caregiver" project, which targets individuals served by HHC's mental health programs. These quarterly events are held at HHC facilities, and focus on the process of making career decisions and setting goals. Many of the participants express interest in becoming Peer Counselors; others consider alternate types of employment, job training, or volunteering; or enrolling in GED preparation courses or returning to school to complete a college degree. The ultimate goal expressed by many consumers is to earn money and be self-sufficient. HHC collaborates with other providers of mental health services and with community-based programs to provide information about peer support, community resources, wellness self-management, and other skills that help foster the transition from service recipient to employee. To date, more than 460 consumers and 91 HHC behavioral health staff have participated in these events. These activities have served as an impetus for continued expansion of consumer workforce initiatives in HHC and in the mental health community. "Recovery can be a long process but I finally realize that I can make it..." (Consumer after educational event)

As a national leader in expanding employment opportunities for peer staff, HHC was recently awarded the 2007 Public Health Community Award by the Pub-

lic Health Association of New York City (PHANYC) for Peer Counseling and Case Management Services. The Public Health Community Award is reserved for organizations in recognition of their leadership and advocacy that promotes public health in New York City communities. And, HHC was selected as a finalist in the 2007 American Psychiatric Association (APA) Achievement Awards competition (Gold Award) for their Medication Dialogue Project.

HHC continues to work closely with facilities to identify needs pertaining to hiring more peers as providers, and to increase staff awareness about the unique contribution that Peer Counselors make. Integrating Peer Counselors in HHC's psychiatric services has far-reaching implications for thousands of individuals who receive mental health services in HHC's programs.

The HHC facility clinical and administrative leadership have been essential in leading the transformation that has incorporated Peer Counselors within treatment teams. The success has been dependent on many people's vision, on the hard work of those committed to the notion of rehabilitation and recovery and by the help of friends in the community such as Harvey Rosenthal and Mathew Mathai at New York Association of Psychiatric Rehabilitation Services (NYAPRS), Jim Rye at the Alliance-Empowerment Coalition, and LaVerne Miller, Esq., at Howie-The-Harp Peer Advocacy Center - to name just a few. We're thankful for everyone's help and support and look forward to making further inroads to helping those with disabilities live a more meaningful life and making the HHC system of care one that is truly reflective of what works and what consumers need.

According to the research by William Anthony done at Boston University Center for Psychiatric Rehabilitation, it is a person's skills and supports that predict vocational success, not psychiatric symptoms. HHC's work in the mental health community demonstrates both a belief that recovery is possible and supports the idea that consumers should be personally involved in their recovery. Consumers, in collaboration with other stakeholders, must serve as agents of change in behavioral health service delivery.

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Housing from page 25

impact the course and nature of recovery; and most importantly (g) it assumes hope and success.

The issue of healing is an elusive concept as it measures a person's ability to begin to reconstruct him or herself physically, emotionally, and existentially. As it relates to safe and supportive housing, one is able to heal through positive and predictable transitions. This is true regardless if the person is returning home or to a structured treatment placement.

The positive and successful transition into safe post-hospitalization housing can serve to foster two integral internal characteristics within the person: attachment and positive self-concept. Reintegration into the community allows for social connections to be re-established, for family

connections to be continued, and for attachment to the larger community. As a by-product, one's own self-concept, or the way by which they view themselves and their effectiveness in the world, is bolstered. Therefore, positive identifications are made as an independent adult contributing to a larger collective.

This article was written using the information disseminated through the Family Education Group. The FEG is designed for individuals who have a family member or loved one struggling with a mental illness. We meet the second Wednesday of every month.

Hudson County Meadowview Psychiatric Hospital is located at 595 County Avenue, Secaucus, NJ 07094. For more information about the Family Education Group or Meadowview Hospital, please contact Meghan Farrell at (201) 319-3660.

Pathways from page 25

In 2003, the Interagency Council on Homelessness to provide housing and services to chronically homeless populations coordinated a Collaborative Initiative to Help End Chronic Homeless. Seven of the eleven programs funded used the Pathways Housing First model and they achieved similar housing retention results successfully replicating both the model and the findings on retention across diverse contexts.

Further analyses have focused on psychiatric symptoms. An examination of the relationship between stable housing and psychiatric symptoms shows a reduction in psychiatric symptoms if the person has been stably housed for the preceding six months. In analyses comparing the impact of

consumer choice, a principal component of housing first, on the mental health of housing first and control participants. Ratings of perceived choice were significantly higher for participants in housing first compared to those in the control group; and perceived choice significantly accounted for a decrease in psychiatric symptoms, a relationship that was partially mediated by mastery (perceptions of personal control).

The Pathways model, now called Housing First, has prompted many programs and agencies around the country to adopt this respectful, revolutionary, and highly effective approach in their efforts to end homelessness.

For additional information please visit us at www.pathwaystohousing.org.

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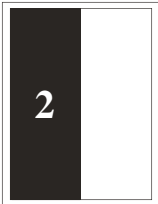
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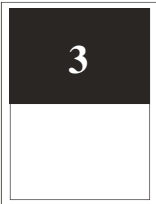
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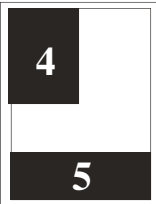
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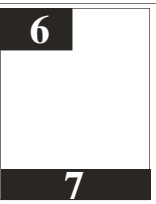
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