MENTAL HEALTH NEWS™

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Housing For People With Mental Illness and Substance Use Disorders

A Perspective on Mental Health Housing in New York State

By Peter D. Beitchman, DSW
Executive Director
The Bridge

The New York State Capitol Building in Albany

What an accomplishment! In the past 25 years (I may be off by a year or two) the New York State Office of Mental Health (OMH) has supported the development of 30,000 residential units for persons who have serious mental illness. Development began with the establishment of congregate supervised programs, single-purpose buildings with 24-hour staffing, medication monitoring and, most importantly an opportunity for intensive rehabilitation services so that residents could prepare for more independent housing. Apartment Treatment was developed as the next level in the continuum. These residents live in scatter-site apartments in conventional rental buildings in the community with visiting case management support services. Next, OMH developed a permanent housing alternative, supported housing, in which residents continue to receive rent subsidy and case management services. More recently, OMH developed the CR-SRO and Supported SRO models to fill out the continuum.

The robust housing network developed with OMH support stands as a singular achievement of the partnership between government and community-based agencies (with the participation of a number of committed advocacy organizations). The quality housing provided in these 30,000 residential units has given their occupants an indispensible foundation in their path to recovery. Government, providers, recipients and advocates agree that housing is an essential keystone service in New York's recovery-oriented mental health system.

Today, as the mental health system in NYS is undergoing major reform through the work of the Governor-appointed Medicaid Redesign Team (MRT) and other related efforts, it is a time to reflect not only on the accomplishments of mental health housing to date, but how it can remain a vital force for recovery in the emerging integrated health and behavioral health system. In this context a number of issues emerge:

Sustaining the Current System: A first priority is the maintenance of the current residential system. While it is robust, there are also some concerning signs of fraying. Government funding must keep pace with rising expenses or else current housing will be in jeopardy. In supported housing, for example, rents rise steadily. Whereas licensed housing has always had the benefit of a property cost pass-through to cover increased rents and operating costs, unlicensed supported housing has not. When funding remains frozen in

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Stable Housing: Key to Closing the Mortality Gap

By Michael B. Friedman, LMSW
Mental Health Policy Advocate

Stable housing is critical to closing the disparity in life expectancy between people with serious mental illness and the general population. Providing it should be a major part of the effort to confront the mortality gap.

People with serious mental illness die considerably younger than the general population. Most people these days say 25 years younger, because of a study of 8 states in which this was the average difference in life expectancy.[1] Other studies have put the gap at about ten years.[2] 25 or 10 -- either way it's a dreadful fact that has finally become a major concern of mental health policy and resulted in several mental health policy changes that were long overdue. These include: (1) health promotion activities designed to get people with serious mental illness to stop smoking, to avoid obesity or lose weight, and to exercise, (2) improved access to good physical health care, and (3) integrated physical and behavioral healthcare services.

This is all for the good. But it is not enough. It leaves out of account the fact that many, if not most, people with serious and persistent mental illness have hard, dangerous lives at some point along the way because of substance abuse and/or homelessness.

Substance abuse contributes to exposure to communicable diseases such as hepatitis, venereal diseases, and HIV/AIDS. It also exposes vulnerable people with mental illnesses to criminals who often prey on them. People with co-occurring mental and substance use disorders are frequently victims of crime, including assault. They suffer injuries that often weaken them even if they seem to heal fully.

Homelessness is also dangerous. Living on the street when it is freezing cold or pouring rain is not good for one's health. Sleeping under a cardboard box or huddled on a heating grate is not safe. Homeless people -- whether substance abusers or not -- are frequently victims of violent crime that can leave them physically and psychologically scarred for life.

Here Are Some Facts[3]

1. People with co-occurring serious mental and substance use disorders are far more likely than other poor people to have heart disease (over 4 times as likely), asthma (over 3 times), other acute respiratory problems (about 2 times), cancer (about 2 times), and diabetes (1.5 times).

2. People with co-occurring serious mental and substance use disorders are at higher risk for infectious diseases, especially hepatitis B (19 per 100,000 vs. less than 1 per 100,000), hepatitis C (16.2 vs. 1.9), and HIV 5.5 vs. .5).

3. People with serious mental illness are 12 times as likely to be victims of crime compared to other urban poor people.

4. People with serious mental illness alone or with co-occurring mental and substance use disorders are more than 5 times as likely to experience physical and sexual abuse than the general population.

5. Transient housing status triples the risk of criminal victimization.

6. People with serious mental illness or with co-occurring disorders are 4-5 times more likely to become and remain homeless than people without serious mental illness.

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The Correlation Between Housing and Recovery
How Independent Living Can Pave the Road to Recovery

By Theresa Manuel, MS, MSW
Program Director, Brooklyn & Far Rockaway Apartment Programs
JBFCS

If a person with a mental illness is striving to better him or herself, is aiming to reduce symptoms and lessen the impact of his or her illness, where do you think such recovery would best take place? Do you think safe and secure housing has an effect on the path a person takes in life? Adequate housing can and does provide a better plan for someone in recovery. It becomes not just a place to live but a place for clients to work on achieving life goals.

Housing is probably one of the most important factors that help a client fully immerse and integrate into society. It also reduces stigma because the client is not set apart and removed from the community. What we at JBFCS' Brooklyn Treatment Apartment Program have found is that given the opportunity to lead a more independent life, most people will grab at the chance. When asked about housing in New York City, John Stern, a resident in one of our apartments, stressed that "housing in New York City is very tight for poor people." And if you think about it, people living with mental illness rank high among the city's poor. Having a

Theresa Manuel, MS, MSW

place to call home is integral to the success of a person's recovery.

The apartment programs at JBFCS come in various forms. There are supportive treatment programs that cater to residents transitioning from an institutional setting. Here, residents are introduced to a home-like environment where Case Assistants assist the residents in learning basic living skills and help them develop recovery goals—goals that clients might never have even thought about if they hadn't been given an opportunity for safe housing. Then there are supported apartments that offer subsidized housing to adults living with mental illness who are able to live independently. These residents manage their own finances and run their own households. Case Assistants are available on an as-needed basis and through bi-monthly apartment visits.

Clients with mental illness know they cannot attain life goals without having a roof over their heads first. They also know that having housing greatly reduces their chances of returning to the system that provoked their mental illness in the first place. Dorian King, a resident in JBFCS' Brooklyn Graduate Apartment Program, spoke about his experience in the program at a resident dinner held on September 22, 2011. "Having my own room is not just housing; it is rehabilitation, which is a major part of my psychiatric recovery." If we look more deeply into this statement, we can see and begin to understand its deeper meanings. What does it mean to have a place you can call your own? Think about it. Where would you feel better—in a place where you decide what you want for dinner and what to watch on TV or in place where those decisions are made for you? If you are a capable adult on the road to recovery, striking out on your own is a positive step, something that says, "I am somebody. I can do and I can improve." Clients are able to function better when they feel safe, secure, and supported. They are better able to focus on the next stage in their lives.

Some statistics from our housing programs back up this idea of independent living paving the road to recovery. One in four Americans will experience a mental health disorder, yet with appropriate medication and a wide range of services, including housing, most people who live with serious mental illness can significantly reduce the impact of their illness and find a satisfying measure of achievement and independence. What's more, 50 percent of JBFCS apartment program residents are involved in meaningful community activities, including employment and volunteer work, and 20 percent of our residents have obtained college degrees. Research shows that there is a correlation between housing and mental illness—housing reduces the rate of recidivism hospitals and the legal system.

Housing not only improves the quality of life for individuals with mental illness, but it is also likely to make the individual better able to manage his or her mental

see Independent Living on page 33

The Redesign of Housing

By Mark H. Fuller, President, DePaul and Moira Tashjian, Interim Director, Bureau of Hosing Development and Support, NYS Office of Mental Health

In the Spring of 2007, the NYS Office of Mental Health, reached out to the residential providers in New York State asking them to review and provide feedback to the Guiding Principles for the Re-design of the (OMH) Housing and Community Support Policies.

The message from the OMH was that safe, decent and affordable housing is a cornerstone of recovery from mental illness. Stable access to good housing was a fundamental problem for many people with mental illness because of poverty, the limited supply of very low income housing, the rising cost of rental market, and discrimination.

The fundamental problems listed previously, continue to exist today and there needs to be a change. Change must include an expansion of low income housing for people with mental illness and flexible supports that do not condition housing or services . Housing is a basic need and necessary for recovery. Most people want permanent integrated housing. We must move forward with local systems of care that can provide housing and support needs in the housing preference at any level of recovery.

In 2007, the OMH revisited the structures that govern the mental health housing assets in New York. Many of these units were developed using approaches established in the 1980's and 1990's. This period of time emphasized residential treatment strategies, services and supports as a condition of living in the program. Within an accountable system of care there is a finite need for staffed specialty treatment programs.

Reform of housing is intended to balance access to housing for all individuals with the need to reform older models of residential care. Person centered principles of recovery guide the redesign efforts. Additional OMH goals include: expanding access to supported housing, re -evaluating existing staffed single site housing programs, developing permanent integrated housing, and reducing acute care stays. Flexibility is necessary for housing reform to be responsive to individual recipient wishes, needs, and system goals, and to work effectively as a tool in creating local systems that avoid institutionalization and homelessness.

The OMH has worked with stakeholders such as local government, consumers, family advocates and providers to incorporate flexibility, choice, want and need into projects on a local level of change. Since 2007, the OMH has worked with over 30 agencies to redesign housing programs in their community, reducing the number of congregate staffed housing, expanding apartment treatment and supported housing capacity and embracing the desire to change for the future. One such agency is DePaul.

DePaul, a progressive Western New York not-for-profit organization founded in 1958, is committed to providing quality residential, rehabilitation and treatment services to the elderly, persons with mental illness in recovery, persons with a developmental disability, and those with a history of homelessness as well as, addiction, prevention and support programs. Over the past seven years, DePaul has embraced the housing redesign model.

According to Mr. Mark Fuller, President of DePaul, "We've worked hard to convert many of our community residences into apartments. Our consumers have truly benefitted as the approach to treatment has evolved from a one-size-fits -all approach to a more personalized venue that fits individualized needs.

Supported housing - independent apartments with financial stipends and case management - clearly remains a therapeutic option for consumers but it is not necessarily for everyone, at least not immediately. The meteoric increase in home ownership has resulted in a negatively-impacted renter's market, with riskier, less stable neighbors and neighborhood relationships for consumers in individual apartment settings. This situation is most keenly felt by those moving directly into supported housing with few skills.

Consumers living in single-site, one-bedroom supervised apartments and consumers living in service-enriched SROs stated they have the best of both worlds including the availability of staff supports tailored to their individual wants and needs (ie. medication supervision, symptom management, socialization, support and advocacy, etc.), as well as the ability to retreat to their own apartment when they preferred to be alone. Residential staff assist consumers as they practice skills learned in treatment or skill-building programs, while residing in a safe environment. Consumer satisfaction surveys indicate many consumers in treatment apartments and SROs advocate for and support each other while residing in these programs, creating a peers-helping-peers mentality and environment.

Another major benefit to single-site treatment apartment programs and service -enriched SROs is the opportunity to socialize with others in the program. These programs encourage consumer interaction and socialization through in-house activities, community-based activities, or simply befriending other program residents. Surveys confirm concerns in this area, as consumers don't often have the opportunity or motivation to go into the community and meet new friends when living independently.

It is important to remember that treatment apartments and service-enriched

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When Government Looks for Healthcare Savings Supportive Housing Has the Answer

By Jason Lippman, Senior Associate For Policy and Advocacy The Coalition of Behavioral Health Agencies and Member of the NYS Medicaid Redesign Team's Affordable Housing Work Group

These days, it seems that on all levels of government, healthcare programs are being reexamined for cost savings, efficiencies and better outcomes. Nationally, healthcare reform and the Affordable Care Act will provide new opportunities to serve the most vulnerable populations and perhaps bend the country's healthcare expenditures downward. States and localities are also looking at their own healthcare expenditures in order to help close burgeoning deficits.

In New York State, Governor Andrew Cuomo has undertaken an initiative to restructure the State's Medicaid program. The overall aim is to improve health outcomes and reign in spending. To accomplish this, Governor Cuomo created a Medicaid Redesign Team (MRT) with appointed representatives from the State Legislature, Executive Branch, State agencies, New York City agencies, healthcare industry and consumer advocacy groups. The MRT was tasked with proposing recommendations to save a total of $2.85 billion in Medicaid ex-

Jason Lippman

penses in the current fiscal year, and $4.6 billion next fiscal year. Through the work of the MRT, the State has approved a package of 73 proposals to streamline its Medicaid system, one of which is a supportive housing initiative (State of New York, 2011). While Medicaid, aside from some restorative services, does not pay for supportive housing, tenants and potential tenants are indeed Medicaid recipients who use public health services.

Under the MRT, 10 workgroups were formed to provide further review and recommendation. They include Affordable Housing, Behavioral Health Reform, Health Systems Redesign, Health Disparities, Managed Long Term Care Implementation & Waiver Reform, Basic Benefit Review, Programming Streamlining & State/Local Responsibilities, Payment Reform & Quality Measurement, Workforce Flexibility & Change of Scope of Practice, and Medical Malpractice Reform (State of New York, 2011).

The Affordable Housing Work Group plans to take an in-depth look at New York State's "supportive housing" programs (the mission statement of the workgroup defines supportive housing as "any combination of market rate or subsidized housing and services that will meet the needs of the targeted populations") (New York State Department of Health, 2011). The group will examine the availability and adequacy of such programs to make sure that people are not otherwise being improperly housed in institutional settings or denied appropriate care and services.

In addition, the housing workgroup will identify barriers to the efficient use of supportive housing resources, and make recommendations to overcome them. This may include mandate reform, as well as reassigning State resources and accountabilities with regards to development and oversight. The group will also look for Medicaid savings and service improvements from the investment of new resources into supportive housing (New York State Department of Health, 2011).

As the Affordable Housing Work Group begins to meet and make recommendations, it is important for us to realize that supportive housing is and has been a key component to reducing physical and behavioral healthcare related expenses, including savings in the Medicaid system. Evidence-based practices have demonstrated that supportive housing helps consumers manage their existing health conditions. Without stable housing in place, an individual's health conditions would likely worsen. Vulnerable populations can quickly become at-risk for homelessness and the chronic medical conditions that seem to come along with it. When crises arise, individuals, who lack stable, affordable housing, and adequate care coordination, often seek treatment in hospitals and emergency rooms. These settings are very costly places for care, which are mostly paid for with public dollars.

Supportive housing's daily expenses are only $45 per individual. On the other hand, in New York State it costs $1,820 a

see Healthcare Savings on page 34

Supportive Housing: A Cornerstone to Recovery in a Changing World

By Jeffrey Seward, Program Specialist, Meggan Schilkie, Deputy Director, and Trish Marsik, Assistant Commissioner, Bureau of Mental Health, New York City Department of Health and Mental Hygiene

Advocates, providers, recipients, and policymakers are adjusting to the rapid pace of change in the mental health care system including behavioral health organizations, Health Homes, Medicaid reform, and many others. These changes, while challenging, present opportunities to improve efficiency, health integration, and consumer driven health care, reducing disparities and improving access. The Bureau of Mental Health within the New York City Department of Health and Mental Hygiene is responsible for improving the mental health of all New Yorkers and supportive housing is an essential part of the continuum of mental health services, promoting community integration and recovery. Toward that end, supportive housing is a top priority for our Bureau, comprising approximately $75 million or 40% of our overall funding to community-based providers throughout the City. The Bureau provides oversight, training and technical assistance to supportive housing providers to improve the quality of supports for tenants who reside in these programs as well as leadership on policy and planning activities within New York City on major mental health issues including supportive housing.

We at the Department are working with consumers and providers to continuously improve services to individuals living with mental illness who are homeless especially those with co-occurring substance use problems. Over the past year, the Department of Health and Mental Hygiene has articulated several priorities for community-based supportive housing providers:

- Recovery
- Improved care for individuals with co-occurring disorders
- Harm Reduction
- Health integration including smoking cessation
- Employment
- Engagement
- Access for individuals exiting the criminal justice system; and
- Consumer choice

Based on a random sample of 20 housing programs conducted in 2010, it was reported that more than 30% of individuals currently living in supportive housing were actively using illegal drugs or alcohol and more than 40% were smokers. We have come a long way from the paradigms of the past which required abstinence and periods of sobriety prior to acceptance into supportive housing. We still have a long way to go. To further improve service delivery, we provided harm reduction training to 85 supportive housing providers throughout New York City. Harm reduction promotes tolerance and engagement and acknowledges the challenges faced in changing addictive behaviors especially in the context of recovery from a mental illness. It enables tenants with the support of program staff to set clear goals and objectives and work toward achieving them in a measurable way.

Additionally, the Department supported an extensive series of trainings on "Integrating Tobacco Dependence Treatment Services." More than 200 housing programs received extensive training on integrating tobacco cessation into their programs. This has helped shift many housing programs from inadvertent, tacit acceptance of smoking to supporting people in quitting. While the training specifically addressed nicotine dependence, it was built on a broader framework of Motivational Interviewing. Motivational Interviewing is strength-based and focuses on the individual's own motivations to change rather than attempting to impose change externally. While smoking is damaging to an individual's health it is also damaging to a supportive housing program and community, causing indirect risks to others through second hand smoke, chance of fire and damage to apartments and belongings. Smoking cessation is just one important way to integrate healthcare into a supportive housing setting. Many community-based providers are doing so in creative innovative ways including creating gyms in lounge spaces, partnering with local health organizations, holding on site cooking and nutrition classes and many more. Integrating health care is no longer an optional enhancement for the behavioral health system. Improving physical health is a part of recovery and necessary for better mental health and a top priority for us at the Department.

Employment is a vital component to recovery from mental illness. Employment facilitates social inclusion promoting economic empowerment and self-sufficiency. The employment rates for individuals with serious mental illness are abysmally low. Increasing the number of individuals with serious mental illness who are competitively employed has become a top priority for our Department. Toward this end, we have been working with providers to implement vocational assessments within their standard operations in supportive housing. Throughout FY11, employment rates for adults with serious mental illness under the age of 62 living in DOHMH-funded supportive housing units hovered around 11% down slightly from previous years. Some of the

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Bringing It All Back Home:
Housing Innovations and the NYS Medicaid Redesign Teams

By Peg Moran, LMSW
Senior Vice President
Residential and Housing Services
F·E·G·S Health and Human Services System

Much discussion has occurred during the last few years on reducing the high health care cost and improving outcomes for people with a serious mental illness. These individuals use a disproportionate amount of care, much of which may be unnecessary or avoidable, and tragically die 25 years earlier on average than people without a mental illness.

Since coming into office in January 2011, Governor Cuomo has implemented ambitious efforts to transform Medicaid spending in NYS. He created Medicaid Redesign Teams to look at how to reduce costs and increase quality and efficiencies. Much of the focus of these Teams has been on the high users – often people with serious mental illness.

Out of these efforts, Behavioral Health Organizations (BHO) and Health Homes have been designed to address better care coordination for people with serious mental illness and people with chronic health conditions, and to reduce the use of inpatient psychiatric and substance use services, readmission, and emergency room visits. By 2014, people with serious mental illness or substance use disorders will be folded into managed care - Special Needs Plans - for their health and behavioral health services. These Special Needs Plans will provide care coordination and become the fiscal intermediary, similar to those in place for people with HIV.

Peg Moran, LMSW

Ongoing Need for Housing

While policy makers will continue to refine how to right size New York State's Medicaid expenditures, the value of supportive housing needs to be in the forefront. Housing programs have a proven track record of keeping people out of hospitals and emergency rooms, connecting with medical and psychiatric services, and coordinating care for the people who live there. Numerous studies have shown that supportive housing improves the quality of life and reduces medical and institutional costs. [(1)(2)]

Housing is a key determinant of a stable, productive life, and the foundation for recovery for people with a mental illness or substance use disorder. For all of us, housing is one of the most basic necessities. This incredibly valuable resource needs to expand to address the needs of the thousands of New Yorkers who are targeted by the BHO and Health Home Initiatives. The Governor has recently announced a Medicaid Redesign Team for Affordable Housing. This is a big step in recognizing and showcasing the impact of housing, and the need to develop more units. A NY/NY IV Supportive Housing Agreement to increase the existing supply of supportive housing is sorely needed.

F·E·G·S Housing

F·E·G·S houses over 1300 people each day, more than half (800) are people with serious mental illness who formerly were homeless or lived in a variety of settings: state psychiatric centers, shelters, prison, adult homes or hospital inpatient units.

The mission and core values that drive the work of staff each day is:

- Keep people housed
- Help the men and women live as independently as possible

The Motto of the F·E·G·S Residential and Housing Services Division is "Whatever It Takes." People with mental illness often have fragile lives due to ravages of the illness and the trauma from institutionalization, foster care placement or living on the streets. Support is necessary to keep them in housing and out of hospitals or other institutions. F·E·G·S has adopted two practices that are making a difference:

- Critical Time Intervention, providing critical linkages during transitions
- Creating Crisis Beds to keep people housed instead of calling 911 or being lost to care

Critical Time Intervention

Critical Time Intervention (CTI) is an Evidence Based Practice designated by the Substance Abuse and Mental Health Services Administration (SAMHSA) that promotes housing stability by providing

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Suffolk Agency Expands into Brooklyn

By Ralph Fasano, MA, MED, CRC
Executive Director
Concern for Independent Living, Inc.

After over 25 years of developing primarily small, scattered site projects in Suffolk County, Concern for Independent Living is pleased to open The Rochester Avenue Apartments, our first Single-Site Supportive Housing program in Brooklyn. Using New York New York III funding, this 65-unit apartment building provides safe, affordable housing and on-site supportive services for individuals recovering from mental illness. Fifty-five percent of the residents came from OMH-operated psychiatric centers. The remaining 45% are chronically homeless single adults with a severe and persistent mental illness. Residents enjoy their own studio apartment with private bathroom and kitchenette. The building includes a fitness center, computer room/library, laundry facilities, several lounges, roof-top patio and community garden.

The Rochester Avenue Apartments began as an outgrowth of Concern's successful conversion of three adult-homes in Suffolk County. In 2004 some advocacy groups asked us to get involved in an impending housing crisis on Long Island. Since the beginning of 2004 over 12 Long Island adult homes, which housed over

Ralph Fasano, MA, MED, CRC

800 people with mental illness, have closed. While the adult homes have never been great places to live, they were a home for the people that lived there.

Concern recognized that this crisis was an opportunity to create new housing that would be far superior to the existing institutions that were closing. Known as Pollack Gardens, our first OMH-licensed 50-unit Single-Site Supportive Housing program is located on Main Street in West Sayville. The building is the site of the former Family Lodge Adult Home where 64 individuals once resided in 32 rooms. With the support of the Town of Islip and the Town of West Sayville, construction was completed in 2007. Three years after the opening of Pollack Gardens, this project continues to enjoy the support of its neighbors. Planning Department Commissioner Eugene Murphy stated "we have not gotten one complaint about that facility [Pollack Gardens] since it opened." He continues to state that Concern "provided the opportunity to dramatically upgrade the building" and that the "genius" of Concern is that we "perform." "Right down to the architectural touches on the building, they [Concern] perform in a humane way for the people that live there."

Riding on the success of Pollack Gardens, Concern continued to develop Single-Site Supportive Housing programs in Suffolk County. Our second adult home conversion transformed the Henry Perkins Adult Home in Riverhead into Concern Riverhead in 2008. Prior to its tenure as an Adult Home, this building was a cornerstone of the Riverhead community. Known as the Hotel Henry Perkins the building was a place where politicians, attorneys, judges and reporters were regulars. The hotel was eventually turned into an adult home in the 1970s where as many as 120 individuals resided at one time. As an adult home the building fell into disrepair. As Concern Riverhead, residents each enjoy their own private studio apartment. Residents are encouraged to socialize in the building's many amenities, including a fitness center, lounges, computer room/library, and communal dining room. Concern was able to restore this blighted building located on Main Street back to its former magnificence and won a downtown revitalization award from Vision long Island in 2010.

Our third adult home conversion, Concern East Patchogue, included the razing of the South Country Adult Home, where up to 170 individuals resided at one time. Concern East Patchogue, which provides housing and supportive services for 50 individuals with mental illness, opened in 2009. As stated by a Concern East Patchogue resident, "I grew increasingly depressed living there [Suffolk County adult home]. . . Living at the Patchogue SRO has allowed me to reestablish independent living."

Drawing on our experience converting adult homes into beautiful Single-Site Supportive Housing apartments, Concern applied for, and was awarded, funding from the New York State Office of Mental Health through the New York New York III Agreement in 2007. Using this funding, Low-Income Housing Tax Credits issued by NYS Homes and Community

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Concern for Independent Living

Is pleased to announce our 2011 openings of *three* 65-unit Single-Site Supportive Housing Programs in **BROOKLYN, NY**

MacDougal Street

East New York

Rochester Avenue

Concern for Independent Living, Inc. is a non-profit agency committed to helping low income persons and persons with psychiatric disabilities to live in the community with dignity and enhanced opportunities through the provision of housing and support services. We are one of the largest housing agencies of this kind in New York State, currently serving approximately 600 individuals and families in over 200 locations. Concern offers a variety of housing options with individualized support services designed to support personal growth and independence.

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- **APARTMENT TREATMENT RESIDENCES**
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Accredited by CARF Smart Growth Award from Vision Long Island United Way Member Affiliate
Recipient of the Metropolitan Life Foundation National Award for Excellence in Affordable Housing

At EDCSPIN People Live In "Houses Like Mine"

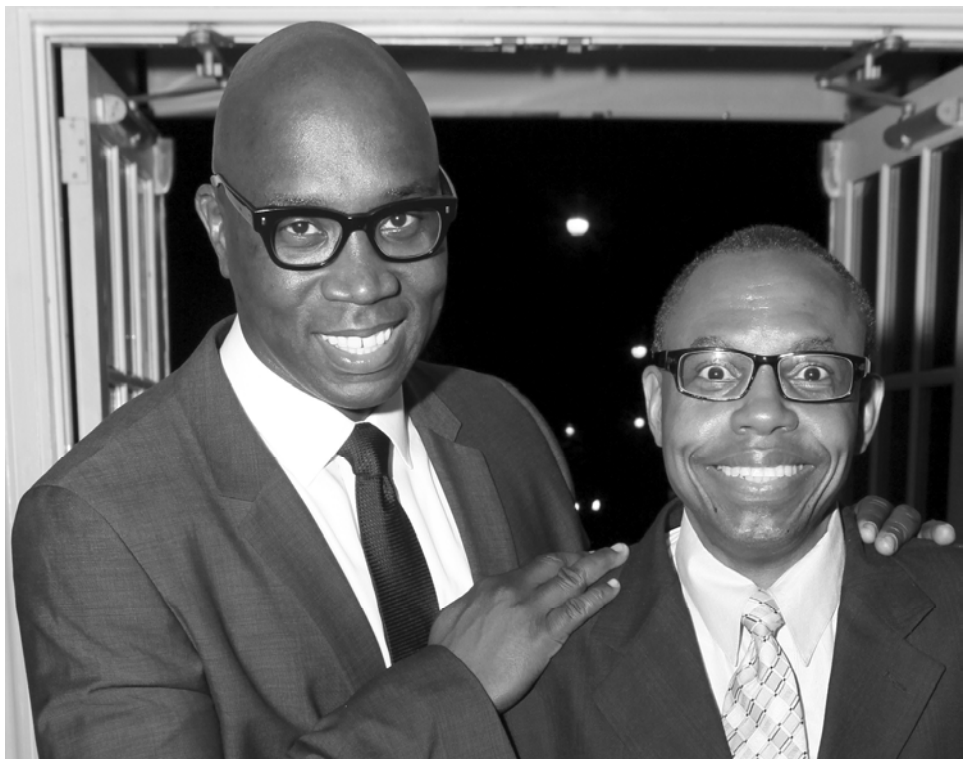
By Charles A. Archer, Esq, MPA, CCEP
CEO, Evelyn Douglin Center for
Serving People In Need, Inc. (EDCSPIN)

Housing for People with illnesses, disorders and disabilities should reflect the community and be like their neighbors. The notion that people who require support, services and programs should live differently misses the point that they will benefit from inclusion, not exception.

At EDCSPIN, our People live in "Houses like Mine"

"Houses like Mine" is a constant reminder that the block, neighborhood, furnishings, community involvement and cultural access of those who need help should not be anything less than we want for ourselves. Of course no two houses are identical and the internal characteristics of houses are as individual as those who reside there. Therefore, when we try to provide residential services we are always mindful that each individual plan of service needs to be person-centered and individualistic. People with illnesses, disorders and disabilities want to participate in the world and enjoy a special place in the community just as the rest of us do. And they should.

Evelyn Douglin Center for Serving People In Need, Inc.'s (EDCSPIN) focus is on providing individuals with developmental disabilities and/or mental retardation the opportunity to learn skills needed to reach their highest level of independence while insuring they experience the same privileges and opportunities enjoyed by all members of our society. Our philosophy is to provide individual services that address their specific needs within their own communities promoting a positive learning experience. Through this person-centered approach, EDCSPIN encourages our program participants to strive to reach their potential within familiar environments. Within "Houses like Mine."



Charles A. Archer, Esq, with a Recipient of EDCSPIN Services

Any person, government entity and/or organization involved in residential care for persons with special needs may wish to consider the following *Statement of Values* we aspire to at EDCSPIN in servicing people with disabilities:

Persons With Disabilities First

We will measure everything we do against a simple standard; is this good for the persons with disabilities we serve? If not, we will not do it. The safety and well-being of those we serve can never be compromised. We always welcome input from families, advocates and providers.

Integrity

We will honor the trust of the families of those we serve and those who pay for our services. We will conduct ourselves ethically and within the law at all times. We will communicate honestly.

Respect

We will act with fairness at all times. We appreciate the need to balance work and family life. We respect individual differences. We welcome open communication and promote inclusiveness.

Opportunity

We value teamwork and the need to have everyone paddling at the same time, in the same direction, toward the same goal. We want our employees to grow so the reach of our good works can also grow. We seek to recognize effort and achievement and to express gratitude for jobs done well.

Accountability

We are accountable for the proper use of funds. We are committed to transparent reporting that is so essential to healthy and trusting relationships.

Togetherness

We value each other and believe no one's role is more important than another's. We are all about serving those in need and we are all in this together, working to enhance the lives of those we serve.

If you grapple with the question of what should "Housing for People with Mental Illness, Substance Use Disorders and Developmental Disabilities" involve, you may want to ask yourself, what would I want in my own house? For most of us, what values are lived out is more important than what amenities there are. Ideally a home is a place where we can count on Love, Trust, Safety and Respect. When you consider that those with disabilities deserve no less, you may soon realize that they really only want a place they are proud to call "Mine."

At EDCSPIN, we believe it is not how you fill the house but how you fill the hearts of those we serve in the house. For us, that takes a daily commitment to our own values.

"More Than a Roof Over Their Heads" Meeting the Housing Needs of Young Adults with Behavioral Health Challenges

By Giselle Stolper
President and CEO
Mental Health Association of NYC

Imagine being 18 years old, or even 25, and having no place to call home. For a young person with few or ruptured ties to family and community, a roof overhead is simply not enough. A growing body of neuroscientific evidence confirms what we have long known intuitively, that brain development and the associated features of reasoning, judgment, regulation of emotion and impulse develop gradually and continue to develop well through the mid-twenties.[1] We also know that trauma and disconnection from supportive networks significantly reduces the chance that a young person will make a successful transition to adulthood.

Putting this knowledge to work, however, requires that we think and act across agencies and across the divide that generally exists between the child and adolescent service system and the adult system of care. For most young people lucky enough to have experienced normal social and emotional development, the nature of the

Giselle Stolper

supports available to them doesn't abruptly change on the day of their 18th or 21st birthday. This is not the case for many adolescents and young adults who are ageing out of foster care, reentering the community after being incarcerated or who have returned home following years of care in a residential treatment facility. These young people face not only the usual challenges and bumps along the path to adulthood, but frequently do so with less social capital, fewer skills in independent living and a whole new cast of social service providers, who may be unaccustomed to providing the degree of guidance and support still needed by young adults.

"More Than A Roof Over Their Heads: A Toolkit for Guiding Transition Age Young Adults to Long-term Housing Success,"[2] authored by Nina Aledort, formerly of the NYC Administration for Children's Services, Jim Bolas of the Empire State Coalition of Youth and Family Services, and Susan Grundberg and Yusyin Hsin of the Mental Health Association of New York City, is an invaluable guide to understanding the ever changing developmental needs of young adults and effective strategies for transitioning young adults between youth and adult systems. The toolkit is a product of the Young Adult Housing Workgroup which was established by the Citywide Oversight Committee of the Coordinated Children's Services Initiative of NYC and importantly brings the brings together the perspectives, concerns and experience of leaders from children and youth services, housing services, adult services and youth advocates.

The Toolkit recognizes the importance of peer-to-peer work in helping young people transition to adult systems, a practice that MHA-NYC has long supported through employment of youth advocates in our programs. As a call to action, "More Than a Roof Over Their Heads" provides us with a starting point to rethink how our provider community can make housing options that are little more than shelter for young adults feel like a home—and how we can foster the long-term social connectedness that is necessary for them to make a successful transition to adulthood. We are grateful to CCSI of NYC and the Young Adult Housing Workgroup for the opportunity to work with leaders across multiple systems to find solutions to issues that none of us alone can solve.

1. "The Adolescent Brain: New Research and Its Implications for Young People Transitioning From Foster Care", The Jim Casey Youth Opportunities Initiative, 2011.

2. To download the report, please visit http://www.ccsinyc.org.

Perspective from page 1

supported housing programs, more and more of the dollars go to the landlords, less and less to services. This issue has become so critical in some areas of the state that some agencies are hesitant to take advantage of new housing opportunities because of concern about sustainable funding.

Special Populations: OMH has recognized the importance of meeting the housing needs of some special populations; many years ago it supported the development of specialized MICA housing (although much more of this type is needed in the system) and, more recently, it is supporting the development of young adult housing. There are at least four other special populations that require some specialized housing: housing for older persons who have serious mental illness and medical conditions that can be managed in the community; housing for persons with mental illness who have been in the criminal justice system; veterans housing; and housing for families that include a member who has a mental illness.

Housing for older persons is a pressing need and will become a more pressing need as the population ages. While there have been some model programs developed that have demonstrated that older persons with serious mental illness and serious medical conditions can live successfully in the community with some enhanced on-site medical services, OMH has not yet formulated an initiative in this area. This kind of housing, offered in a congregate community setting, not only maintains the quality of life of its residents, it also avoids much more expensive nursing home placements.

The *trans-institutionalization* of so many persons with serious mental illness

Peter D. Beitchman, DSW

to the criminal justice system is a well-documented phenomenon. With many thousands of persons with serious mental illness in State and local correctional facilities, the needs of this population are also a pressing matter. Again there have been models developed to address the special needs of this group. A small number of community-based agencies have developed in-reach teams in cooperation with selected correctional facilities to identify and work with offenders who have mental illness while still incarcerated. Upon release, these individuals transition to community-based agency housing that has appropriate support services. This approach has had significant success in promoting positive integration back to the community and drastically reducing recidivism. While OMH has begun to address this need, a recovery-oriented housing model has not yet been fully developed.

The housing needs of veterans have been well-documented in recent months. This population also deserves some special attention. Quality housing, with access to vocational and behavioral health services, are essential for successful reintegration. Similarly, housing for families in which there is a member with mental illness has been woefully neglected. As more and more mental health recipients achieve recovery, family housing will also become a more urgent need.

Housing in the Emerging Integrated Managed Care Environment: Several policy issues emerge in the context of an integrated, managed care behavioral health system. First, it is essential that our housing resources be allowed to be used more flexibly. So many of the beds in the system, particularly those developed since the mid-90s, are designated for specific populations – i.e., the homeless through NY/NY I, II and III; persons who have had long stays in state psychiatric centers. Housing providers, family members and advocates have always recognized that there are other populations that need mental health housing who have little access (those with serious mental illness who have never been homeless or don't meet the criteria of a specific NY/NY-designated program, for example). In addition, the current system is highly regulated with each kind of housing having its own set of detailed regulations and funding restrictions.

If housing providers are going to be able to respond to the needs of an integrated health and behavioral health system, they must have the flexibility to create the kind of admission diversion crisis beds and inpatient step-down beds that are needed to both improve recipient outcomes and to reduce costs. OMH has stimulated thinking of this kind in recent years. What are needed now are the concrete actions to begin to make this vision a reality.

One of the elements of a successful integrated system is the positive role that peers can play in the housing. Peers have a role to play in all levels of housing, especially in inpatient admission diversion crisis housing and in step-down housing after hospitalizations.

The place of housing in the State's *health home initiative* is also important. In many instances, a resident's primary service connection is to the housing staff with whom he/she works. It is often the housing case manager who has the closest, most effective therapeutic relationship with their clients. It is crucial, therefore, that in constructing health homes the State take this reality into account. Severing crucial existing therapeutic alliances by assigning residents to new unknown care coordinators might well undo years of resident stability and progress. On the other hand, building on current residential case management relationships to achieve comprehensive care coordination is an important potential strategy to achieve the goals of health homes.

This raises the general question of how housing will fit into an integrated health and behavioral managed care system. It is clear that mental health housing will be an important element of the service system. Over the next two years, as plans for the emerging system are developed, it will be essential for the mental health housing community "be at the table" to play a major role in the design decisions.

The production of new housing: One of the most ominous signs to have emerged in the past year is OMH's release of an

see Perspective on page 14

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MHA-NYC
Innovations in Mental Health

LifeNet is a program of MHA-NYC (Mental Health Association of New York City), a non-profit leader in behavioral health services. LifeNet is funded through contracts with the New York City Department of Health and Mental Hygiene and the New York State Office of Alcohol and Substance Abuse Services.

Integrating Peer Wellness Services into Housing First

**By Ana Stefancic, MA,
Neil Harbus, LCSW, CPRP,
and Jessie Ulsoy, MPA
Pathways to Housing**

Since 1992, Pathways to Housing has provided individuals who experience homelessness and mental health conditions immediate access to permanent, independent housing and consumer-driven supports. As a Housing First agency, part of Pathways' mission is to end homelessness; however, this is just the beginning. Once housed, consumers have a new sense of hope and possibility, but also face the challenges of maintaining housing and taking next steps. We saw an opportunity to enhance the services provided by Pathways' existing clinical teams by adding a program that utilized the strengths and perspectives of peer providers. This program would be the first large-scale inclusion of a team of peer providers within the Housing First model.

In 2009, Pathways launched the Peer Wellness Program to provide consumers with recovery-oriented wellness services delivered by peer specialists who assist consumers to achieve goals of their own choosing. Funded by a 5-year SAMHSA Services in Supportive Housing grant, the core mission of the program is to deliver wellness services that foster hope and self-determination using a peer-to-peer, strengths-based approach. The Peer Wellness Program uses tools and interventions designed to address in-depth, long-term recovery goals that may not be a focus of clinical support teams who are often focused on responding to immediate needs. Any Pathways consumer is eligible to receive services from the Peer Wellness Program. Now in its third year, the program has served over 190 participants with a team of nine peers.

Peer Wellness Specialists: The Importance of Training

The Peer Wellness Specialists are individuals who have had their own experience with mental health issues, substance use, and/or homelessness and who have demonstrated their resilience. They assist consumers to reconnect with children, take better care of their physical health, enroll in college, find employment, or cope with mental health symptoms. In addition to lived experience, Peer Wellness Specialists have also received extensive training at Howie T. Harp Peer Advocacy and Training Center (HTH). They have completed 6 months of coursework and a 3-month internship to receive Peer Specialist Certification. This training and experience ensures that staff have already learned concepts of wellness, recovery, and engagement, and have been introduced to Evidence-Based Practices, as well as administrative responsibilities. Building on that base, our in-house training can then focus on orienting staff to the Peer Wellness program and covers specific topics such as intentional peer support, wellness tools, stages of change, motivational interviewing, and minimizing burnout. The Peer Wellness Specialists have emerged as a team of highly skilled and effective peer providers.

Program Start-up: How to Integrate with Integrity

The Peer Wellness program was created as an enhancement to Pathways' services. Therefore, a service structure had to be created that would allow for the Peer Wellness Program to be integrated into existing operations while maintaining the integrity and specialized mission of the new program. The overall goal was to expand and enhance the quality of services provided by other Pathways staff, while not replacing or duplicating existing services. The goal was to maximize Peer Wellness Specialists' ability to engage in deeper, long-term recovery-oriented activities (e.g., reuniting with family, improving management of mental health symptoms, and obtaining employment) and to minimize the degree to which they would be involved in more routine aspects of service delivery (e.g., obtaining entitlements, addressing housing repairs, managing medications). This was accomplished in two ways: 1) Peer Wellness Specialists were assigned to work *with*, but not *for*, Pathways' existing service teams and 2) The Pathways Resource Center, which offered groups and classes for consumers, was converted to a center where all recovery services became peer-led by the specialists.

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RFP for new housing that will fund services only. The implication here is that OMH has suspended its capital funding of new beds. For the past 25+ years OMH has provided either direct capital funding for the development of new beds or, in recent years when tax credit financing has been the major source of capital development, it has provided debt service funding that is an essential element of such projects. The OMH pause in supporting capital or debt service funding is of great concern. While the 30,000 beds it has developed so far are an outstanding achievement, there is still substantial unmet need for additional beds.

Hopefully, the recently established MRT Affordable Housing Workgroup will address this critical development issue. Included in its charge are: "to develop a statewide plan for increasing access to affordable housing, so that New York State Medicaid beneficiaries are not forced into institutional settings because they cannot access affordable housing… [including] identifying options for financing construction."

The entire mental health community can take justifiable pride in what has been accomplished in housing over the past three decades. As the process of major reform and restructuring unfolds, housing will remain an essential service. How it will be integrated into the new system, how its future viability will be assured and how the production of new housing will be financed are all major concerns. An active housing community -- of providers, recipients, families and advocates -- is needed to work in partnership with government to address these concerns.

Suffolk Agency from page 8

Renewal, and various grants and loans, Concern has developed 190 Supportive Housing and 30 low-income housing units in Brooklyn. Included in these unit counts are The MacDougal Street Apartments and The Concern Heights Apartments.

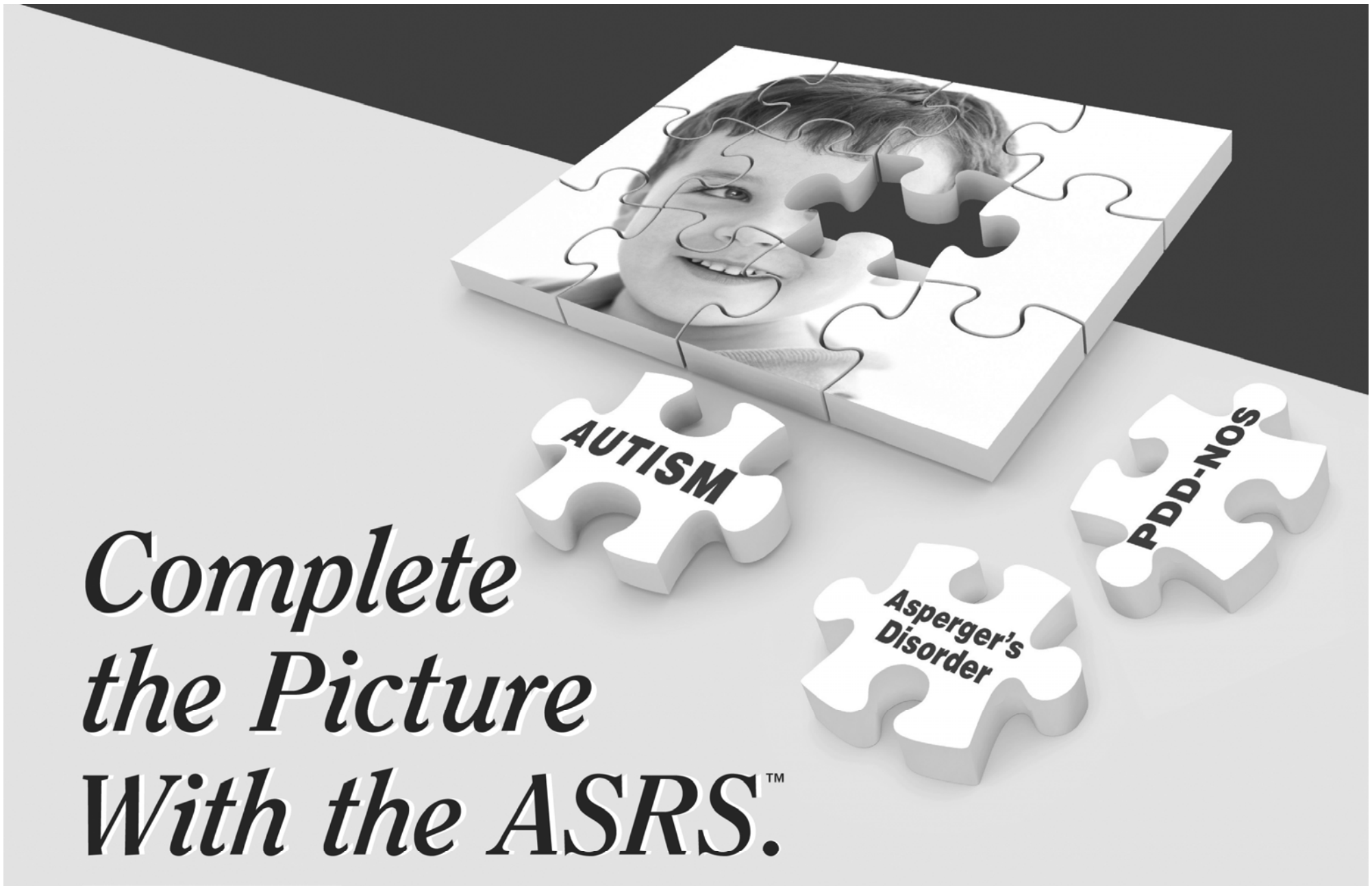
The MacDougal Street Apartments began as a vacant building in Brooklyn. Scheduled to open in October, 2011, this OMH-licensed program will provide housing and supportive services to 65 adults with psychiatric disabilities. Thirty percent of residents will be chronically homeless single adults recovering from mental illness. Sixty percent of residents will be adults residing in OMH-operated psychiatric centers. The development of this program included the demolition of the existing building and the new construction of the MacDougal Street Apartments utilizing modular construction. This project is the first Single-Site Supportive Housing program in New York State to utilize this construction technique.

The Concern Heights Apartments will be Concern's first mixed-use housing program. The construction of this building began on a vacant lot located in the Crown Heights section of Brooklyn in 2009. The project is scheduled for completion in October, 2011. This program will serve 60 individuals with psychiatric disabilities and an additional 30 low-income individuals and families from the community. The Concern Heights Apartments will mark the first time that Concern will provide housing to low-income persons without disabilities.

For over 25 years Concern has developed housing for persons living with mental illnesses. Unfortunately, the development of this type of housing often meets with intense community opposition. All of our Suffolk Single-Site Supportive Housing projects were completed with the support of the local community. Additionally, two of our Brooklyn projects received the strong support of their respective Community Boards. All of these programs transformed blighted structures into beautiful residences. These programs are seamlessly integrated into their neighborhoods and residents of these programs are active members of their communities. With the successful completion of these projects, 310 individuals recovering from mental illness will be able to live with dignity and pride in the community. Over 45 jobs were created and filled mostly by persons from the community.

Capital funding for these projects was provided by New York State Homes and Community Renewal, New York State Office of Mental Health, Fannie Mae, Federal Home Loan Bank of New York, Homeless Housing and Assistance Corporation, The Enterprise Foundation, National Equity Fund, Richman Housing Resources, The Community Preservation Corporation, and Bank of America. Ongoing operational support is provided by New York State Office of Mental Health and Suffolk County Division of Community Mental Hygiene Services. Grants from the van Ameringen Foundation, McCarthy Foundation, Capital One and The Cetrino Foundation have strengthened these programs and our ability to develop and operate high quality housing.

Concern for Independent Living, Inc. is a not-for-profit corporation formed in 1972 by a group of concerned parents and friends of persons in Central Islip State Hospital. Our mission is to provide housing and services for persons challenged with psychiatric or other disabilities and those with very low incomes in a manner that enriches their lives and the communities we serve. Concern currently provides housing and supportive services for over 600 individuals and families in Suffolk County and Brooklyn with over 200 units in development including a project for homeless veterans and their families.



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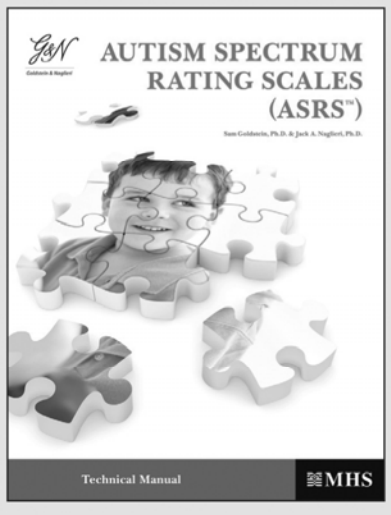

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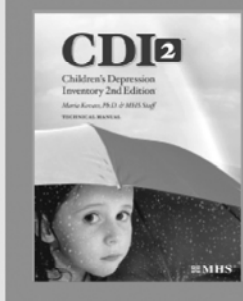

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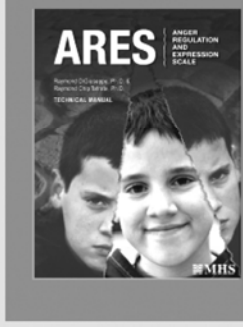

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On the Shoulders of Giants: The Path to Building Supportive Housing

By Steve Coe, Chief Executive Officer Community Access, Inc.

It was the summer of 1979, July 5th to be exact, the first day of my internship at Community Access. My job was to help run a pair of tenement buildings with 44 apartments that provided cheap homes to poor families and single men and women who had been recently discharged from state psychiatric facilities. The buildings had seen better days, but looking at Jacob Riis' photographs of the squalid, cramped conditions almost 100 years earlier, it was difficult to pinpoint precisely when these particular apartments had ever been "nice."

Nevertheless, I was 27 and delighted to be right where I was. I had promised the Board of Directors at Community Access that I would do whatever I could to improve the lot of the tenants and the rundown buildings that they called home. In two months I would start my second year of graduate school, so I knew I had to work fast, not knowing I would have another three decades at my disposal.

Steve Coe

I would also discover, years later, that what I had stumbled upon was a "model program" that would eventually be called supportive housing. I would also learn that there's a long history of visionary efforts to provide humane services and homes for people diagnosed with mental illness. I had no clue I was standing on the shoulders of giants!

One early form of community integration for people with emotional problems appeared in Geel, Belgium. Drawn by the story of St. Dymphna, the patron saint of the mentally ill, thousands of people have made a pilgrimage over the centuries seeking relief from their symptoms. The flow of people seeking a cure became overwhelming and many were eventually taken in by local residents, a tradition that has continued for hundreds of years.

In pre-industrial societies, care for people with mental illness fell to the families and the close-knit communities where they lived—as still happens in many non-Western countries today. There was always a task and a role for someone, no matter what their particular limitations might be. Unfortunately, there were also many misconceptions about the nature of mental illness, which led to bizarre and horrific forms of "treatment" that would be characterized as torture today. Reformers in the late 18th century began advocating for a completely different approach, called "moral treatment" that emphasized compassionate care in asylums, which were widely adopted in the United States through the effective advocacy of Dorothea Dix.

In the 19th century, care by families and the community changed dramatically with the advent of the industrial age and the division of labor. People in the community who needed extra support or attention were suddenly a burden to the family. Asylums, originally envisioned as havens for humane care, became large institutional settings for anyone who was disabled, diseased, or otherwise socially unfit.

In the late 19th century, New York State, in an extraordinary burst of social and political action unimaginable now, undertook to reform the discredited asylum approach by constructing a system of hospitals, mostly in rural communities, that were dubbed "farm colonies" because of their live-and-work treatment programs and emphasis on agriculture."

see The Path on page 29

The Spectrum of Healing: Housing, Recovery, Learning, Working

By Jon Curtis, Communications Specialist, Community Access, Inc.

First and foremost, Community Access is an organization that provides safe, stable housing for individuals with psychiatric disabilities and working families. We've always recognized the fundamental importance of putting roofs over heads, and of giving people the chance—for many, for the first time—to build their lives upon solid foundations.

In our line of work, the twin cornerstones of well-being are good health and a decent home to call your own, and it's no coincidence that these two things are inextricably linked. As we help mental health consumers along the path to recovery, again and again we see how Community Access homes have a transformational effect on our tenants.

Just the same, however, it's been our long experience that housing on its own is no silver bullet. Instead, its positive impact is multiplied by a host of other factors that, taken together, demonstrate the tremendous added value of education and social services—without which Community Access would be unrecognizably different.

Myung Park

Our 21 housing programs around New York City can rightly claim to be the lifeblood of our organization, and yet it is our investment in learning opportunities that bind everything we do together—by fostering a greater sense of community and offering a context for tenants and other people in recovery to tap into their innate abilities and grow alongside one another. In this vein, our education programs are robust and include: the Howie the Harp Peer Advocacy and Training Center (HTH) in Harlem—a job training program, which has garnered national and international recognition as the go-to program for employers seeking to hire trained mental health consumers; East Village Access, a classroom-based health, wellness and recovery program in the Lower East side; a Pet Therapy program that promotes the holistic benefits of pet ownership; and, a flourishing art program, which provides a full series of workshops for artists with mental illness.

We continue to discover the positive impact of these services every day. And nowhere are they more readily apparent than in the countless examples of former tenants and participants who sometimes leave the physical structures of Community Access behind but who retain important friendships, life lessons learned, and the skills to establish meaningful careers.

Take the example of Myung Park, who was living in supportive housing when he first enrolled in our HTH class back in 1998, graduating later that same year. Now a professional peer specialist, counselor and mentor at the Institute for Community Living, Myung says he relies on all the skills he learned at Community Access to help the mental health participants he works with. "We talk about open and honest communication, empathy, how we need to be willing to learn from mistakes, and the importance of setting goals"—all things that Myung had to work hard to learn for himself.

"Survival" is the word Myung would use to characterize much of his life. Shortly after joining high school, he began to experience long spells of depression, caused by a severe bipolar disorder and eventually culminating in

see The Spectrum on page 34

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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:

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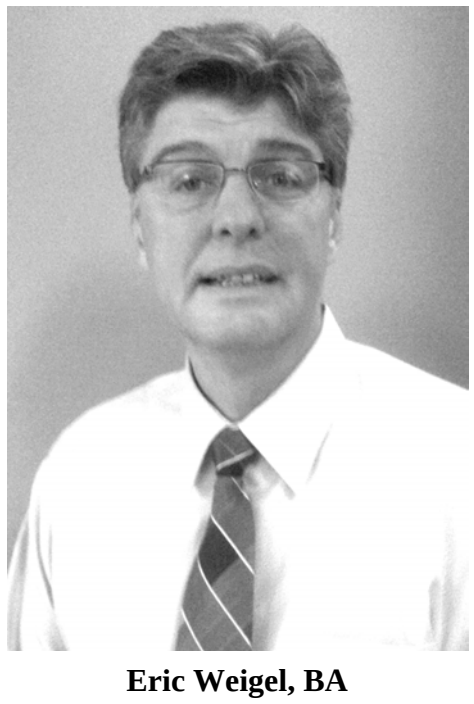
The Use of Harm Reduction in Housing Improves Critical Outcome Indicators in the SMI/CD Population

By Eric Weigel, BA
Director of Housing, Erie County Department of Mental Health

With the current changes in Medicaid reform about to take place, it has become more important than ever to produce measurable results in resource administration. The management of limited high cost Medicaid and or Medicaid support services is imperative as well. With the proposal from the New York State Medicaid Reform Team, the Department of Health will be producing lists of high priority individuals using Medicaid expense patterns. Resource match to need is a method of assuring the right person receives the right service at the right time for the right length of time to achieve the right outcomes. The general goal of the Regional Behavioral Health Organization reflects a decrease in high cost Medicaid services/settings. The bench marks are projected to be associated with a decrease in unnecessary psychiatric hospitalizations/re-hospitalizations, decrease in ER use, decrease in arrests, increase in community based clinical linkages and a increase in consumer's overall heath and well-being.

An important resource that can produce critical outcomes within a community is safe and affordable housing of one's choice. A highly effective method to produce such outcomes with a high end consumer base is harm reduction using the supported housing model. The concept of harm reduction has been a significant contributor in the stabilization of cereal inebriates and rapid recidivist in chemical dependency programs for decades. There are a multitude of clinical studies supporting the results of decrease harm and cost in this population using this approach. Generally speaking, success is measured in any type of improvement weather that is a decrease in substance consumption or just maintaining residential stability in the community. Not being homeless is viewed as a significant event towards recovery goals even if chemical usage and treatment resistance continues. The opportunity for change is viewed as an ongoing process and may occur at any given point in time. Support is unconditional that allows for the individual to emulate positive relationship building that can have a long standing impact on the individual's view of the world and their place in it.



Eric Weigel, BA

Many deep end penetrators into the Medicaid resource pool can be stabilized by using relatively inexpensive supportive housing dollars (Interactive Tool; 1 March 2010. National Alliance to End Homelessness). With the use of the harm reduction model, these housing programs operate under the basic premise that it is important to meet an individual where they are in recovery instead of producing additional obstacles that could elongate the process of obtaining stable housing. Traditional methods in chemical dependency treatment as well as housing management insist the individual with chemical dependency issues provide some period of abstinence (6 months is common) before housing resources will be provided. "There is no empirical support for this practice of requiring individuals to participate in psychiatric treatment or attain sobriety before being housed" (April 2004, No.4, American Journal of Public Health 651-656). Many high end consumers have become disenfranchised by these models which produce limited outcomes while the individual still is engaged in high risk, high cost behaviors. These individuals remain on the streets, in homeless shelters or in places not meant for human habitation such as burned out buildings or under bridges. Combine all these factors with a Severe Mental Illness and the measurable outcome for decreasing high cost services does not seem likely. Attempting to obtain much less maintain sobriety while on the streets is nearly an impossible expectation. The lack of a positive support system combined with the general day to day homeless life style does not support the abstinent model. Many individuals in these situations have untreated medical conditions that are exacerbated by the unstable environments they have been forced to survive in. However, the use of supported housing dollars has shown to produce a significant decrease in the cost of delivering such services

see Harm Reduction on page 30

Residential Support for Individuals with Mental Illness: Its History and Hopes for the Future

By Ashley Brody, CPRP
Residential and Community Services Director, Search for Change, Inc.

The availability of housing for adults living with mental illness in Westchester County, New York, has seldom been scarcer than it is at this time, and for many it is altogether inaccessible. I understand many readers will be surprised by such a bold assertion and some may dismiss it as mere hyperbole. In fact, there are 11 social service agencies in this county (of which mine is one) that operate a broad continuum of supportive and subsidized residential units for individuals with mental health conditions. I imagine the staff of these agencies, their clientele, and the vast array of community stakeholders with which they have developed partnerships may take umbrage at my negation of their efforts. To be sure, residential services are often indispensible to individuals who lack the psychological or financial resources essential to the maintenance of long-term stability and self-sufficiency, and the beneficiaries of these services are undoubtedly fortunate to have accessed them during an era of veritable austerity. Nevertheless, countless residents of Westchester County with chronic mental health conditions languish in shelters or private and state-operated psychiatric facilities.

Ashley Brody, CPRP

Others reside with aging parents or in substandard homes for adults. Many are incarcerated, and some have sought temporary refuge from chronic homelessness in inexpensive rental units or room and board facilities that often operate illegally and lack basic amenities. To these individuals my assertion carries the resonance of a universal truth.

Such a tragic state of affairs is not the inevitable consequence of a global economic recession or a prohibitively expensive real estate market, although both of these factors figure prominently in this seemingly intractable problem. The origin of our housing crisis and its disproportionate impact on some of our most vulnerable citizens may be located in seemingly progressive public policy initiatives that failed to deliver on their promises.

The Kennedy Administration's establishment of the Community Mental Health Centers Act of 1963 marked the inauguration of the "deinstitutionalization" movement through which longtime denizens of state-operated inpatient psychiatric facilities were subsequently discharged en masse to their communities of origin. Such an initiative would have been unthinkable if not for certain developments, not least of which was the arrival of psychotropic medications that offered partial relief to some of the most severely afflicted patients. This movement was laudable in its intention and ambitious in its scope, and it achieved notable successes in the years that followed its implementation. It acquired additional momentum through President Carter's Commission on Mental Health and the subsequent enactment of the Mental Health Systems Act in 1980, initiatives that led to an infusion of federal funds into community-based mental health programs that sought to fulfill the needs of individuals with mental illness in more natural environments. These developments enabled thousands of individuals to emerge from the shadows of institutionalization and to secure housing and continuing treatment in less restrictive settings. Public attitudes towards individuals with mental illness evolved in concert with these changes, and concepts such as "rehabilitation" and "recovery" entered our lexicon as many who were formerly relegated to a lifetime of institutionalization realized newfound opportunities for full reintegration into the fabric of community life.

Despite its initial promise, however, the deinstitutionalization movement foundered during the decades that followed as changes in public policy deprived it of its initial momentum. Through the Regan-era repeal of the Mental Health Systems Act and related developments the federal government abdicated much of its responsibility for the direct financing of services. Responsibility for the financing and provision of care devolved from the federal government to its state and local counterparts during the final decades of the 20th Century. These developments might not have been altogether unfortunate insofar as state and local governments are customarily more equipped than federal bureaucracies to respond to the needs of their constituents. Nevertheless, a confluence of other developments and policy

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Mortality from page 1

The implications of these terrible facts are clear. We need to do more to address the dangers of life on the streets and consequent risks to health and life faced by people with serious mental illness, particularly those with co-occurring substance use disorders. This should include major efforts to prevent exposure to crime and dangerous, infectious diseases.

The single greatest antidote to these dangers is stable housing.

Sadly, housing development for people with serious mental illness has slowed considerably due to the determination of current governments in the United States to reduce the costs of caring for people who rely on our society to survive and hopefully to recover. What a travesty!

Michael Friedman retired as the Director of the Center for Policy, Advocacy, and Education of the Mental Health Association of New York City in 2010. He continues to teach at Columbia University's schools of social work and public health. Mr. Friedman can be reached at mbfriedman@aol.com.

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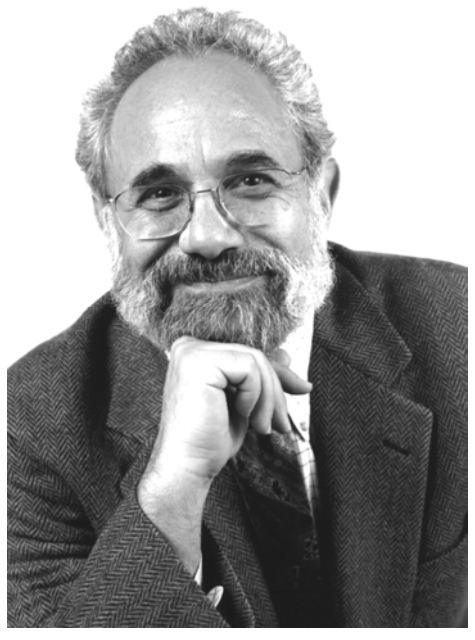

Michael B. Friedman, LMSW

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The Role of Intimacy on the Road to Recovery

By David Kamnitzer, LCSW
and Brian Mundy, LMSW
Institute for Community Living (ICL)

The crucial role of romantic relationships is often overlooked or avoided when working with people who are on the road to recovery. Understanding that factors such as hope, connection and social support significantly minimize isolation and prevent relapse, the Institute for Community Living (ICL) has recently expanded its lens of recovery support to include the role of intimate partnerships and has developed curriculum to address it.

Addressing a Service Gap

The focus on the role of intimate partnerships in the psychiatric rehabilitation process arose from a perceived lack of available services within one of ICL's congregate treatment and support programs to specifically assist residents with cultivating healthy intimate relationships. As a not-for-profit agency that assists annually over 10,000 individuals and families affected by or at risk for mental illness and developmental disabilities with services and support designed to improve their quality of life and participation in community living, ICL actively identifies and addresses barriers that can challenge the ability of consumers to transition into permanent housing within the communities of their choice.

Before developing programming to address the role of intimate partnerships, our team first researched the topic of intimacy and relationships among people with mental illness and found that it has been largely neglected by the scientific and provider communities. While there has been significant examination of the role of social and/or peer support in the recovery process, these studies fail to address intimate relationships as a key factor. The literature also indicates positive correlations between social support and empowerment or self-esteem, but the influence of intimate relationships is by and large left unaddressed.

In order to better investigate the role of intimate relationships within the recovery process, program staff paired together with a specialist from ICL's Program Design, Evaluation and Systems Implementation department and ran five focus groups over the course of two months with program residents. The main goal of the focus groups was to generate dialogue to better understand consumers' experiences and challenges in building and sustaining intimate partnerships, as well as their impressions on the relationship between recovery and intimate partnerships. An average of 18 people attended each group, with each group lasting approximately 60 minutes. A series of 14 questions guided the discussion.

The participating residents largely expressed interest and excitement to have an open forum to communicate their concerns and discuss their feelings and experiences with each other. Many consumers viewed the focus groups as a rare opportunity to discuss a topic traditionally associated with a high degree of stigma and misunderstanding.

Our Findings

Based on a qualitative analysis of notes taken during the groups, the following conclusions were made – each of which underscore the need for more rigorous research:

1. Intimate partnerships can significantly impact the recovery process in both negative and positive ways. For example, one male consumer stated, "[Intimate partnerships] can make you or break you," while another declared, "you may have thought

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THE MENTAL HEALTH LAWYER

The Padavan Law and Group Home Placement

By Carolyn R. Wolf, Eric Broutman, and Douglas K. Stern, Esqs, Abrams, Fensterman, Fensterman, Eisman, Greenberg, Formato & Einiger, LLP

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

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

The Padavan Law

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

Carolyn R. Wolf, Esq

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

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

The Padavan Law in Practice

Since the Padavan Law's inception, some communities have continued to challenge the opening of group homes for the mentally ill. Instead of circumventing the law or outright objecting to its validity, objecting communities have attempted to use the law itself to further their NIMBY goals. There has been a great deal of litigation pitting objecting communities against group home proprietors where the community has invoked the Padavan's Law's over-concentration language. Despite this litigation, no community has ever successfully challenged an OMH determination that a facility would not fundamentally alter the nature and character of an area, and therefore the residence should be allowed to open.

Communities have argued that opening facilities will affect such disparate concerns as overloading the septic system, increasing traffic, eroding of the tax base and fears of residents over what they perceived to be the unsavory nature of the proposed residents. Yet, Courts have concluded that these concerns are not valid and the only consideration is whether or not an over-concentration of facilities will result from the opening of the proposed facility.

Concerns with the Padavan Law

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

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

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

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

— The NYSPA Report —
Families of Suicided Soldiers to Get Letter of Condolence From President

By Michael Blumenfield, MD

During July of this year, President Obama announced that he would begin sending letters of condolence to the families of troops who kill themselves in combat zones. He noted that this was a decision that was made after a difficult and exhaustive review of the former policy and he added, "I did not make it lightly….This issue is emotional, painful and complicated but these Americans served our nation bravely. They didn't die because they were weak."

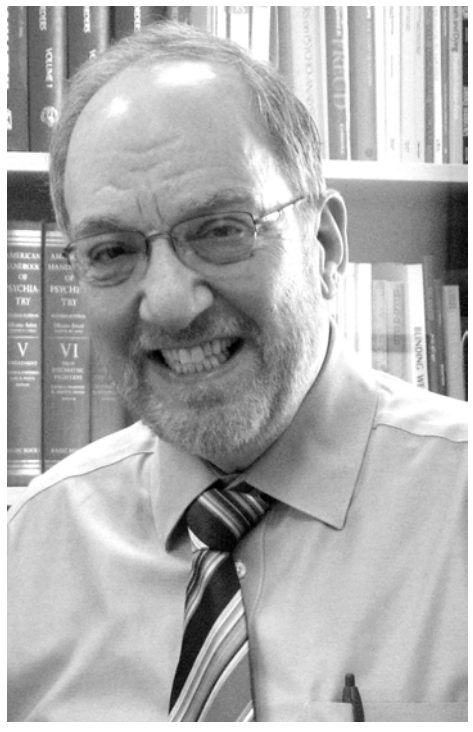
Long Campaign to Change

There has been a long standing campaign to get the President to change the previous policy. It has been led by families which had soldiers die by suicide, various veteran groups, members of Congress and various mental health professionals, myself included, who have been publicly advocating that the President change the policy. I was drawn to this issue because I believe that the policy to exclude these families from receiving the gratitude of the country, expressed by the President, is another example of stigmatization on the basis of mental illness.

The Keesling Family

I first wrote about this issue in my blog (Psychiatry Talk.com in December 2009) after reading a NY Times piece the previous month about the tragic loss which the Keesling family suffered when their 25 year old son Chance killed himself in Iraq in June of that year. He was in his second tour of duty when the stresses of combat combined with an argument with his girl friend over the phone led to hopelessness and suicide. Hours before his self-inflicted fatal gunshot wound the Keesling family received a rambling despondent email message from their son.

His father Gregg commented on my blog and we began a correspondence about this issue. He and his wife had decided to share some of their grief with the public in order to try to bring about a change in the Presidential policy, which was so hurtful to his, and other families who suffered similar losses. They would receive a folded flag, a letter from the Army praising their son, a rifle salute at his burial and financial death benefits. But the letter of condolence from the President of the United States, which is the symbol of the voice of the people of our country, which is sent to every other fallen soldier in war since the presidency of Abraham Lincoln, was conspicuously absent. There was an increasing frequency of articles touching on this subject in the media. I wrote about it again in my blog and in the Huffington Post and received more comments than any other pieces that I have written. The House of Representatives voted in May 2010 to add an amendment sponsored by Representatives Burton and Napolitano to the Defense Authorization (HR 5136) that urged that the



Michael Blumenfield, MD

policy be overturned. The only response from the President was that this policy was being evaluated.

Why There Was Resistance to Change

It was difficult to say exactly why there was resistance to changing this policy. It appeared to come from certain factions within the military who had the misguided idea that such recognition would encourage suicide or would be rewarding those who were "weak" and couldn't deal with stresses compared to those who did. These ideas were antithetical to the fact that there were so many accounts of the comrades of these soldiers who did die from suicide who were quite devastated by these losses and very supportive to the families of their fallen comrades and to their memories. There also was no psychological basis for such theories. I could not help but feel this was another example of the stigmatization of mental illness.

APA Weighs In

As a Past Speaker of the Assembly of the American Psychiatric Association (APA) I believed that it was important that American Psychiatry speak out on this issue. I wrote a resolution with Dr. Roger Peele of Washington D.C. which was also co-authored by several of my colleagues which was approved by the APA Assembly in May of 2010. The Board of Trustees of the American Psychiatric Association then approved it. In July 2010 James H. Scully Jr. M.D., CEO and Medical Director of the American Psychiatric Association wrote to President Obama representing the 37,000 psychiatric physicians. He called upon the President to eliminate the stigma and shame associated with suicide for families and survivors by reversing current policy and forwarding Presidential condolence messages to families of individuals who complete suicide while in military service. In October of 2010 the APA issued a public statement urging President Obama to reverse the policy of barring such letters. A number of other mental health groups including the American Foundation for Suicide Prevention and Mental Health America had officially come out in favor of this policy change. APA President Carol Bernstein, M.D. issued a statement in which she noted, "The contributions of these men and women to their country are not less for having suffered a mental illness. A reversal of this policy to allow condolence letters to family members will not only help to honor the contributions and lives of the service men of women, but will also send a message that discriminating against those with mental illness is not acceptable."

The Long Awaited Change

The number of suicides in the military continued to go up either approaching or in some analyses exceeding the number of combat deaths. The problem of PTSD and the mental health of our combat troops became a high priority of the military but there was still no change in the Presidential policy.

Last month (June 2010) I met with Gregg Keesling for breakfast as he was in Los Angeles for a business meeting. He had received some indication that the President was reconsidering his policy but nothing had come down yet. Senator Barbara Boxer had just sent a letter to the President, which was made public. We reflected in our discussion whether this issue might come to a head sooner if fate had led to a high profile family to lose a military family member to suicide rather than unknown but valiant people such as Gregg and his wife. It was clear that he and others like them in memory of their lost loved ones were not giving up the fight and were continuing to push for a change in the Presidential policy.

The Keeslings were notified in advance of the official announcement that henceforth the families of soldiers who die in a combat zone by suicide will receive a Presidential letter of Condolence. They understood that this would not be retroactive but were nevertheless overjoyed that the battle that they had fought in memory of their son was won. While there is nothing that relieves the pain of the loss of a child, hopefully the significance of this accomplishment will help in a small way.

I certainly am very pleased that the President has seen fit to make this change in his policy. I imagine that it was not an easy thing to do since there apparently was strong resistance in the military.

Still Unfair Discrimination

However, it should also be pointed out that there is still something inherently unfair and discriminatory about the new policy. As I understand it, letters of condolence will only be sent to families of

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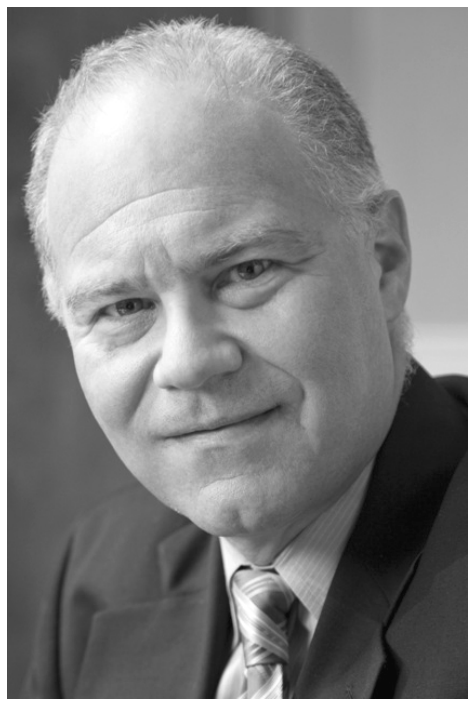
— Social Security Matters —
The Impact of Special Housing on Social Security Disability Claims

By Lewis B. Insler, Esq
Insler & Hermann, LLP



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Gabriel Hermann, Esq

We are thrilled to be writing the first of what we hope will be many articles for *Mental Health News*. I hope that the quality and content of our columns will be up to the high standards I see as I look at the current issue .

Many people who struggle with a mental illness also have difficulty maintaining a job. Under the Federal Social Security Disability programs, individuals suffering from a disability including mental illness may receive benefits provided they can show that they are unable to work for at least one year due to their illness.

The Social Security Administration has two programs for people who fall under this category. Social Security Disability ("SSD" or "DIB") does not look at an individual's outside income or living arrangements, but requires a prior work history. By contrast, Supplemental Security Income ("SSI") requires no work history, but does take into account the individual's outside income and assets, as well as his or her living arrangements.

Mental illness is one of the three most common impairments for which disability is claimed and can be either the sole basis for a Social Security Disability claim or one of a number of impairments that, in combination, can render an individual disabled.

With regard to establishing disability, the Social Security Administration is not concerned about living arrangements under either Social Security Disability ("SSD" or "DIB") or Supplemental Security Income ("SSI"). Housing comes into play only with regard to the amount of benefits payable under SSI once the medical aspect of a disability has been established.

SSI is payable to disabled persons who typically have limited or no work history and therefore who have not paid enough into the system to qualify for SSD. That is often the case with people who have long term mental illnesses. In fact, the inability to hold a job for extended periods is such a common feature of many mental illness claims that it can often be a shorthand reference to the presence and severity of the condition for both the attorneys handling a claim and the adjudicators, though there is no legal basis for that. As in any claim for disability, whether it is SSI or DIB, there must be medical evidence to support the disability in a claim for mental illness. Even a comprehensive Functional Capacity Assessment must be supported by treatment notes.

One must also meet both an asset and an income test in order to be eligible for SSI, no matter how severe the disability may be. SSI benefits are payable at a fixed rate by categories that depend upon one's living arrangements. There are two categories for persons who may be living in housing due to mental health problems. These categories apply to children, as well as adults, although the criteria for establishing disability for children are far different from the adult criteria.

Category C is for persons living in Level 1 Congregate Care Facilities;, Category D is for Level 2 Congregate Care. The definition of these various facilities is found in the Social Security POMS (Program Operations Manual System) at https://secure.ssa.gov/poms.nsf/lnx/0501415026NY. A summary of the requirements for each category is also typically found in the SSI award letter detailing retroactive and future payments that a claimant receives after his or her claim is approved.

In both Category C and D, the monthly payments are made directly to the facility, which then gives a small stipend to the resident. The benefit amounts, including the state supplement for New York, can be found at https://secure.ssa.gov/poms.nsf/lnx/0501415026NY.

Claimants who receive SSD but not SSI do not automatically have their payments made to the facility where they live. However many facilities require that the payments be turned over to them as a requirement of residency. Also, many of those recipients might have their payments made to a representative payee, which can be the facility itself.

I expect that much of this is familiar to the practitioners and administrators who read this publication regularly. But we find in our practice that for the claimants , and in our practice, these categories and rates are secondary to the process of actually claiming and establishing disability and entitlement to either SSD, SSI or both. I expect that most of our future columns will be focused on the hows and whys of actually obtaining the benefits, or maintaining them when claims are reviewed periodically.

Whether on SSD or SSI, persons in these categories and facilities can have some income, though the amount they are allowed to earn and its impact on continued receipt of benefits differs depending on whether the person is receiving SSD or SSI. The specifics of these offsets can itself be the subject of another column or, if you have any specific or more pressing questions about income, feel free to contact me.

At some point during our representation, almost every client asks me what they have to do to help their case. I always respond: "your job is to try to get better." And with the help of the practitioners, staff and administrators, we often see that happening, especially for those in Level 2 facilities.

Providing Supportive Housing Options for Young Adults

By Robin Sklarin, MA, MS
Director, SafeTY.net
Staten Island Mental Health Society

Supported housing for young adults living with mental/emotional challenges, including chemical dependency, is a rare commodity in New York and is almost non-existent on Staten Island. No government funding, no agency contracts, no housing plans or programs for youth over 18 years old who have aged out of foster care (roughly 1,000 kids per year, according to a report by the Center for an Urban Future) to provide a roof over their heads as they transition into adulthood. If they are under 21, they are not eligible for city shelters. They face a waiting list of several years for subsidized low-income Section 8 housing. The one local agency that provides some housing opportunities for persons with mental challenges serves older people.

This vulnerable youth population has been abandoned by the system. They are on the fringes of society, forced to seek a temporary "home" on a friend's or relative's couch, or worse, in a car. When they run out of options, they may live on the street, turn to prostitution, or become victims or perpetrators of crimes.

The Staten Island Mental Health Society's (SIMHS) SafeTY.net (Safe Transition for Youth) program was created to address this and other needs of challenged

Robin Sklarin, MA, MS

youth. The program provides a quartet of transitional services in education, employment, housing, and community living to individuals between 16 and 23 who live with behavioral or mental health challenges, such as PTSD, substance abuse, or emotional disorders.

A collaboration among the SIMHS, District 75 (special education) of the New York City Department of Education, the Coalition of Voluntary Mental Health Agencies, and other business and educational agencies, SIMHS's SafeTY.net is funded by the New York City Department of Health and Mental Hygiene.

The transitional years between 18 and 23 for youth challenged with mental/emotional disorders are crucial because their government support ends. They are most frequently left on their own without housing options, and even the few who can afford apartments are not treated or regarded as well as their typically-functioning peers who don't have to deal with health care, psychiatrists, and medication issues.

The most difficult transitional life challenge faced by SafeTY.net clients is finding housing. We have a network of contacts in the business sector to provide employment experience, our partnerships with various organizations furnish a diversity of services, our doors into the educational system offer GED preparation, remedial and vocational classes, and our 24/7 "life coaches" assist with the vital living skills and routines that a young person must develop. But our efforts to provide housing usually fall into the category of "lucky accidents."

Several case histories will shed more light on the critical housing dilemma faced by so many SafeTY.net clients and other young adults with special emotional needs over the age of 18. Every day we work to find safe and clean housing for these youths.

William* (names have been changed) is one of our few lucky SafeTY.net program participants, for now. He currently resides with an older couple who knew him when he lived on the block with his parents. In order to earn money, William had been doing odd jobs for his neighbors, including shoveling snow, mowing lawns, and running errands. When he turned 18, his parents abandoned him and moved to another state. Fortunately, this senior couple, both of whom suffer with health problems, knew William to be trustworthy and hard-working, so they offered their home—trading room and board in return for his being their helper and handyman. If not for William, they would be in an assisted living facility; if not for them, William would be homeless. In order to boost his chances for future success, William attends college full-time and works at a fast food restaurant.

Other SafeTY.net clients have not been as fortunate.

Debbie is in drug rehab and wants to move into a "sober house" or independent apartment, in order to continue her recovery. If she moves back with her mother, Debbie knows that she will be exposed to her old "friends" who will try to influence her to continue her drug dependent lifestyle.

Louis lived in several foster homes during his childhood. After relatives assumed guardianship for him, they kept all the support money they received from the city, and when Louis aged out of eligibility

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direct support during the transition to a new home or other critical periods in a person's life.[3] Transitional periods are often difficult for people, and CTI offers staff support to ensure that residents adjust and remain in their new home.[4] The connection with staff who know the person, regardless of where they move, has made a difference in keeping people in housing.[5] An example of the effectiveness of CTI is Robert Q.

Robert Q. began his road to recovery when he moved to the F·E·G·S Simon Community Residence (CR) in 1995. Prior to that Robert experienced periods of homelessness. Robert moved into the F·E·G·S Brooklyn Apartment Program in 2002 where he relapsed, was hospitalized multiple times and hit a roadblock in his recovery. With his symptoms reappearing, Robert moved to Simon CR where he would receive 24-hour staff support to help him get back on his feet. Robert was his old self; he socialized, kept appointments, and remained hospital free. He was ready to move back to the Apartment Program. Unfortunately, following his move, he became very depressed and anxious and was having a difficult time adjusting. But this time around staff did something different; they adopted CTI. The staff from Simon CR made multiple visits to Robert as he was struggling and plans were put in place to support Robert's stay in his apartment. The staff from Simon worked collaboratively with the Apartment staff sharing what had worked with Robert in the past. The continued connection with the Simon staff meant a great deal to Robert. Robert said that he never knew how much the staff cared for him. He has remained hospital free for over a year and now is thinking of moving to Supported Housing. He knows he is not alone and confident he is on the right path.

Flexing Residential Beds as Crisis Beds to Avert 911 Calls and Hospitalizations

F·E·G·S had designated Riveredge Community House (RCH) as its in-house crisis residence. When residents of the apartment programs in NYC have a relapse or experience issues where 24 hour staff support and structure would make the difference between calling 911 or losing their apartments, residents are temporarily moved to this residence while retaining their housing. At the in-house crisis residence, people can receive the mental health or substance use services to get them back on the road to recovery. After a short stay, consumers move back to their apartment or to another location that may be better suited to their recovery. In-house crisis beds are also used when hospitals discharge a resident who is in need of additional support before moving back to their own apartment. During a recent 5-month period, 72% of the admissions to the CR were for crisis stabilization. We believe this model can be built upon to provide crisis services for people showing up to emergency rooms, or leaving inpatient care in other environments as regulatory and funding models are revised. An illustration of how crisis stabilization beds keep people in the community is Paul's story.

Paul came to the F·E·G·S Program at the Willow Shelter in the Bronx in 2000. He gained the skills to move to a Community Residence, then an SRO, and into Supported Housing in 2008. His success in staying in housing while working towards more independent living was a major life accomplishment. He continued attending groups at the F·E·G·S outpatient program and had become fully integrated into the community at large. Paul was very articulate and able to advocate for himself in many situations. In December 2010, Paul needed additional support in the area of substance abuse to safely stay in his apartment. Not wanting to be hospitalized, he agreed to move to RCH where he would receive 24 hour staff support. At RCH he began once again to attend substance abuse groups, participate in in-house recreational activities, volunteering and helping his peers. While at RCH, he was able to remain sober and continued to attend support groups in the community. Paul moved back to his apartment in August 2011. He continues to do well and he receives support services from the CTI team at RCH and his supported housing case manager.

Paul has come a long way, utilizing the resources of each housing program toward his recovery goals. His desire to achieve self-sufficiency has contributed to his personal goal of independence. Paul accomplished all of this without the need for hospitalization and with the full range of community support services available to him. He is an example of the recovery process dynamic that include staff partnerships and flexibility in housing to meet his needs.

Conclusion

These are true life stories of where housing enabled someone to stay out of a hospital and remain in the community. Let's advocate for the Medicaid Redesign Team for Affordable Housing to recommend the expansion of supportive housing as a smart, well proven way to help people live decent lives and reduce unnecessary health care costs.

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Housing…Then and Now

By Ellen M. Healion, MA
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Over 20 years ago the Office of Mental Health awarded several agencies a contract to provide Supported Housing. Supported Housing created a housing program that provided permanent housing to individuals with a severe and persistent mental illness who could live independently in the community. That level of independence would be determined when the individual could make and keep appointments, maintain their medication regime, pay their rent, maintain their recovery and maintain their home, etc. The provision of case management was optional and there were no conditions of program attendance attached to the housing.

This housing was a tremendous opportunity to individuals who were living independently in the community in substandard housing. For most, unsanitary, unsafe and undesirable apartments were all they could afford on a fixed income. Due to their budget, many could not afford furniture or appliances in their homes. Supported Housing offered safe, clean, accessible apartments for 30% of an individuals' income. The program also provided furniture and appliance to set up an apartment; furniture that the individual now owned and if they moved out of the program they could take the furniture with them. People applied in droves, were housed and remained in their housing until they required a higher level of care, usually, for physical illness. Today, over 25% of HALI's tenants have been in our housing for over 10 years, 50% over 5 years.

There have been two distinct issues that have resulted in major changes in Supported Housing.

First, the budget to operate the program failed to increase as rents increased annually. This forced the agencies to, among other things, discontinue furniture start-up and recycle the furniture. The tenant was only able to take their mattress with them. Fiscal concerns also moved providers to create two or more bedroom apartments. To plan for that glass ceiling, where the budget will no longer be enough to house the contracted amount of individuals, agencies began to purchase houses, apartment buildings and condos. The purchase of homes limited the geographical choice of potential tenants, but created a fixed housing payment.

The second issue was created with the closing of hospitals and cuts in the amount of psychiatric long term hospital beds. Due to the decrease, more people needed placement in Community Residences, which created waiting lists in step down beds and eventually huge waiting lists for Supported Housing. The problem is that the people applying for Supported Housing beds do not have the skills needed to live independently. Add to that the rising numbers of individuals (over 90%) that also struggle with addictions and relapse often.

The housing department at HALI provides an average of 3-4 visits each month (contracted to provide 1 visit per month) to individuals who are not able to maintain drug and alcohol free living. Even at that intense level of case management, HALI needs to respond to public officials receiving complaints, house mates that are at risk for relapse, damages to the home from active users and the loss of rental income from non payers. HALI prided itself on not having to evict anyone since we began this program over 20 years ago. Sadly that is no longer the case. Now, providers need to determine on a daily basis whether they are landlords of service providers.

To resolve some of these issues, OMH has to commit to be fiscally responsive to the rising costs of housing, especially in high rental geographic areas. Agencies need to work closely with each other, especially housing agencies and case management agencies. Too often, case managers and housing providers become adversaries when it's in the best interest of the tenant to be allies. HALI has seen that the tenant, who has HALI and outside case management that work together, is the most successful in their recovery, their housing and in their life. Isn't that what we ought to be about?

The Path from page 16

Many featured golf courses and spacious private homes for the senior directors. And much like prisons today, the institutions were a source of stable employment for generations of New Yorkers, whose elected representatives protected their survival for decades. By 1910 over 31,000 patients were in these facilities, the largest institutionalized population in the country. By 1955, at the peak of the institutional system, there were over 93,000 patients living in 33 overcrowded facilities in which treatment often included physical restraints, seclusion rooms, and frontal lobotomies.

The enormous cost of maintaining this system, combined with another wave of social reform and the widespread adoption of psychotropic medication, led to the creation of community-based clinics and outpatient services, but little housing, for thousands of discharged patients. In New York City, as in many other communities, former patients crowded into single room occupancy (SRO) hotels and rooming houses. And, with the creation of the Supplemental Security Income (SSI) program in 1972, many people with disabilities were able to manage a semi-independent life.

This fragile arrangement didn't last long, however. Using a law (J-51) created in 1955 to encourage owners to install hot water plumbing, SRO owners were rewarded generous property tax abatements ("…just a lovely gift from the city…") to convert their low rent SROs into market-rate apartments. An estimated 150,000 SRO units disappeared between 1970 and 1990, leading to a surge in homelessness for the thousands of poor and disabled people who relied on this housing resource.

My path to Community Access started in 1978 as a project for the Mayor's Office of SRO Housing. This unit was created in 1973 to develop policies and monitor conditions in the SROs. As part of this mandate, our team of students at the New School was asked to evaluate the various approaches being attempted to either replace the lost SRO units or preserve them and improve the care of the tenants. We were fortunate to meet not only the founders of Community Access, but many of the pioneers of today's supportive housing movement.

However, there were a lot of things I didn't know in the summer of 1979: A young corporate lawyer, about my age, Bob Hayes, was preparing a lawsuit that would radically change public policy and its response to homelessness by establishing a right to shelter. Two researchers, Kim Hopper and Ellen Baxter, were also conducting field work that would lead to their seminal study, "Private Lives/Public Spaces," which documented the prevalence of mental illness among the street homeless. Ellen went on to form the Committee for The Heights Inwood Homeless (now Broadway Housing Communities) and renovated an apartment building on West 178th Street into 55 units of supportive housing for the homeless. Bob, Kim, and Ellen also formed the Coalition for the Homeless in 1981.

Also in the works during the summer of 1979 was the development of the first St. Francis Residence, a 97-unit building developed by two Franciscan Friars, John Felice and John McVean, which opened in 1980. This model retained the basic features of an old SRO and brought services to the residents on an as-needed basis. They developed two more sites, over 300 units, and then stopped, based on the principle that this was as many people as they could know personally at one time.

During the 1980s, many other groups began to reclaim the threatened SROs, perceiving them to be a valuable housing resource in their community. Primarily on Manhattan's Upper West Side, many of these buildings remain in operation today. The early leaders in this group include Goddard-Riverside, Broadway Housing Community, CUCS, Jericho Project, Project FIND, West End Intergenerational Residence, West Side Federation of Senior and Supportive Housing, and Urban Pathways. These groups helped form the SRO Providers Group in 1988, which was renamed the Supportive Housing Network in 1992.

In August 1990, then-Governor Mario Cuomo held a press conference on the sidewalk in front of St. Francis Residence III to announce a new initiative called the New York/New York Agreement to House Homeless Mentally Ill Individuals. This landmark, 6-page document resolved years of debate between New York City and the State over who should take responsibility for mentally ill people on the streets and in the city's shelters.

The NY/NY agreement committed the parties to develop and fund 5,200 units of supportive housing in New York City and was the foundation for two subsequent agreements to add over 10,000 more units. Combined with a new federal affordable housing initiative created in 1986, the Low Income Housing Tax Credit program, there was now a stable source of construction, operating, and support services funding for nonprofit groups to develop new housing. The Corporation for Supportive Housing (CSH) was created in 1991 by Julie Sandorf to help nonprofits package and develop projects using these new sources of funds. CSH now has offices in eleven states and is a leader in financing new housing and disseminating information on innovative practices.

Today there are over 43,000 units of supportive housing across New York State, developed and operated by almost 200 nonprofit organizations. In addition, many nonprofits are now collaborating with for-profit developers as supportive housing has evolved into a mainstream option for any affordable housing development. As an example, Community Access recently helped 47 formerly homeless people sign leases in a 225-unit affordable housing project sponsored by a private developer, Kiumarz Giula.

My experience managing the two tenement buildings between 1979 and 1981 (when they were eventually razed for an urban renewal project) led to future Community Access initiatives, including the development of 17 housing programs—several of which integrate low income families and formerly homeless adults with mental illness—and the active inclusion of program participants and peers in our planning and program operations.

So what began in 1979 as a summer internship, has turned into a career that has allowed me to be a part of a revolution in the way New York, and now many other communities throughout the U.S. and abroad, approach the housing needs, and human rights, of people who in past generations would have lived out their days in institutions or desolate squalor.

Residential from page 20

failures at various levels of government has added to the burden of individuals with mental illness who have sought essential housing and support services outside of institutional settings.

For instance, state expenditures on mental health services in 1997 were 30% lower than in 1955 when adjusted for population growth and inflation (Alakeson, Pande, & Ludwig, 2010). In addition, the application of a managed care model of service delivery for individuals with mental illness has led to stringent limitations on the quality and scope of services available to them (Mechanic, 2007). These developments have frayed the social safety net for some of our most vulnerable citizens, especially when considered in relation to the aforementioned policy changes at the federal level. Regulatory changes in the realm of housing policy have had similarly deleterious effects. For example, housing programs sponsored by the Department of Housing and Urban Development (HUD) are invaluable to many with mental illness, yet these programs have become increasingly scarce for these individuals in the wake of budgetary retrenchments and policy revisions. Since 1992, HUD has permitted many public housing authorities to alter the eligibility criteria for housing developments that were previously available to both elderly and disabled individuals. Under revised guidelines, many of these developments are now reserved for the sole occupancy of elderly individuals and are no longer available to younger applicants with mental illness and other disabilities (Newman & Goldman, 2009). Moreover, as even the most casual observers of housing policy are aware, the availability of the Section 8 Housing Choice Voucher Program has become increasingly scarce to all of its potential recipients, including those with mental illness. This program provides substantial rent subsidies that enable many to secure safe and affordable housing. Insofar as individuals with serious mental illness are frequently unemployed or underemployed, many rely on federal disability benefits that provide little more than a subsistence level of income. By some estimates, an average rent payment (for an individual who receives no subsidy and pays rent at the prevailing market rate) constitutes 96% of a monthly Supplemental Security Income benefit (Newman & Goldman, 2009). It is therefore unsurprising that homelessness among individuals with serious mental illness has increased significantly as dwindling public funding and adverse policy developments have effectively conspired to produce this result. Indeed, some authors have suggested the deinstitutionalization movement is more aptly characterized as one of "trans institutionalization," as former patients of state-operated psychiatric treatment facilities now occupy homeless shelters and correctional facilities at alarming rates (Sheth, 2009). By some estimates, one third of homeless persons suffer from a severe mental illness, and more individuals with mental illness languish in jails and prisons than receive treatment in state-operated hospitals. Perhaps most frighteningly, during the final decade of the 20th Century 400 prisons were erected as 40 mental health facilities closed (Sheth, 2009). The legacy of deinstitutionalization is a sordid one, indeed.

Its failures notwithstanding, the deinstitutionalization movement has fostered the development of a continuum of residential care to meet the diverse needs of its recipients. This fact is most evident in Westchester County where a variety of organizations have emerged to address these needs in partnerships with stakeholders in both the public and private sectors. As indicated previously, 11 separate agencies administer a variety of programs that include supervised community residences, semi-supervised apartment programs, rent-subsidized apartments for single individuals and families, Single Room Occupancy (SRO) facilities, and innumerable other units that embody elements of various residential models. Some are available to any individuals who satisfy general criteria pertaining to their mental health status, whereas others are designed to serve specific subpopulations (e.g., homeless individuals, those with comorbid psychiatric and substance abuse conditions, etc.). Some researchers claim residential programs for individuals with serious mental illness have developed without an evidentiary basis of support, and they suggest additional research is needed to assess their efficacy in achieving desired outcomes (Rog, 2004). Nevertheless, it is unsurprising that these programs should proliferate in the absence of an evidentiary basis or a coherent public housing policy, as the rate of deinstitutionalization in recent decades has necessitated the rapid development of community-based alternatives. To the extent that research on residential programs has progressed its findings have been largely inconclusive (Rog, 2004). Some studies (Lipton, Siegel, Hannigan, Samuels, & Baker, 2000) have suggested that more intensively supervised programs (e.g., group homes or community residences) enhance the stability and community tenure of participants, whereas others have failed to demonstrate differential effects with varying levels of residential support (Newman & Goldman, 2009). Some have found that certain subpopulations, specifically individuals with comorbid psychiatric and substance abuse conditions and those who had recently been discharged from state-operated psychiatric facilities, were less likely to achieve demonstrable progress in stability and community tenure (Hurlburt, Hough, & Wood, 1996). Other studies determined that individuals who receive contemporaneous residential and case management services are more likely to achieve successful outcomes (Newman & Goldman, 2009). Nearly every study surveyed revealed some beneficial effects of affordable and supportive housing on residential outcomes, regardless of the nature and intensity of residential and case management services provided (Newman & Goldman, 2009; Rog, 2004). Perhaps not surprisingly, these studies suggested the availability of such housing is the most significant determinant of success for individuals with mental illness when success is defined as increased stability and community tenure.

In view of these (seemingly obvious) findings, it is incumbent upon policymakers to allocate additional resources to expand the stock of affordable housing. Any initiatives that alleviate our housing shortage would likely have corresponding effects on rates of homelessness, hospitalization, and incarceration among individuals with serious mental illness. Our social safety net, as it currently exists, is in grievous disrepair and has inflicted incalculable suffering on many of our most vulnerable citizens. It has also exacted an enormous financial toll, as the "trans institutionalization" of individuals with mental illness is hardly cost effective when compared to costs associated with the provision of affordable housing and residential support services. Significant policy initiatives currently under consideration include a radical redesign of the New York State Medicaid Program and the establishment of Regional Behavioral Health Organizations and Health Homes for individuals with serious mental illness and other chronic health conditions. All of these initiatives are targeted to enhance the quality of care delivered to these populations while reducing costs associated with institutionalization. These initiatives must include provisions for the expansion of safe and affordable housing with appropriate support services if they are to achieve their ultimate aims and restore the promise of a movement that began nearly 50 years ago.

Harm Reduction from page 18

(Culhane, Dennis, 2002. The NY/NY initiative Housing Policy Debate 13.1 (2002):107-163).

Coordination of care is another significant factor in reducing the utilization patterns of such individuals. The use of the Continuous Case Management Model has shown to be a successful practice in working with individuals in housing with various needs (Drake,et al 1993; Journal of Nervous Mental Disease; 181:606-611). This model is based on the premise that a single case manager will be responsible for the coordination of service and communicating change in the individual's profile. These services include housing issues, medical, clinical, chemical dependency and any other significant service need that is assessed. The primary goal is to engage, make linkages, assure linkages are in place and maintained and then introduce natural support systems in the community that will eventually illuminate the need for continued usage of reimbursed services. Generally, these services are front loaded in nature, meaning the frequency of contact is highest in the engagement phase and decreases as the individual goals are met. Case management in supported housing remains with the individual until alternative permanent housing has been secured in the community. This allows for case management to remain in place much longer than other traditional Medicaid reimbursed Intensive Case Management services. Relationships can be developed further and trust can be fostered. Individuals who may have refused services in the past may now be willing to explore methods that may create long term achievements in reducing harmful behavioral activities. This model allows for an ongoing relationship that can be increased or decreased depending upon changing needs.

In conclusion, the cost savings in supported housing has been well demonstrated across the high cost resource pool. With the anticipated changes in Medicaid reform, these savings become more important in the management of such resources. Harm reduction in housing allows for the availability of housing to become more accessible and therefore more likely to produce critical outcomes and cost savings against Medicaid billable services. Ongoing case management in housing allows for the opportunity to provide important support that can create long term stability in the community. Meeting individuals where they are in recovery produce a nonjudgmental frame work and can support movement in treatment goals. Harm reduction uses abstinence as a long term goal that the individual needs to embrace first before attempting to obtain. One of the most significant outcomes is the improvement in quality of life indicators. Harm reduction in housing can produce both, cost savings while providing safe and affordable housing in the SMI/CD population.

Redesign from page 4

SROs are transitional in nature. People will likely leave the program in two years or less. These programs heavily emphasize recovery and self-sufficiency. After operating residential programs for many years, DePaul has learned that consumers are better prepared to live independently once they graduate from one or both of these two programs.

In conclusion, DePaul believes that single-site treatment apartment programs, service-enriched SROs, and supported housing are cutting-edge housing programs. Our experience demonstrates that they are more therapeutic than community residences and scattered-site, licensed apartments. Community residences still serve a legitimate role in housing for adults with psychiatric disabilities, yet have experienced a decreased demand over time. This may be due to the fact that individuals only rarely spend the amount of time in institutions as prior generations once did. Therefore, congregate living in a close-knit group home, without much privacy, may appear institutional for many of the younger people in the mental health residential system. The proof is waiting lists for apartments, while we have vacancies in community residences!"

Mark H. Fuller is the President of DePaul. DePaul, a progressive, private not-for-profit organization founded in 1958, is committed to providing quality services including assisted living programs for seniors; residential, rehabilitation and treatment services for persons with mental illness in recovery, some of whom have a history of homelessness; addiction prevention and support programs, and residential and support services for persons with developmental disabilities. DePaul is located in Rochester, New York and provides services in eight counties in Western New York and ten counties in North Carolina.

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Wellness from page 14

Peer Wellness Specialists based with Pathways support teams work alongside clinicians, attend team meetings, visit clients in the community, and facilitate groups. However, they act as consultants on the team – a role that signifies they work with the team but are there to provide a specialized service. This buffers them as much as possible from routine tasks assigned to other team members that might dilute a focus on Wellness services. It also allows the peer specialists to operate explicitly under the auspices of the Peer Wellness Program and to maintain a perspective and approach distinct from the team.

At the Center, Peer Wellness Specialists facilitate a wide range of classes and groups (e.g., Wellness Self-Management, Financial Wellness, Nutrition, Journaling, and Spirituality) and conduct individual counseling sessions. The Resource Center gives the Peer Wellness Program a "home base" and provides an environment that is completely separate from the support teams. Many of the Peer Wellness Specialists have also developed specific areas of expertise, or sub-specialties, including employment, education, financial literacy, nutrition/health, and parenting.

The Importance of Flexibility and Consumer Feedback

Fundamentally, it is the Peer Wellness Program's flexibility that truly accounts for its success. Peer specialists deliver services in locations of the consumer's choosing–in the person's apartment, at the Resource Center, or anywhere in the community. Staff can also meet with consumers singly or in groups, as the consumers prefer. While peer specialists have an assigned caseload, they can refer consumers to other Peer Wellness staff for specialty services (e.g., employment, education, financial) and thus also serve consumers as a team. In this manner, staff members are able to deliver services both as a team and as individual providers.

Consumer feedback plays a large role in shaping the program, both formally and informally. Formal evaluation activities document participant needs, goals, and outcomes and feed this information back into the program. For example, social isolation and parenting emerged as two priority areas from the baseline evaluation; in response, the program started a parenting initiative and a host of activities aimed at expanding social connectedness. Consumers also provide feedback informally, requesting new groups or modifications to existing services. For example, the program incorporated an informal "warm line" after consumers began calling Peer Wellness Specialists outside of their regular hours. A consensus emerged among the peer specialists that the ability to reach a caring peer after hours was a need that they could readily identify with, and therefore wanted to provide for.

Wellness Tools and Curricula

The program uses a combination of evidence-based practices and program-specific tools and curricula. The Wellness Self-Management (WSM) workbook, a curriculum consisting of 57 individual lessons that allows consumers to flexibly proceed in addressing a range of wellness topics, is a core component of the program. New and original curricula have also been developed for the program based on the literature, but customized with the input of consumers. This has included manuals such as: spirituality ("Healing from Within") developing meaningful activity ("Leading a More Enjoyable Life"), and men's trauma ("Becoming a Better Man.") These standardized guides help groups remain on-topic, sustain groups through staff turnover and allow for replication across sites.

Monitoring Fidelity: Supervision and Support

Fidelity to core principles is monitored through on-going supervision and support. Since many services are delivered outside the office, it is critical to support peer specialists "in the field." Field supervision targets two areas: 1) how Peer Wellness Specialists are interacting with consumers including engagement and intervention strategies, 2) how they interact with other Pathways staff – is their voice heard in team meetings, are they able to advocate for consumers and appropriate tasks. Office-based group and individual supervision are also conducted and include routine discussion of caseloads, engagement issues, and documentation. However, more unique to the program, is time set aside to discuss how interactions with other clinical staff are going, to clarify responsibilities and mitigate role strain, and to provide support around job expectations. In addition to allowing Peer Wellness Specialists to brainstorm challenges as a team, these meetings also afford an opportunity to celebrate successes to sustain positive energy. Finally, progress notes written by Peer Wellness Specialists are reviewed on a daily basis to provide feedback on practice, suggest edits, and ensure that the peer perspective is maintained.

Challenges and Establishing Buy-in

As any new initiative, the Peer Wellness Program faced skepticism from some staff regarding the value of a new program. Further, even in agencies where there is a history of employing peer specialists, peer staff may encounter negative reactions or pose challenges to existing operations. To counteract these negative responses we have used in-vivo supervision to target the dynamic developing early on between the Peer Wellness Specialists and the clinical teams with which they work. Another effective strategy has been encouraging the peer to identify a staff member on their team who is most supportive of their role and to use that team member to help broker other staff relationships. We also educated team members around the role of the peer wellness specialist, reiterating how those specialized services are different from "business as usual." Finally, since several Pathways consumers were hired as Peer Wellness Specialists, procedures had to be established that would support the individual in their role both as staff and consumer.

Skepticism regarding the peer specialists can also extend to consumers, who

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Intimacy from page 22

you were garbage or nothing and [an intimate relationship] might help you out of that." Consumers stated that positive relationships could result in decreased isolation, increased confidence and increased intrinsic motivation: "No man is an island … it's good to know that someone cares," said one female consumer, while a male consumer shared, "relationships can help develop confidence in yourself." On average, consumers endorsed that developing and sustaining an intimate partnership would almost always increase happiness.

2. Communication, safety, trust, and understanding are key elements to developing and sustaining intimate partnerships. Participants rated trust as the most important factor in successful intimate relationships with emotional support and open communication as the second and third priorities. Incidentally, consumers endorsed "my recovery goals" as the fourth most important domain.

3. Intimate partnerships may be easier to develop with others that have mental illness. Many group participants shared that it is less burdensome to develop and sustain intimate partnerships with others facing mental illnesses. Focus group members cited reduced stigma and the potential for more understanding as key reasons to why relationships with those with mental illness may be easier. As one consumer clarified, "You have to be with someone who is mentally ill, otherwise they don't understand."

4. More sufficient support to address the topic of developing and sustaining intimate partnerships in treatment settings is needed. Many of the participants reported that they had never or rarely experienced direct opportunities to discuss their feelings surrounding intimacy, relationships and sex. Participants expressed interest in continuing to discuss this topic in other discussion forums.

Most consumers reported that they experienced a lack of support in the murky waters between social skills training and sex education, and there was rarely any guidance, information or assistance in developing or sustaining intimate relationships. Based on the responses made during the focus groups, most consumers are eager to discuss their feelings and experiences surrounding relationships and intimate partners but rarely have the distinct chance to do so.

Developing New Curriculum:
Sexuality, Sensuality and Sensibility

The results from these discussions have been used internally to develop curriculum for a small skills development and support group entitled *Sexuality, Sensuality and Sensibility*, which has been held in two separate three-month sessions this past year. Preliminary results indicate increased awareness and appreciation of the relationship between intimacy and recovery, as well as increased willingness to be more open with participant's partners about mental illness. Through *Sexuality, Sensuality and Sensibility*, participants began to receive the support that they need for fostering the kinds of social connections that can greatly aid the recovery process.

Other observations shed light on this historically wide gap in service. Throughout this project, some of the staff's reluctance to broach the issue of intimate relationships among clients became evident. It seems useful to examine this hesitance among clinicians and providers as well as any larger systems issues that may be relevant. As clinicians work to address and understand all aspects of a client's recovery, the clinician can begin to consider and explore experiences, hesitations, frustrations and successes in building and sustaining intimate relationships as they impact the client, thus providing a more comprehensive service. Training for clinicians may also need to be developed in order to assist them in appropriately addressing these topics with their clients. The role of case managers in filling this gap in service is also important to consider given that they often work more closely with clients than any other provider.

An integral part of the field of modern mental health services is to continue to determine additional and enhanced ways to positively impact recovery and aid consumer efforts to attain permanent housing. For persons with severe mental illness, the lack of intimacy and social isolation may often to lead to low self-confidence and despair. Yet far too often, discussions between clients and mental health workers around sex and intimacy only include highlighting the importance of safe sex practices, leaving little room for the myriad related issues in between. There is a clear need for service surrounding the development and sustainment of intimate relationships among people with serious mental illness.

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Independent Living from page 4

illness. Housing for the mentally ill empowers them and gives them hope, resulting in a sense of pride and belonging. These are all factors that promote, foster, and maintain stability. Living independently—and that can mean on one's own or with roommates—makes a person responsible. Although help is certainly available, there are basic expectations of the residents as well. If you are managing cooking breakfast or dinner for yourself and your roommates every day, then you are looking after yourself and boosting your self-confidence. If you can do that, then perhaps you can take control of other goals you wish achieve. Having adequate housing implies some sense of self-reliance. That puts a positive spin on a person's life outlook. If I can do this, then surely, I can do that as well. The road to recovery just got a little smoother.

Housing for these individuals allows them to live "normal lives," where they are not seen as "individuals with mental illness" but rather as people, fellow citizens, people with rights, and responsible individuals in society.

Housing for the mentally ill empowers individuals, giving them hope, a sense of pride, and a feeling of belonging. These are all factors that promote, foster, and maintain stability for adults living with mental illness and working toward recovery.

For more information about housing programs at JBFCS, please contact Theresa Manuel at 718-859-9760 or by email to tmanuel@jbfcs.org.

President from page 25

troops who have killed themselves in a war zone.

I am certain that if a soldier is critically injured by an explosive device but does not die until he or she is back in the United States receiving treatment, his family would not be denied a letter of condolence from the President. Similarly what if a soldier develops a mental disorder related to the stresses which he or she is experiencing in a combat zone and is transferred to the US to be treated but unfortunately succumbs to this condition and commits suicide. Shouldn't this soldier also be considered to be a combat victim and shouldn't his or her family also receive a letter of condolence. Sometimes changes come in small increments and perhaps this important step and the attention to this issue will help the destigmatization of all mental disorders.

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Wellness from page 32

sometimes discount the peer specialist's role by dismissing them as individuals who lack clinical credentials. Time, persistence, creativity, and accomplishments have paved the way for greater acceptance of peers.

Outcomes

Thus far, two areas where consumers have made the greatest gains are social connectedness and functioning in everyday life. However, progress is highly relative and very individualized. For one individual, progress is measured by getting a job; for another, it may be more subtle - dressing professionally, leaving the house regularly, and seeing the identity shift that this process creates. The Peer Wellness Specialists have been particularly successful working with a few subgroups: 1) consumers who are new to Pathways, 2) those have disengaged from their clinical team, 3) those preparing to graduate to less intense services, and 4) those who have identified a recovery goal but needed extra support in moving forward to achieve it. As one Peer Wellness Specialist stated, beyond ending homelessness, "what we do is… allow a person to see the possibilities, the things they can achieve. Through sharing, mentoring, encouraging, and inspiring hope…what we do most of is getting people to re-discover themselves."

Adults from page 27

for such support, threw him out of their home. He has been depending on the kindness of friends, and is currently "couch surfing" with a family of six in a one bedroom/one bathroom apartment. He has no health insurance from his job as a nurse's aide because he works fewer than 40 hours per week, but still earns too much to be eligible for Medicaid.

Abby is a transgendered female whose mother abandoned her when she was 17. After living in shelters on and off, she was able to move into the very small apartment where her biological brother and his family live. In return, they demand many hours of baby-sitting and take any money she earns.

Paul lived on the Island with his emotionally abusive adoptive grandparents from the time he was 5 years old, suffering post traumatic stress disorder as a result. When he turned 18 and the state's kinship foster care support ceased, his grandparents made him leave their home. He was forced to seek out his mother, a drug addict, in the Bronx. For short time he slept on her couch, traveling to the Island six days a week to attend college. After his mother took his Metrocards (supplied by SafeTY.net) he left her and returned to the Island. Although we tried to find him housing, we were not successful, and he currently lives in a Manhattan shelter.

These formidable circumstances are too common among the young adults served by SafeTY.net on Staten Island. Once they reach their 18th birthdays and their state support ends, their adoptive parents all too often want nothing more to do with them. They are abandoned and left to fend for themselves, abandoned not only by their relatives, but by the system. This segment of our youth comes from a broad array of socioeconomic, racial, and ethnic groups, but they experience the poorest outcomes compared to their peers living with all other forms of disabilities.

I do believe there is a solution to these tragic situations. Supported apartments in buildings must be set aside for young adults with mental and emotional challenges, with a social service connection to address their individual needs and levels of care management. With a roof over their heads, these young men and women will be more likely to progress to better outcomes in the future.

Healthcare Savings from page 6

day for a person to stay in a hospital (Kaiser Family Foundation, 2010). A night in jail in New York City costs $167 per individual, and $72 in a homeless shelter (New York City Department of Homeless Services, 2009). Meanwhile, a typical state spends about $80 to $95 per inmate each day in prison (Moore, 2009; Steinhauer, 2009).

In fact, a small percentage of Medicaid recipients drive up costs from high use of services like inpatient and emergency care. In 2008, the top 5% of recipients accounted for more than half of all Medicaid spending, and 1% accounted for a quarter of expenditures (U.S. Department of Health & Human Services, 2008). In The New Yorker's "The Hot Spotters" article that portrayed Dr. Richard Brenner and his pioneering care coordination initiative, it was calculated that 1% of the 100,000 people that made use of Camden, New Jersey's medical facilities accounted for 30% of healthcare costs (Gawande, 2011).

Across the range of available supportive housing options, individuals with chronic medical and behavioral health conditions can live in community settings and receive less costly outpatient care and support services. In the groundbreaking study called "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing," it was calculated that a homeless person with mental illness used on average $40,449 per year in shelter, hospital or criminal justice services before being placed into housing. After being stabilized in permanent supportive housing, expenditures on these services were reduced by $16,282 per person annually (Culhane et al, 2002).

Supportive housing services provided by the community-based mental health and substance use sector include social and other non-health services that enable people to live and work independently, in the community. Individuals can be linked to various social supports, job training, employment services, and be helped with budgeting and finances. Tenants learn or relearn the daily living skills that get lost with institutional placement like cooking, cleaning, laundry and shopping.

Supportive housing units can be scattered (individual apartments in multiple buildings) or congregate (located in one building). Some buildings are mixed use, which could mean that individuals from different types of supportive housing programs live there, or that residents who do not require supportive services live there too. Buildings usually have front-desk security, providing safety to the tenants and the communities in which they live.

Maintaining New York's supportive housing system is crucial to the success of the MRT. Each year, it gets more expensive for housing providers to make ends meet. Rent and building-related expenses rise, while funding remains level. This means that fewer dollars are available each year for support services. With this essential caveat in mind, the development of new supportive housing will also be advantageous in meeting the MRT's objectives to save Medicaid expenditures and improve healthcare outcomes. In this vein, another MRT initiative plans to implement 5 regional behavioral health organizations (BHOs) across New York State. Over the next 2 to 3 years, the BHOs will be responsible for reviewing behavioral health inpatient length of stay and seeking to reduce unnecessary readmissions (State of New York, 2011). As the State realizes savings from decreasing inpatient length of stays and/or avoiding them all together, resources should be reinvested into supportive housing programs. This is also true with savings reached from declining use of emergency, homeless and criminal justice services, as well as other costly systems that people with severe mental illness and substance use are more likely to come into contact with if they do not have stable, affordable housing options available.

Among the BHOs' other goals are to improve the engagement rates of people who are discharged into outpatient treatment, and facilitate cross-system linkages. This is something that supportive housing providers, through case management, are quite familiar with. Case Managers offer help navigating the health and behavioral health systems, keeping doctor appointments and applying for government benefits. Nevertheless, building a more robust community-based system of care will require new investment into support services like housing. BHOs are a transitional phase before all Medicaid recipients become part of a managed care system or special needs plan. The relationship building and non-health supports component of supportive housing will certainly need to be preserved in whatever type of system comes next.

On the federal side, provisions in the Affordable Care Act offer incentives for care coordination, which New York State will be taking advantage of. In the category for behavioral health, this involves the implementation of health homes, which will be funded at a 90% federal match for 2 years. Health homes add to the medical home model, by focusing on improving all levels of coordination between medical and behavioral health care for people with multiple chronic conditions (New York State Department of Health, 2011). Health homes are not a physical space, but a strategy for complex care coordination. Mindfulness of housing support services will be vital as a stabilizing factor in people's lives.

As the healthcare system moves toward increased care coordination and management, we must not forget that supportive housing is already an effective tool for bringing together support services and linkages in the community for vulnerable populations. Case Managers, employed by supportive housing providers develop very strong relationships with tenants; and according to Dr. Jeffrey Brenner in The Hot Spotters, "high utilizer work is about building relationships with people who are in crisis" (Gawande, 2011). Because of community-based supportive housing, many New Yorkers with chronic medical and behavioral health needs receive the supports that they individually require to recover and thrive in the community. Moreover, it is cost efficient.

A Cornerstone from page 6

drop in employment rates can be attributed to the economy. People with mental illness are being affected just as the rest of the country is. When the rates are already so low, however, the slightest loss is disheartening.

An additional 9% of individuals in our supportive housing are in job training or supported employment while 80% remain neither in jobs nor job training. The barriers include stigma, real conflicts with benefits and the need for training on available incentives and programs to help individuals on disability maintain benefits while returning to work. Toward that end, the Department hosted two major forums on economic self-sufficiency for people with serious mental illness in January and June of this year. The forums included national and local speakers who informed the people we serve, providers, advocates and other policymakers about tools to help people achieve self-sufficiency. Presenters discussed Individual Disability Asset Accounts (IDA), earned income tax credits, personal banking and saving, and the Medicaid Buy-In among others. Hundreds of individuals we serve flocked to these forums to learn more. Subsequently, the Department co-hosted with the New York State Office of Mental Health a five day intensive training for mental health providers on a range of benefits issues. More than half of those that attended were supportive housing providers.

We hear from every corner of our community how important housing is. In May of this year at our planning forum, the demand for greater access to affordable housing for individuals recovering from serious mental illnesses was a common chorus. The Bureau of Mental Health within the Department has also recently constituted a Consumer Advisory Board for mental health and held our kick off meeting on October 4th. Over 100 consumers applied to sit on the board and 23 were selected for the inaugural class. In the very first meeting, board members identified housing as one of the biggest priorities.

Reflecting the prioritization of our community, The Department has worked hard to protect housing programs from the barrage of budget cuts over the past several years. Our current portfolio of over $75 million of supportive housing includes both congregate and scatter-site programs serving more than 5,000 people and continues to grow as we work to bring thousands of NYNYIII units on line. Currently, the Department funds more than 70 providers to provide supportive services to help people recover from serious mental illnesses while maintaining a home – an integral part of recovery. While we have come a long way; we still have a long way to go. We will continue to support our community-based partners and to learn from our consumer advisors to improve the quality of care, help people with mental illness realize greater economic self-sufficiency, receive integrated care for their health, mental health and alcohol or drug use needs and to participate more fully in their communities, their families, and to fully realize their dreams. While we continue to fund the building of new supportive housing every day we also recognize that simply building more housing is not enough. There will never be enough to meet the demand. We will have to work with all of our partners to improve access to affordable housing for people with serious mental illness, reducing barriers, removing stigma and promoting recovery in all we do.

The Spectrum from page 16

hospitalization. From early adolescence and into adulthood, he endured verbal and physical abuse from family members and teachers alike—a long spell of years Myung now regards in hindsight as tarnished by feelings of self-loathing and isolation. "I felt like my brain was breaking down piece by piece," he says, "and the sensation was made worse by a Korean culture in which there is often stigma about mental illness that can be very harsh. After my psychiatric inpatient treatment, everyone was so ashamed that they didn't want to have anything to do with me."

"We immigrated to the United States in 1981; my father died that year, and even though my mother and brothers were close by, I still had to cope with my psychiatric disability on my own." Without a support system or family to lean upon, Myung continued to face multiple hospitalizations—the last of which dealt the heaviest blow: "I lost my home. The landlord pushed me out because of my disability and there was nothing I could do. It took me a long time to have the ability to recover."

Connecting with Community Access, and HTH, was a key turning point. "It was the beginning of real healing for me," he reflects, "and suddenly it was like a rainbow had appeared: at every step of the way I started discovering a new color—something new about myself. The program really helped me understand how important it is for us to be united as one in order to not be against each other."

Moreover, for Myung, learning and healing were never just job-related but also a family matter too: "I'm closer to my mother, and even my younger brothers respect me now. Most of my life, they were never understanding of my illness, but now I am able to speak candidly about what was happening in my life—my situation and environment. Howie the Harp helped me to have these types of conversations, and opened a door to the future."

Myung now lives independently in his own home, and continues to be an active member of HTH's alumni group. "Helping to support others ended up being an amazing support for me," he concludes, "and I appreciate everything that Community Access has done for me—for helping add color to my life, and courage."

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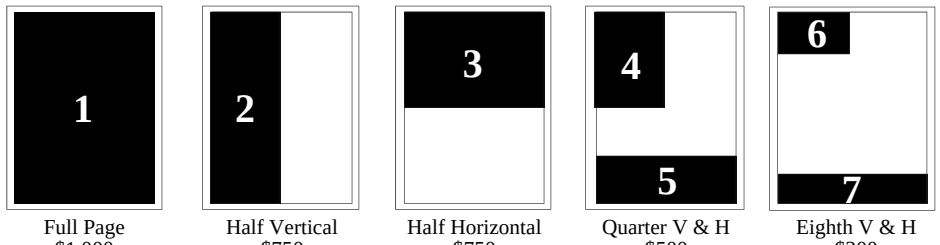

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