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The Vital Role of Housing and Employment in the Recovery Process

Housing and Employment: Cornerstones of Self-Directed Recovery

By Ann Marie T. Sullivan, MD
Acting Commissioner, New York State Office of Mental Health

Ann Marie T. Sullivan, MD

I recently heard from a New York State supported housing consumer who said, "Starting over with no place to live, no money, food or furniture can be terribly overwhelming. It was then that my counselor introduced me to Saint Joseph's Medical Center. I found out their Residential Services department provided housing for people with mental illness. I couldn't believe places like that existed. After my interview they accepted me into their program. I was now overwhelmed with excitement and disbelief in how my life has changed. The program at Residential Services is set up to help men and women like me get a second chance."

In the years since I began my psychiatric practice over thirty years ago, there has been a dramatic evolution in our approach to working with individuals with mental illness. Some of this is due to advances in our understanding of brain function, but even more important has been what the recovery movement has taught us about resiliency, recovery and real community integration for individuals with mental illness. Numerous longitudinal studies and research have shown that individuals with a mental illness are resilient and that they can recover. Mental health treatment now goes far beyond the regularly scheduled interactions between provider and patient. Families, friends, employment, and housing are all part of the therapeutic community that helps people become less dependent on external resources and promotes the development of their own internal resources and coping strategies. This person-centered care marks a paradigm shift in the delivery of behavioral health care and allows for success stories like we see above.

The mental healthcare system of today is a holistic and comprehensive service array that addresses the person, their environment and their future, while using the individual as the primary driver of their own recovery. By offering opportunities for life within the community, through housing programs offering community stability or employment programs enabling self-sufficiency, we create the reality of recovery.

New York State has made great strides in developing housing for individuals living with mental illness, but there is much more to be done. Currently, the New York State Office of Mental Health (OMH) has over 37,900 housing units that can be accessed by individuals with mental illness. Our agency is committed to developing and expanding a housing structure that provides a continuum of opportunities which support people with serious or persistent mental illness. We currently have over 9,000 additional units of affordable, accessible supportive housing in the pipeline, with more on the way. Supportive housing allows consumers to participate as complete members of our communities and society. This vision of recovery includes an understanding that more than health care is necessary—that living independently, securing employment and otherwise making a meaningful contribution to the community can dramatically improve one's well-being. This vision of recovery allows for individuals to become a collaborative participant in care decisions and an active informed participant in their treatment. This vision is dedicated to promoting access, in every community, to competent mental health care that supports recovery. Supported

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Creating Culture Change: NYC Tackles Housing and Employment

By Trish Marsik, Assistant Commissioner, Bureau of Mental Health, Gilbert Nick, Office of Housing Services, and Olga Ivnitsky, Employment Specialist, New York City Department of Health and Mental Hygiene

The New York City Department of Health and Mental Hygiene (DOHMH), together with community partners and providers, is working to increase access to employment and affordable housing for all people with mental illnesses. Local governments, including health departments, are ideally positioned to promote a broad view of what makes a community healthy. Safe, affordable housing and equal access to job opportunities are two of the most important factors in promoting health and wellness. At DOHMH, we seek to foster access to housing and employment as key elements to promoting recovery from a mental illness. Our triple aim is to improve access to care, increase the economic self-sufficiency of all those we serve and to help people live integrated lives in their communities. To achieve these goals we are: (A) Advocating for changes to laws that create barriers to employment and housing; (B) Creating access to affordable housing; (C) Improving employment services for individuals with serious mental illness including access to City-wide vocational supports; and (D) Strengthening the peer workforce of individuals with lived mental health experience.

1) Advocating for change: People living with mental illness want to work. In a survey conducted by DOHMH, more than 70% of people living with mental illness reported that they want to work. Unfortunately, numerous studies over the years have shown a consistent pattern: people with disabilities have high unemployment rates and people with serious mental illnesses have the highest unemployment rate of any group with disabilities, despite the fact that most of these people have both the desire and the capacity to work (SAMHSA/NASMPHD, 2007). For people living with serious mental illnesses, unemployment rates can be as high as 90 percent (National Governors Assoc., Center for Best Practices, 2002).

The road to work should be smooth for individuals with disabilities. However, the existing Social Security system creates inadvertent barriers for beneficiaries who aim to become self-sufficient and financially stable. National research consistently shows that many people with serious mental illness who receive Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits hesitate to participate in paid employment out of fear they will lose critical cash benefits as well as Medicaid/ Medicare health insurance. Although there are ways for people to maintain these benefits, they are not widely known nor understood. Under the existing regulations, Medicaid can be maintained by persons who formerly received SSI once they begin working, provided their annual income is under $46,000/year. DOHMH is working to raise awareness of these benefits by providing training. To date, DOHMH has trained 342 staff representing 230 providers of Assertive Community Treatment, Rehabilitation and Supportive Housing services on Social Security work incentives in order to promote employment. DOHMH is also tracking the employment rates for these programs

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Housing and Employment: Key Components of Behavioral Health Reform

By Arlene González-Sánchez, MS, LMSW
Commissioner, NYS Office of Alcoholism and Substance Abuse Services (OASAS)

Housing is one of the most important recovery supports for many people who struggle with substance use disorder. There is also a very strong link between recovery from substance use disorder and economic self-sufficiency, including employment. These two support services very often go hand in hand. OASAS is committed to the care, recovery and sustained well-being of individuals with substance use disorders.

Housing

OASAS has long valued the need for adequate housing - be it affordable, transitional, or supportive. OASAS has had a long history of providing housing for those suffering from substance use disorder. From the first medically monitored crisis services in 1978 to temporary shelter services to supportive housing, OASAS has long offered a diverse and creative housing portfolio.

OASAS' permanent supportive housing initiative has its roots with the HUD Shelter Plus Care program that began in the early 1990's. By the mid-2000's, other housing programs began to emerge: New York New York III Singles; NY/NY III Families; Re-entry; Upstate Permanent Supportive Housing; and most recently, MRT Housing. Today, OASAS offers more than 1,800 units of permanent supportive housing through six programs supported by a nearly $30 million budget derived from federal and state resources.

OASAS' commitment to permanent supportive housing stands out because of its commitment to families and its programmatic link to each rental unit to include case management and other necessary support services. Tenants after one year in permanent supportive housing have high rates of long-term retention, enrollment in school, and employment.

OASAS Commissioner
Arlene González-Sánchez, MS, LMSW

Most recently as part of Governor Cuomo's Medicaid Redesign Team (MRT) efforts, an Affordable Housing Workgroup was created. The MRT initiative has helped shift the perception of housing from an ancillary service to one where it is accepted as an invaluable part of a long-term strategy to improve health care.

In New York State many systemic changes are occurring simultaneously. Behavioral Health Organizations (BHO's) and Health Homes have taken their place in shaping care for Medicaid recipients, and we will ask the Centers for Medicare & Medicaid Services (CMS) to allow New York State to supplement our efforts through the development of new 1915(i)-like home and community-based services.

Peer recovery coaches and residential supports for those who meet functional need criteria to meet independent living are taking their place in the behavioral health system. Success for all these dynamic changes will not be possible without permanent supportive housing being available.

Additionally, OASAS is embarking on a plan to redesign its residential system. The plan calls for the current Intensive Residential, Community Residential, Supportive Living and Medically Monitored modalities to be redesigned into a residential model comprised of three phases of care: stabilization, rehabilitation, and reintegration.

This new model will be patient-centered and recovery-oriented by matching patients to the phase of care that best meets their needs. It will focus on goal attainment and moving people towards community re-integration. Permanent supportive housing must be available for this redesign to be successful.

Based on the strong foundation established by the above efforts, OASAS is poised to assist the state in meeting the triple-aim for Medicaid Redesign: better care; better health; and, lower costs.

Employment

Along with permanent supportive housing, employment ultimately benefits the recovering individual, his or her family, the employer, and the community at large. Research demonstrates that an important outcome indicator in the substance use disorder recovery process is the individual's ability to successfully obtain, maintain, and/or reintegrate into the workplace.

It is critical to treatment and the recovery process for OASAS treatment programs to integrate comprehensive vocational rehabilitation (VR) counseling and supported employment as evidence-based practices that also support improved treatment outcomes for people recovering from substance use disorders.

In 2013, OASAS oversaw a nearly $10 million budget providing employment support services statewide for individuals in our treatment system. While that is significant, we must continue to work with other agencies whose primary function is to provide employment services.

Since the 1980's, OASAS has had an ongoing collaborative working relationship with the New York State Education Department's Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR) and the state Department of Labor, that work hand in hand with OASAS to assure positive employment outcomes for people in recovery.

In New York City, OASAS works closely with the Association of Vocational Rehabilitation in Alcoholism and Substance Abuse (AVRASA). AVRASA's relationship with OASAS dates back to the 1980's and includes a membership of approximately 250 vocational rehabilitation counselors and employment specialists. Presently, OASAS is working with AVRASA towards expanding their VR counseling support to Long Island and the upstate region.

We at OASAS are committed to our mission of helping all New Yorkers improve their lives and shape a future where all can reach their potential. Supports for permanent supportive housing and employment are two important strategies for achieving this goal.

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Supportive Housing and Job Development Anchors Individual, Family, and Community Health

By John Coppola, Executive Director
New York Association of Alcoholism and Substance Abuse Providers (ASAP)

Access to safe, affordable housing and stable living-wage employment are fundamental to long-term health, wellness, and recovery for individuals, families and communities. New York State efforts, such as the highly successful *New York/New York III* program, have been a cutting-edge example to the nation, as we have successfully demonstrated the connection between housing and employment services and positive health and behavioral health outcomes. *New York/New York III* is a New York State/New York City partnership that has provided supportive housing for individuals and families with a range of special needs since 2006. This effort represents the first time government, services providers, advocates, and consumers joined together, resulting in a pledge to create 9,000 units of permanent supportive housing. Over 7,000 units are now in operation, bringing significant hope to thousands of individuals, their families, and the communities which have benefitted from the new-found stability, recovery, and self-sufficiency of the program's participants.

The success of *New York/New York III* has spawned new housing and employment initiatives serving a broader target population across New York State. New York's Medicaid Re-design Team, for example, has initiated an affordable housing initiative that includes suburban counties on Long Island and in the Lower Hudson Valley as well as the Upstate "Thruway Cities" from Albany to Syracuse, Rochester, and Buffalo. In addition, ten rural counties have been awarded supported housing grants. In 2014-15, New York's Medicaid re-design efforts will include a second round of funding for supportive housing. This new funding will be available for the development of at least fifteen pilot programs involving partnerships between behavioral health services providers, housing services providers, and health homes that serve persons who have both chronic medical conditions and behavioral health challenges.

John Coppola

The New York Association of Alcoholism and Substance Abuse Providers, (ASAP) has over fifty member agencies that operate supportive housing programs. These agencies have significant experience in "bundling" housing, daily living skills, care coordination, job development, post-employment support, and other recovery support services and activities, because they have been able to successfully secure funding targeted toward each of these activities. Approximately 90% of all admissions originating from substance use disorders services providers remain in permanent supportive housing programs for at least one year; with less than a 10% incidence of addiction-related hospitalizations during that time period. More than one-third of participants originating from substance use disorders services providers become employed within that first year, with another 15% enrolling as full-time college students. Over 90% of all families in permanent supportive housing programs remain intact; one-half of families in housing provided by substance use disorders services providers who had children placed in the child welfare system were re-united with their children by the end of their first year.

Permanent supportive housing programs associated with substance use disorders services providers emphasize the realization of their residents' potential and economic self-sufficiency. An employment specialist, using a specially tailored job plan, is frequently used to work closely with residents. Residents might receive job coaching or help enrolling in a college-based skills training certificate program. After a resident secures employment, a range of post-employment support services are offered. Substance use disorders housing and employment programs have a culture that values self-sufficiency and independence through stable employment. As residents "Move On" to full independent living, they "Make Room" for the next person to enter their supportive housing unit. This is achieved when employed residents are able to contribute an amount toward their rent that exceeds the Public Assistance Shelter Allowance of @ $200 per month. When a significant number of residents are able to make such a contribution, the voluntary agency is able to rent several additional units without the need for additional government support.

The current housing portfolio for substance use disorders services providers is approximately 2,000 units statewide, with approximately one-third of the housing for families. Permanent supportive housing provided by substance use disorders treatment programs includes approximately 1,000 units of HUD Shelter Plus Care programs for single adults and families (400 of these units are in Upstate communities); 600 units of New York/New York III Housing (400 for Single Adults and 200 units for Families); 75 units of permanent supportive housing in seven upstate counties; and 300 units of Medicaid redesign supportive housing for single adults (100 units in NYC; 55 units on Long Island and in the lower Hudson Valley; and 145 units in upstate New York).

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Behavioral Health Services Critical to Success of Managed Care in NYS

By John Coppola, Executive Director
New York Association of Alcoholism and Substance Abuse Providers (ASAP)

As New York State implements healthcare reform, Medicaid re-design, and the integration of primary care and behavioral healthcare, substance use and mental health disorder prevention, treatment, and recovery services will have to play an important role if the hoped for transformation is to be successful. At the first meeting of the Medicaid Re-design Team, discussion focused on the need to reduce unnecessary Medicaid expenses, improve patient health outcomes, and strengthen cross-systems collaboration. It was noted that *New York State leads the nation in unnecessary hospitalizations* and that unnecessary hospitalizations have accounted for a significant amount of the State's unnecessary health care expenditures. Healthcare and Medicaid experts on the Medicaid Redesign Team pointed to the fact that 80% of the people who were unnecessarily hospitalized were persons with *untreated substance use and mental health disorders*. To address these untreated behavioral health issues at the same time that unnecessary hospitalizations will be addressed, New York decided to *manage all Medicaid behavioral health services*. This significant transformation, a shift from fee-for-service to managed care, is supposed to become operational in January 2015.

The economic impact of the failure to treat substance use and mental health disorders has been a major driving force in New York State's Medicaid redesign efforts. Not only are untreated behavioral health issues at the center of unnecessary hospitalizations, they are also highly concentrated in the population of folks who have the highest levels of overall healthcare expenditures. Access to and utilization of treatment for substance use and mental health disorders drives down unnecessary use of expensive healthcare services and is a critical ingredient for the achievement of NYS' healthcare service outcome and expenditure goals. Managed Care has been identified as the vehicle to improve health and behavioral health outcomes and to decrease unnecessary healthcare expenses.

The Medicaid Redesign Team created a Behavioral Health Workgroup to ensure that New York gets better behavioral health and primary care outcomes. A Children's Behavioral Health Workgroup was also formed. These groups have been working with staff from the NYS Department of Health, Office of Alcoholism and Substance Abuse Services, and Office of Mental Health and have been helping to shape the framework that will be used when services become fully "managed" in January 2015. Advocates for community-based behavioral health services providers have been working with the Health Plans and Managed Care Organizations to try to create common understanding and commitment to quality care and quality outcomes using diverse services models.

A comprehensive continuum of substance use and mental health disorder prevention, treatment and recovery support services must be included in the behavioral health services package offered by Plans that manage Medicaid behavioral health benefits. Like other chronic conditions, there are varying degrees of severity for substance use and mental health disorders and a continuum of care is necessary to ensure that people can receive the appropriate level and type of care, including evidence-based acute care, behavioral health services, access to medication, care coordination, and recovery support services. Research shows that prevention and early interventions reduce the incidence of mental health and substance use disorders and other costly co-occurring chronic illnesses such as diabetes, hypertension, heart disease and certain cancers. These services must be included in the behavioral health services package. The important role of peer services is also increasingly being recognized and will be an important part of the continuum of managed services.

National and state healthcare reform presents us with a tremendous opportunity to improve public health outcomes, reduce costs, and ensure coverage and access to necessary care for all New Yorkers. With full implementation of the Affordable Care Act in the state, New Yorkers with limited or no access to behavioral health services in the past will now have coverage for these services. As we transition from fee-for-service to managed care we must all work together to ensure that a comprehensive continuum of behavioral health services is accessible in communities across the State and that those services are diverse, culturally competent, and available on demand.

New York Association Alcoholism & Substance Abuse Providers

NYASAP

ABOUT ASAP

New York Association of Alcoholism and Substance Abuse Providers, (ASAP) represents the interests of the largest substance use disorders and problem gambling services system in the United States. Through advocacy at the state and federal levels, ASAP champions the urgent message that substance use and problem gambling are public health issues that with adequate resources can be effectively addressed.

ASAP offers professional development, program development, technical assistance, and community education to strengthen and increase access to prevention, treatment and recovery support services.

ASAP serves as a catalyst for cross systems collaboration with public health, mental health, criminal justice, juvenile justice, child welfare, and social services, policy makers and service providers. We represent the field on numerous policy development and implementation work groups with a regional, statewide and national focus.

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Housing for Older Adults with Psychiatric Disabilities: A Continuing Critical Need

By Michael B. Friedman, LMSW
Behavioral Health Policy Advocate

For adults with psychiatric disabilities of all ages, stable housing is a critical need—perhaps, in fact, their most critical need. Sadly, appropriate housing is not adequately available at any age. For older adults with long-term psychiatric disabilities, finding decent, affordable, and stable housing is an even greater challenge than it is for younger adults. Why?

- Because they are less likely to be able to live at home with their parents, who are increasingly likely over time to become disabled themselves and, ultimately, to die
- Because there are very few housing programs designed for older adults with psychiatric disabilities
- Because older adults with psychiatric disabilities are increasingly likely to have co-occurring physical disorders and/or dementia.

Recognizing these complications, in 2008 the Geriatric Mental Health Alliance of New York published a report entitled

Michael B. Friedman, LMSW

Housing In The Mental Health System For Aging People With Serious Psychiatric Disabilities.[1] The report was based on work done by a consensus workgroup chaired by Antonia Lasicki of The Association for Community Living with representatives from The NYS Offices of Mental Health and of Aging, The Supportive Housing Network, the Alzheimer's community, and mental health housing providers. The workgroup suggested three overall goals:

- Help older adults with psychiatric disabilities to live where they choose—generally in the community—and to avoid institutionalization in adult homes, nursing homes, psychiatric hospitals, and correctional facilities.
- Increase life expectancy of older adults with psychiatric disabilities, who generally die considerably younger than the general population
- Promote recovery and improved quality of life.

In order to achieve these goals the Consensus Workgroup's primary recommendations were:

- Develop *additional community housing* for older adults with serious mental disorders
- Develop *additional home-based mental health services*
- Help families currently caring for family members with psychiatric disabilities with *future care planning*
- Modify housing programs in the mental health system to:
  - ✓ provide additional permanent housing,
  - ✓ improve accessibility and safety,
  - ✓ enhance wellness programs and health care on-site,
  - ✓ increase supports for those with limited activities of daily living skills (ADLs), and
  - ✓ deal with issues regarding death and dying.

Because it did not have adequate information about the numbers of older adults with psychiatric disorders living in adult homes, nursing homes, and supportive housing, the Consensus Workgroup *recommended data gathering regarding where older adults with psychiatric disabilities live and the nature and quality of care they receive*.

Recommendations regarding housing outside the mental health system could be developed on the basis of these data.

What has happened since these recommendations were made in 2008? There is a bit of good news:

- Some additional community-based housing will be made available to help

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The Keys to My Recovery: Stable Supportive Housing and Meaningful Employment

By Carmine Bassano
Community Access Tenant

Depression is something I've not only experienced but witnessed all my life. It runs in my family. There's a lot of abuse in my history, and, looking back, I can see clearly how and why I gravitated towards substance abuse, as an attempt to self-medicate. For as long as I can recall, I have faced psychiatric issues – not only with myself, but with my family.

The Roots of My Depression

My grandparents couldn't speak English. They were from outside of Naples – Salerno – and came through Ellis Island. They were tough people and my parents were as well. Not my mother, particularly, but my father. He was raised in the streets of Hell's Kitchen: an old time New Yorker who would just as soon fight you as he would look at you.

I was born across the river in Hackensack, New Jersey. I grew up there and in Brooklyn. I just have one brother and sister, but many cousins, and because my parents were so social, I was raised in a very busy home. There was never any privacy.

The neighborhoods I grew up in were like small towns, and the world I was accustomed to was always segmented and clannish. Everyone meant well, but there was a lot of ignorance too – my family only ever spent time with other Italians. Instinctively, I couldn't understand the exclusivity of that, but I was also too young to question it more strongly.

My father was a lithographer; he worked in offset printing when that was still a specialized occupation. I don't doubt for a minute that he cared, that he loved us, but he was very tough. He expected a lot from you and used a lot of fear as leverage. Both negative and positive, I got a lot of attention from my parents. They'd make you a wreck, and half the time I didn't know what to think. They were overly strict, but equally my childhood was often tremendous fun, too. A real contradiction; I was ultimately spoiled and abused, that's the best way I could phrase it.

Nobody set out to specifically hurt me or anything like that. It's just the way things worked out. I loved him dearly but my father was a difficult and domineering presence. His name was Albert.

He never drank much at all, yet he had the very distinct behavior of an alcoholic or a drug user. The pattern was there even

Carmine Bassano

without the substance: the self-centeredness, always feeling sorry for himself, barely being able to hold a job because he had a temper problem (frankly, he was constantly beating people up – even, one time, at the age of 80).

Self-Medicating

There have been many times in my life when I could barely function. I was very unhappy for years – depression so bad I could barely get out of bed. I didn't want to do anything. It still comes back sometimes and I don't think you are ever really "cured." It's like everything takes forever. You have to force yourself to do everything, and you feel listless and old. It's terrible. You're alternately nervous and feeling almost drugged. It's a strange combination of things, and completely understandable when you're in the throes of something like that why someone would attempt to self-medicate.

It's very easy to be tempted, especially when you're younger. With alcohol or pills or whatever's available. You're just very unhappy. There's a vacancy, a core, that's much too easily colonized by substances.

My drug of choice was pills, but you start combining things with alcohol. Everybody does. Anything that I could get my hands on. It gave me more enthusiasm for things and made me feel more comfortable – instead of constantly feeling uncomfortable and never feeling like you fit in. In my experience, almost everyone in recovery says that. You want to know the best definition of an alcoholic or an addict? Okay: an egomaniac with an inferiority complex. There are so many contradictions and paradoxes.

Employment and Recovery

Work was my salvation. It was the only thing in my life that seemed to go right back then. I went through a lot of money – wasted it – but I always managed to work. For several years, in fact, I worked in rehab, among a lot of psychiatrists and therapists. It was a good place to hide: you don't have a minute to wind your watch, and you don't have to focus on yourself at all.

Throughout most of the unhappy phases of my life, I was surrounded by people and almost always working. As the example of my time working in rehab shows, however, employment alone wasn't sufficient to safeguard my recovery. I had major depression and for too long it went untreated.

Nor was my housing situation stable yet. I was staying with friends, babysitting apartments, and sleeping on couches. I was also in the shelter system for a while and bounced around a lot of drop-in centers. With all due respect, I don't necessarily recommend that. (I know the city tries and I don't think we should take lightly what they offer: they put roofs over our heads and thank goodness shelters are available).

I tolerated being in shelters because I kept busy all the time – I know by now that I'm better off being occupied and having structure in my life. I went to therapy and meetings every day, and that's what saved my neck. For me personally, Alcoholics Anonymous worked a lot better than Narcotics Anonymous, even though pills were a bigger issue. I just found a greater comfort level with A.A. But regardless of the initials, it's really the 12-step program that made the difference. I went to the shelter simply to sleep.

Soon after, I was staying with a friend temporarily, a pilot. I was heading for an A.A. meeting, in the West Village, when 9/11 happened. My friend was flying at the time and they tucked him up in Canada.

We were walking around in a daze. Everybody was stunned. That's my major impression – a surreal, dreamlike quality. I'll never forget that in the subway station there were little kids playing with cap-guns, and people were just not in the mood to hear that. Everybody's nerves were stretched. We really needed each other and our meetings. With the whole city having to recover, *everybody* clung to each other. It brought a lot of people closer together.

Stable Housing

I moved into my home at Community Access just a few weeks later, in early 2002. I'm still very grateful because, let's face it, I was homeless. I checked in with two garbage bags, full of my possessions, and was still really shaky. Still pretty messed up, and pretty much in a fog. In recovery, I was barely a year sober and clean. Support from Community Access staff, together with the fact I continued attending daily A.A. meetings, is what kept me anchored. I learned that recovery takes time, and that you have to be patient with yourself and with others.

New York City may be crazy but it's also the most generous city if you're willing to work. When I first became a Community Access tenant, I had a service coordinator that was very forthright about making sure I got back to work, even though, at the time, I was on disability for major depression. Within six months I was working. It really brought a lot of my life back to me and, in fact, work turned out to be my primary expression, my salvation. Twelve years later, I'm still in the same job. I'm the assistant to the president of a small, family-owned jewelry company. I do a little bit of everything, but for the most part a lot of computer graphics for the company's website.

Depression is manageable. But it's tough, especially in the morning. Medication helps. It just takes the edge off, helps you deal with, as they say in the program, life on life's terms. I find that a tiny amount of caffeine helps too (since 2006, I've gotten by without smoking). I'm wary of overanalyzing my situation. Analysis is necessary, but in my experience I think it can sometimes be excessive.

What I do know for sure is that I've been sober 12 years, and have more peace – at the age of 57 – than I ever had before in my life. For all but the first few months of those 12 years, I've enjoyed continuous stability at home and at work. That's certainly no coincidence.

Community Access assists people with psychiatric disabilities in making the transition from shelters and institutions to independent living – providing safe, affordable housing and support services, and advocating for the rights of people to live without fear or stigma. Find out more and get involved at www.communityaccess.org/facebook. And visit www.communityaccess.org/ca-voices to read other tenant stories.

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in order to assess the impact over time with the expectation that employment rates of individuals served by these programs will increase.

Preserving Medicaid eligibility through job gains and losses is another important part of promoting employment. For example, SSI recipients who lose their job can lose Medicaid insurance because they are receiving unemployment or workers' compensation benefits. Additionally, individuals and families frequently face challenges in navigating complex benefits issues. We need to make the benefits rules and systems easier to understand and more transparent. To address the problem of unemployment among people receiving SSI, public education is needed about the ways that they can work, maintain the benefits they need and achieve goals of financial independence. At the same time, we need to advocate for parallel efforts to simplify and improve the benefits system, which remains complex and provides support at levels set decades ago.

The National Association of Benefits and Work Incentives Specialists (NABWIS), National Council of Independent Living Centers, Cornell University Employment and Disability Institute, Virginia Commonwealth University Rehabilitation Research and Training Center, as well as other advocacy groups nationwide have proposed changes to SSI related work incentives regulations that will further help individuals manage their illnesses, go back to work and maintain their benefits. Their proposal allows SSI beneficiaries to keep a higher monthly cash

see NYC on page 39

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Community Access now runs New York City's first peer-operated support line. Open daily from **4 p.m. to midnight**, this support line is a contact point for New Yorkers experiencing emotional distress, offering an opportunity to connect with individuals who have had similar experiences.

Bringing Housing to Scale: A Study on the Housing Needs of Bronx Frequent Users

By Jane Jones, PhD, ACLS Public Fellow/Program Analyst, BronxWorks and Pascale Leone, MPP, Senior Program Manager, CSH

Jane Jones, PhD, ACLS

Pascale Leone, MPP

Despite national declines in homelessness, New York has continued to see a rise in its homeless levels. Lack of stable housing for homeless individuals often results in the frequent use of costly health care services and is a major driver of medical expenses. These are costs that can be avoided. A recent article published in the New England Journal of Medicine cites the lack of investments in social determinants of health, such as housing, contributes to exorbitant spending in medical care. The article makes the case that the costs of investing in innovative health interventions, like supportive housing, are largely offset by the savings generated from reduced health care utilization (Shah, Nirav R., Kelly M. Doran, and Elizabeth J. Misa. "Housing as Health Care: New York's Boundary-Crossing Experiment." New England Journal of Medicine (2013): 2374-77. Print).

Supportive housing combines affordable housing with support services to help people who face the most complex challenges to live with stability, autonomy and dignity. Supportive housing is targeted to individuals and families who are homeless, at risk of being homeless or institutionalized, and experience multiple barriers to independent housing. These individuals tend to cycle through institutional and emergency systems with little to no improved outcomes. Without housing, these vulnerable individuals cannot access and make effective use of vital treatment and supportive services.

New York State (NYS) is responding to the staggering costs of serving frequent users with complex needs through its Medicaid Redesign Team (MRT) Initiative. The MRT was designed to address escalating costs and quality issues in the State's Medicaid program through the development of a comprehensive, multi-year action plan. MRT placed a premium on investing in supportive housing as a critical component to achieving the "Triple Aim" of better health, quality care, and lower costs for traditionally underserved populations. In order to improve health outcomes and contain costs, state and local policies must ensure that an individual's housing needs are also met. New York has also implemented Medicaid Health Homes - community-based provider networks that coordinate and manage the provision of medical, behavioral and social services, including housing, for this high-need, frequent user population. The MRT established the Supportive Housing Initiative to fund new supportive housing through capital investments, rental subsidies and service supports. One of the most pressing issues facing the Initiative is bringing supportive housing to scale for this high cost/ need population. The need for housing units, particularly in New York City, far exceeds the supply and even with crucial investments in capital by the State, there still remains a critical gap.

In this article, we describe the obstacles Health Homes in the Bronx face working with homeless and unstably

see Housing Needs on page 45

HUD's Role in Supporting the Goals of *Olmstead*

By Angela Aloia, Senior Management Analyst, and Adam Glantz, Public Affairs Officer, Region II, U.S. Department of Housing and Urban Development (HUD)

In a landmark ruling on June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that the unjustified segregation of persons with disabilities violated Title II of the Americans with Disabilities Act (ADA), which requires public entities to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. The Court held that public entities, such as states, cities, and counties, must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability-related services from the entity.[1] In its 1991 rulemaking implementing Title II of the ADA, the U.S. Department of Justice (DOJ) defined "the most integrated setting appropriate to the needs of qualified individuals with disabilities" as "a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."[2] The DOJ has also provided additional guidance, characterizing integrated settings as those which "are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing; [and] afford individuals choice in their daily life activities."[3]

The *Olmstead* ruling has helped public entities recognize that individuals with disabilities should have *choice* and *self-determination* in housing, as well as in the health care and support services they receive. It is important to note that *Olmstead* covers not only individuals with disabilities who are transitioning out of institutions, but also those who are *at serious risk of entering* institutions. Quite simply, the Court's decision recognized that segregating individuals with disabilities in institutional settings deprived them of the opportunity to participate in their communities, interact with individuals who do not have disabilities, and make their own day-to-day choices. *Olmstead* supports the right of individuals with disabilities to live, work, and receive services in the most integrated setting possible.

The sweeping nature of the *Olmstead* ruling has resulted in public entities, primarily states, rethinking health care delivery systems that rely on housing individuals with disabilities in institutional, segregated settings, such as hospitals, nursing homes and adult care facilities. Many states are looking to home and community-based services to play a larger role in supporting individuals with disabilities, when appropriate. Many states have begun to assist individuals with disabilities to transition out of institutions and other segregated settings into more integrated settings appropriate to the needs of each individual. Some states are undertaking these efforts as a result of DOJ or private litigation, while others are taking proactive steps to support the integration mandate.

The DOJ, in some cases, has had to go to court to enforce Title II of the ADA. However, it is not uncommon for states to reach a settlement agreement with DOJ, as is the case in New York. Under the New York ADA settlement agreement, the State will provide individuals with serious mental illness residing in certain adult homes the opportunity to live in the most integrated setting appropriate to their needs. More specifically, the agreement will transform the State's mental health system to ensure that individuals with serious mental illness who reside in 23 large, privately owned adult homes in New York City are provided with the opportunity to receive community-based services and housing that will enable them to live, work, and participate more fully in everyday life. The state will create at least 2,000 units of community-based, scattered-site supportive housing to all eligible people who are unnecessarily segregated in these adult homes and who wish to live in supportive housing. Residents will have access to flexible services to support them as needed and desired. The State will also create additional units as needed to ensure that all eligible residents who want to move to supportive housing have the opportunity to do so.

While the states may be confronted with a lack of affordable, integrated housing options, there are some resources at their disposal. Title II calls for state Medicaid programs to provide the revenue stream that funds community-based services that support individuals with disabilities while transitioning to and living in integrated settings. Additionally, state Housing Finance Agencies (HFAs) can utilize the Low Income Housing Tax Credit program and other programs to create affordable housing for individuals with disabilities.

The states' primary partner in creating affordable housing is the U.S. Department of Housing and Urban Development (HUD). HUD is committed to providing individuals with disabilities a meaningful choice in housing and the delivery of long-term health care and support services. HUD enforces the Fair Housing Act and is committed to providing individuals with disabilities a meaningful choice in housing and the delivery of long-term health care and support services. HUD's housing and community development programs play a significant role because

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FEGS Housing and Employment Services: Self-Sufficiency and Dignity for All

By Gerardo Ramos, Martin Sussman, Ellen Stoller, and Jerold Scott
FEGS

Housing and Employment are two pillars of an independent, fulfilling life and both are necessary elements of recovery for people experiencing mental illness. Having a place to call home that is also a supportive and nurturing living environment is essential for coping with life's challenges, managing health conditions and achieving personal goals. Paid employment helps promote recovery by fostering individual pride, self-esteem, and financial independence. FEGS is dedicated to assisting individuals with mental illness in their recovery by providing a comprehensive array of housing, employment, clinical and other services. With as many as 90% of individuals with a serious mental illness unemployed, we must look for new solutions. Addressing the employment needs of people with a mental illness requires more than just presenting people with job postings – it also requires addressing the whole person.

FEGS Health & Human Services (FEGS) was founded in 1934 during the depths of the Great Depression to fight employment discrimination and find jobs for thousands of unemployed men and women. To help meet the complex needs of jobseekers with mental illness and support them in their recovery, FEGS behavioral health programs are working with FEGS Workforce, Education & Youth Services. Last year, Workforce Education and Youth helped more than 9,570 New Yorkers find work by using an employment model that is business and sector focused, locally informed and client-centric. Together we will leverage significant relationships with thousands of employers to develop jobs in high-growth sectors and in-demand occupations, while simultaneously implementing best practices to meet the needs of individuals at every level of job readiness. The following provides an overview of FEGS employment programs serving individuals with mental illness.

FEGS Employment Services For Individuals with Mental Illness

"Bill," a 55-year old, had a long history of mental illness and repeat hospitalizations, since the age of 19. In 2010, he enrolled in FEGS Health & Human Services (FEGS) Bronx Personalized Recovery Oriented Services (PROS) Program, a comprehensive recovery oriented program for adults with serious mental illness, and also began receiving housing services through FEGS Apartment Treatment Program. He identified his goals as finding employment and securing more independent housing. He began participating in PROS groups to help him address his barriers to employment and identify positive coping skills. To help him achieve his goals, Bill attended PROS groups that addressed benefits counseling, symptom management, and the importance of medication adherence.

In March 2013, Bill indicated that he felt ready to begin actively pursuing employment opportunities. His PROS Clinical Supervisor helped Bill transition into the more intensive PROS groups, including "Career Planning" and "Winning that Job." Four months later, with support from FEGS staff, Bill was successfully hired as a Porter at Unitex, a large healthcare laundry company in Mount Vernon, New York. Bill now works 3 to 4 days each week and, as a result of his employment, has experienced significant improvements in both his self-confidence and socialization skills.

Last year, nearly 1,400 clients like Bill enrolled in FEGS Personalized Recovery Oriented Services (PROS) programs in Brooklyn, the Bronx, and Long Island. FEGS PROS programs integrate evidence-based practices, clinical treatment, recovery and rehabilitation in a single, person-centered environment. Participants' goals include obtaining employment, attaining higher levels of education, and securing more independent housing. The FEGS PROS Possibilities Programs help individuals gain and restore the skills and supports necessary to live independently in the community. Employment is a major component of this effort.

An important element of the PROS program model is Individual Placement and Support (IPS), an evidence-based practice designed to help participants attain their individualized employment goals. IPS practices are based on establishing relationships and collaborating with community-based businesses in order to create opportunities for individuals to attain integrated, competitive employment. IPS practices are provided throughout the various phases of the person's employment journey: seeking, obtaining and sustaining competitive, integrated employment. As a distinctive feature of IPS, FEGS ensures that participants can access benefits counseling, as this is a key element to attaining economic self-sufficiency.

FEGS Housing Services And Employment

Residential and Housing Services created a team of dedicated employment specialists who work closely with Workforce, Education & Youth Services to follow up on job orders, attend bi-weekly meetings focused on job opportunities in high-growth industries, and stay abreast of new developments and job orders available for clients. Hiring events have included employers such as Home Depot, CVS, Ricks Beauty Supplies, Victoria Secrets, and Luna Park Amusements to name a few. If an individual meets the requirements for a job opportunity, RHS staff assist them in creating a resume which is then forwarded to an account manager in FEGS Workforce, Education & Youth Services for screening and a possible interview with the employer.

If a client is invited for an interview, staff work very closely with prospective applicants to help them prepare. They advise and assist individuals on proper attire, the importance of timeliness and how to conduct themselves during the interview. FEGS staff utilize their expertise and direct knowledge of the specific job opportunity to provide customized coaching to help applicants succeed in their interview.

"Frank" is another client success story. Frank was in foster care for many years and faced many financial challenges and difficulty maintaining stable housing. Frank moved to the FEGS Duryea Young Adult CR/SRO in 2011. When FEGS identified an employment opportunity to work as a cabin cleaner at JFK Airport, Frank was thrilled, referring to this as his "dream job." Frank went through the rigorous screening process which included multiple interviews and background checks. After obtaining all his clearances, he was hired at a competitive rate and is working full-time. With assistance from the Duryea Young Adult staff, Frank was able to move into a supported apartment in 2014 and sees this as a stepping stone for his long-term goals of financial and personal independence.

Internship Skills Training Program

FEGS Residential & Housing Services launched a new initiative, the Internship Skills Training Program (ISTP). The goals are simple but their impact can be profound: to give individuals with mental illness access to the same employment opportunities that have been available to the general public. The Internship Skills Training Program initiative seeks to develop clients' skills to assist them become more employable. This program was created to engage clients around their interests and knowledge in areas including peer support, maintenance, cooking and transportation guidance. Notably, ISTP was launched at the request of many of the clients, inspired by success stories from their peers who had successfully obtained employment, which helped them maintain their stability, housing and acceptance of their families.

In the first phase of the ISTP initiative, FEGS staff conducted a series of community meetings to survey clients' levels of interest in working, and the response was very positive. Many clients shared stories of their past employment experiences and discussed how work made a different in their life and recovery. The participants expressed a very high level of interest in developing skills to make them more employable.

Based on this overwhelmingly positive response, the Internship Skills Training Program was established. The program's focus is to educate clients about the road to employment by teaching skills specific to a particular job or task, as well as assisting clients in learning behaviors that will help them be successful and independent. The clients who participate in the ISTP program have established themselves in the recovery journey and are currently working on an employment goal. Participants must also have a recent physical, be actively involved in their recovery and be able to communicate with peers, staff and others. Each participant is provided with an orientation that included Safety procedures, Work Assignments, Timesheet submissions and ISTP rules.

Eligible clients are enrolled in the six-month paid internship program, and work together with staff in formulating a time management plan to ensure that their health, mental health and substance use needs continue to be addressed while they participate in the ISTP program. Staff assist clients with completing the ISTP application, writing a resume and learning basic computer skills. Clients perform duties such as peer support, kitchen helper, maintenance technician, transportation escorts and gardening assistant. They receive an orientation prior to beginning working in the areas of safety, assignments and time cards. In addition to the hands-on training they receive, residents also participate in groups focused on topics including "How to Dress for an Interview," "How to Conduct Yourself in an Interview," and "Frequently Asked Interview Questions." ISTP participants work up to 10 hours a week and receive a stipend

After successful completion of the program, clients are referred to Supportive Employment, matched to their areas of interest or experience. Recent placements include Peer Facilitator, Culinary Assistant, Maintenance Assistant, Recreational Planner, Mass Transportation Guide and Clerical Aide

Felicia is a success story from the Internship Skills Training Program. After

see Dignity on page 42

From A Home To A Career

By Laura Fissinger, Peer Counselor
New York City Health and Hospitals Corporation (HHC)

Rock-solid bottom line: I could never keep a job without mental health supportive housing. I can't even imagine maintaining a viable employment search from a friend's couch, a city shelter, or a preferred bench at Penn Station.

It almost came down to shelters or train stations ten years ago. Tough-to-treat Clinical Depression and Generalized Anxiety Disorder with Panic Attacks were worsening under the pressure of no job and nowhere to live, the latter due to lack of funds. I'd been trying to starve myself without realizing it, in terrified response.

My longtime psychiatrist had privileges at a state hospital, and was able to make key phone calls to get me in. After a lifetime of mental illness, the sound of the unit door locking behind me was pure relief.

From the first week, and throughout my five and a half months there, the unit ran Discharge Planning groups. Everyone had to attend. I hated them. I had no idea how to plan for discharge. I didn't even know that supportive housing existed. I'd never heard of SSDI. Food stamps were for people without education or a long work record in freelance journalism, I thought. I had platters of humble pie to eat and a whole lot to learn.

I ate that pie daily, and learned. By the time discharge was imminent, the valiant social work staff had me going out on housing agency interviews as often as possible. I was hard to place, given the disordered eating, but they did it. I moved from the hospital to supervised supportive housing, scared but grateful beyond measure.

I realized that freelance journalism would have to wait a very long time, until I found a part-time job and fought for SSDI. I could imagine climbing those mountains now, however. I had a small room with a bed and closet, plus a kitchenette and bathroom shared with one roommate. The flimsy walls were painted a beautiful shade of pale blue.

Next came two remarkable housing agency career counselors, plus monthly sessions with my psychiatrist, weekly talk therapy appointments, and three years holding a housing agency-supported stipend job in their library. Gone were the days of determining my own schedule and duties as a freelance writer. Now was the time to learn how to do what the boss says, at the times s/he says. Now was the time to change my whimsical artsy resume to one meeting real-world requirements.

That small blue room became my terra firma, my chance to build a next life. I was able to sleep in precious quiet that few shelter dwellers find. I had a small but private closet holding the job interview clothing given by friends and Dressed for Success. Where can job interview clothes be kept neat and ready in a shelter, or at Penn Station?

I'd heard many shivery stories of supportive housing residents with roommates who stole clothing, made noise all night, and much worse. My first roommate and I endured for three weeks and through three threats of physical harm from her. With the second, considerate roommate, I knew how fortunate I was. This was the time to learn how to look for conventional employment, how to find a chance at getting a chance.

The moment to start a more serious search for competitive employment eventually arrived -- at the start of the recession. In spite of the economy, two retail jobs garnered me invaluable experience. By then I'd graduated to an apartment of my own, which held me together during the aftermath of two layoffs.

In the summer of 2011, one of my longtime career counselors asked me what I knew about Howie the Harp's Peer Specialist Training Program. The little I'd surmised from an acquaintance had left me ambivalent.

The information session at Howie the Harp blew that ambivalence into kingdom come. Peer counseling was the new career I'd been looking for.

The training did its job via material and behavioral mandates. We had to treat the 27 hours of classroom work per week as competitive employment. The rewards of those six months became very apparent long before they were over. The classroom material was the obvious gift; less apparent were significant inner changes.

As is common at Howie the Harp, about half the students left before the time for internship came. I could not have done such hard training work, or kept up the demanding pace, without supportive housing. Where would I have put the small mountains of hand-outs and test papers in a shelter? How could I have rested both body and mind, how could I have worked on symptom management, necessary with chronic anxiety disorders and depression? On countless nights, I regrouped through the privilege of watching television in private, picking something funny that would bring the wellness medicine of laughing out loud. Exercise and prayer dispensed their power to heal several times per evening. A home made all of it possible.

After a game-changing three month internship at Harlem Hospital, my Howie the Harp career counselor submitted my resume to the New York City Health and Hospitals Corporation, at its Central Office. Their Office of Behavioral Health was hiring peer specialists to co-facilitate groups in psychiatric units, plus outpatient clinics, at many of their hospitals, on a part-time basis. Those brought on to the team would be handing out a booklet called "Guide to Keeping Healthy After the Hospital," plus fostering client discussions of its many wellness topics. The co-facilitators' own stories of illness, hospitals and wellness journeys would play a potent part in the encouraging of group members. The fact that the HHC peers were consumers themselves would often give needed hope.

I liked the interviewing supervisor instantly. The interview itself felt right. I

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Innovative Housing Initiatives Support Recovery-Based Care

By Stella V. Pappas, LCSW-R, ACSW
Optum

The Substance Abuse and Mental Health Services Administration (SAMHSA) identified a safe and stable home environment as one of the key dimensions that support a life of recovery from a mental health or substance use condition.[1] That's why Optum strives to promote healthy living environments as part of their person-centered and recovery -based approach to improve the well-being and resiliency of those they serve. Frequently, Optum partners with local communities to develop supportive housing programs that offer safe and affordable living environments which are free of stigma and discrimination. The programs also provide available resources that promote resiliency and improve community tenure, including Peer Support Services.

Optum works to identify and develop key community-based resources in each market that we serve. One size does not fit all, and partnerships are essential to develop needed services in each community to support housing and social supports. One such example is the Permanent Options for Recovery-Centered Housing (PORCH) program. The PORCH program is a partnership between the Washington State Division of Behavioral Health and Recovery (DBHR), Optum Pierce County and Chelan-Douglas Regional Support Networks (RSNs), Washington State Department of Commerce, and local mental health and housing providers. PORCH's goal is to encourage independent living among adults with a history of mental illness and housing instability or homelessness. PORCH is funded through a five-year Mental Health Transformation Grant from SAMHSA.

Optum has partnered with the PORCH Team at Greater Lakes Mental Healthcare, a community mental health agency, in Pierce County, Washington. The program includes a Team Leader — a mental health professional who provides program administration, grant administration, clinical supervision, education and outreach — and four Certified Peer Counselors.

Optum's experience in developing systems of care has demonstrated that Certified Peer Counselors are effective advocates for supporting recovery-based practices and can help foster resiliency for those they serve. The Certified Peer Counselors associated with the PORCH project are typically individuals who have lived experiences with mental health and wellness challenges, received peer support and recovery training, and are well-grounded in their own recovery. Additionally, they model competency in ongoing coping and resiliency skills for program participants.

Examples of the actions taken by Certified Peer Counselors in the PORCH project are outreach, providing peer counseling, conducting independent living skills training, and assisting with crisis intervention and stabilization when needed. The Certified Peer Counselors are able to use their personal lived experience and training to successfully engage and support PORCH participants. This includes helping them to identify person-centered health and wellness goals that promote recovery and identify services and activities to help them reach their goals. They are able to assist participants in developing their personal skills in order to achieve successful independent living. This is achieved as they are able to obtain and maintain stable housing which supports their ability to pursue vocational and educational goals. Additionally, the Peer Counselors help participants develop effective natural supports, and assist them in obtaining and maintaining use of appropriate mental health, medical and other community resources based upon self-identified needs.

Since May, 2011 the PORCH program has served 162 individual participants in two sites in Pierce and Chelan-Douglas counties. At any time there are 50 participants at each of these sites. Optum's preliminary data indicates that two thirds of enrollees completed one or more years of services. For those PORCH participants who were enrolled for at least 12 months, more than half demonstrated improved recovery scale scores, and housing stability and satisfaction scores improved substantially. The overall average length of enrollment in the PORCH program was 20 months.

One element of the PORCH program which was designed to foster engagement is the PhotoVoice project. The mission of PhotoVoice is to build skills within disadvantaged and marginalized communities using innovative participatory photography and digital storytelling methods to promote and achieve recovery. PORCH participants have the opportunity to represent themselves through photos and create tools for advocacy and communications to achieve positive engagement. Individuals were given cameras to record sites or items that had an impact on their recovery journey and provide a qualitative view of the impact of the services provided through the PORCH program. Individuals were then interviewed to articulate the significance of their pictures.

As an example of what the program could represent, we have included a sample illustration below showing the journey. One of the PORCH participants in this program selected a photo of the hospital where she had resided for many months. As a starting point for her PhotoVoice, this image was a powerful expression of how an imposing building structure represented the challenges she faced at the beginning of her recovery journey. A second picture selected by this individual

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Treatment and Housing: A Seamless Service Model for High Need Populations

By Janice Slaughter, MSW, CASAC, Director of Mental Health and Housing Services, and Peter Provet, PhD, President and CEO, Odyssey House

A report published by Columbia University Mailman School of Public Health in 2013 found that: "Supportive housing has been demonstrated to end homelessness for persons with complex needs and to reduce overall public systems' involvement and costs." These "complex needs" include an array of problems familiar to us and other providers of substance use disorder treatment and mental health services. At Odyssey House, we manage the urgent care of individuals who frequently cycle in and out of jails and homeless shelters, hospital emergency rooms and inpatient psychiatric hospitals, residential substance abuse and mental health treatment facilities.

This 'cycling' comes at enormous cost to the individuals who suffer from untreated mental health and substance use disorders, the families who struggle to find their loved ones appropriate care, and the taxpayer who largely foots the bill for expensive crisis intervention services.

For close to 50 years Odyssey House has been a strong provider and advocate for community-based services that work to stabilize and treat people with chronic substance abuse and mental health disorders. We are known for providing intensive and extensive, cost-effective, evidence-based care for a diverse range of populations that includes: mothers with young children; adolescents; senior citizens; incarcerated adults; the homeless; people living with HIV/AIDS; and those with chronic mental illness. These populations require specialized services tailored to specific behavioral needs that, if left untreated, not only limit a person's chances of living a healthy, independent life, they end up costing more in emergency shelter, criminal justice involvement, and healthcare services.

Janice Slaughter, MSW, CASAC

Peter Provet, PhD

Extending Our Treatment Mission

Helping people faced with the challenges of mental illness and/or substance use disorders is our mission. Our mission also extends to providing services for these individuals and families in their own homes. Odyssey House housing specialists and case managers offer tenants access to vocational, peer recovery, substance abuse, medical and mental health treatment in a range of permanent and transitional living situations.

In 1994, we opened our first congregate care, intensive residential treatment program for people who are living with mental illness and/or in recovery from substance abuse. This 60-bed program in East Harlem, the Odyssey House Harbor, currently provides essential transitional services for severely mentally ill homeless adults referred from city and state psychiatric hospitals who, with support, can live independent lives in the community. Since then, our housing portfolio has grown to include a wide range of housing options for more than 456 single adults and family members who have either completed residential substance abuse treatment, are homeless and living with HIV/AIDS and other chronic medical conditions, or are homeless and working to manage their mental illness and/or substance disorders.

With the support of our government partners at New York State Department of Health (DOH), New York State Office of Alcoholism and Substance Abuse Services (OASAS), New York State Office of Mental Health (OMH), New York City HIV/AIDS Services Administration (HASA), and New York City Department of Housing Preservation and Development (HPD), our portfolio has grown to include scattered site apartments, community residences, and apartment buildings in Upper Manhattan, the Bronx, and Brooklyn.

Investment in Special Needs Housing

In the last few months we completed construction of two new apartment buildings in the Bronx. In partnership with OMH and private tax credit investors we custom designed, developed, and managed the construction of a 56-apartment green building (applying for LEED certification) on Soundview Avenue and a 65-apartment building on Tinton Avenue. Both of these new buildings (designed by Urban Architectural Initiatives) provide supportive housing for homeless men and women living with mental illness.

The capital and ongoing revenue funding for these new programs falls under New York State legislation to provide mental health services, including housing, within the community. With the opening this Spring of these two new buildings (and the 50-apartment building we opened in 2010 on 123rd Street and Park Avenue), Odyssey House currently manages the housing and supportive services needs of 171 formerly homeless New Yorkers who, despite serious mental health challenges, are now living independently in their own homes.

Working to Support Recovery In New York State

The demand for safe housing is also acute within the population of people in recovery from substance abuse disorders. Almost a third of the participants in our intensive residential substance abuse treatment programs are either homeless or marginally housed when they enter treatment. As part of their recovery process from chronic substance abuse, we work with them on relapse prevention techniques, work skills, job placement, and finding and maintaining secure housing. In New York City, where housing is premium priced and affordable housing is in short supply, we dedicate an increasing amount of our resources to helping clients secure housing and work closely with our partners in government to address urgent housing needs.

In the last several years, OASAS has partnered with us in providing a variety of housing options in either a transitional community residence or scattered site permanent apartments for 150 individuals and families who complete treatment. We count ourselves fortunate to be supported by our partners in OASAS whose mission statement calling for "safe, affordable housing and stable living-wage employment are fundamental to successful long-term recovery," is congruent with the needs of our treatment population.

We are equally grateful to our partners in OMH for committing to "a future when every New Yorker experiences

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The NYSPA Report: An Interview with Ann Marie T. Sullivan, MD Acting Commissioner of the New York State Office of Mental Health

By Barry B. Perlman, MD
Director, Department of Psychiatry,
Saint Joseph's Medical Center

The members of the New York State Psychiatric Association (NYSPA) and the American Psychiatric Association (APA) were extremely proud of the appointment of their colleague, Dr. Ann Marie T. Sullivan, as the Acting Commissioner of the New York State Office of Mental Health (OMH) by Governor Andrew M. Cuomo as of November, 2013. It had been 30 years since the last psychiatrist, Steven E. Katz, MD, had been appointed to that important position. New York State has long been a national leader among the states in the development of public policy as it affects those with mental illness, especially those suffering with what is often referred to as 'serious and persistent mental illness' (SPMI). While NYS has been served by a number of excellent individuals since the requirement that the commissioner be a medical doctor ended many years ago, members of NYSPA believe that having a psychiatrist as commissioner brings added value to the position, especially when that person has been as directly involved with the provision of care in the public mental sector as has been Dr. Sullivan.

Dr. Sullivan is a product of New York City, having completed her undergraduate and Medical degrees at NYU where she also did her residency training on the NYU – Bellevue Services. She is Certified in Psychiatry by the American Board of Psychiatry and Neurology. Her career has been spent working in the New York City Health and Hospitals Corporation, most recently as the Senior Vice President of its Queens Health Network and prior to that as its Regional Director of Psychiatry, and the Director of Psychiatry at Elmhurst Hospital Center. It is of note that while directing systems she has continually maintained a clinical practice. A Clinical Professor at the Mount Sinai School of Medicine, she has published in scholarly journals, presented widely and served on a wide array of councils and committees engaged in shaping public policy in the field. She has for years been a leader in both NYSPA and the APA.

Recently I had the pleasure and opportunity of 'interviewing' Dr. Sullivan after her first 5 months in office. I put the quotes around 'interview' as it was as much a conversation with a professional colleague and friend with whom I'd worked closely over past decades in both NYSPA and APA related activities. Now she is the Commissioner overseeing, in no small measure, the future direction of NYS's policies for those suffering with mental illness. It is anticipated that she will be confirmed as 'commissioner' in the near future by the NYS Senate.

Q: What aspects of your new position have you found most exhilarating since assuming the position.

A: It is exciting to be part of shaping a system which is undergoing major transformation. Specifically, the pending movement of all persons with mental illness insured by Medicaid into managed care on a scale not previously undertaken offers both promise and reason for careful implementation. This is an opportunity to truly integrate medical and behavioral health care. We are at the same time moving our state hospital system from a very inpatient hospital based system to a more community focused system of care that enables individuals with serious mental illness to lead full lives in the community. On balance the hope is for greatly enhancing preventive services and community based care.

Q: Having yourself been based in the NYC metropolitan area, what have you seen and learned as you've visited state facilities and community based mental health providers across our state?

A: It has been interesting visiting with mental health providers across our diverse state and coming to appreciate the differing regional challenges, especially in the rural areas. Cultural differences are evident across the state. For example, in smaller, more rural communities providers have come together in innovative partnerships to share resources. The different distribution of workforce too is plainly seen, which is why those practicing in more remote regions would welcome increased access to psychiatric consultation via telepsychiatry, an interest of mine.

Q: What surprises or unexpected aspects of the system have you encountered?

A: I've been excited to learn more about the depth and breadth of OMH's programs and research endeavors. For example, suicide prevention is an area which has been ongoing and one I'd like to see expanded. The breadth of our adult and child services is impressive. I'd like to see the practice innovations research being conducted at NYS Psychiatric Institute further developed and initiatives such as 'Project Teach' which supports psychiatric consultation to pediatricians expanded. Together with Department of Health in the Medical Home Initiative we have piloted one of the largest collaborative care initiatives with primary care across New York State at 20 Academic medical centers and 31 primary care clinics. In summary, NYS should be proud of its research efforts at the Nathan Kline and Psychiatric Institute and its leadership in innovative clinical practice.

Q: As the first psychiatrist to serve as Commissioner in decades, what differences do you think being a psychiatrist brings to the role?

A: I believe that psychiatrists often have a broad view of the system based on their experience of both having direct treatment responsibilities along with their experience working within the system. Psychiatrists are physicians first and as such are trained to view the whole person. Their training helps psychiatrists grasp the emphasis being placed on the real integration of general medical and mental health services, such as the importance of screening and treating depression in a primary care setting and the importance of monitoring and assisting in the treatment of medical problems in our setting. I think as I am immersed in working on redesign of the Medicaid system, my many years of clinical practice helps to keep me grounded and focused on client and clinician needs.

Q: All working within the NYS mental health system have observed the increasingly central role of the Department of Health (DOH) in relation to the roles of the "O" agencies and their respective missions. Can you comment?

A: All the "O" (OMH, OASAS, & OPWDD) agencies are actively working towards a more integrated system, and this really is a positive. Clearly we have to be sure that we have adequate payment for the integration of care. As we move into Medicaid managed care it has been a large learning curve for all the agencies in trying to understand how to be sure the needs for individuals with mental illness are protected.

Q: You have candidly stated that placing all persons, including those with SPMI, within Medicaid managed care has both upside potential as well as reasons for caution. As such, as you've said, it needs to be done "right". What does doing it "right" entail?

A: Working under a federal 1915(i) waiver, state government will be working closely with Medicaid managed care organizations to widen the array of services reimbursed. We'll emphasize 'peer services, crisis services, employment support, among others to support wellness and recovery. We'll be trailblazing a service array aimed at improving 'quality of life.' The model of managed care is no longer focused primarily on utilization management but on accessible appropriate care when and where the patient needs it and care that leads to improved quality of life. Positive change will be encouraged in large measure by indicators on which the plans are measured and on which payments are made – things like clients not being lost to care, avoidable readmissions, successful treatment of medical problems, quality of life, etc. The involvement of local governmental units (LGUs) as monitors of the system will also provide important feedback to state government. Needless to say, right from the beginning we need to be sure that the benefits are right and the dollars allocated to the undertaking sufficient, which I believe they are.

see NYSPA on page 42

Employment Opportunities Off the Battlefield Help Veterans Combat Mental Health Challenges

By Kimberly Williams, LMSW
Vice President, The Center for Policy, Advocacy, and Education, Mental Health Association of New York City (MHA-NYC)

People are most fulfilled when their career goals lead to financial security, personal identity, and meaningful contributions to community. For a significant number of individuals, many of whom are military veterans, nothing would be more fulfilling and mentally stimulating than simply landing a job. Although the unemployment rate for all veterans has declined in the last year to 6.6 percent making it in line with the overall unemployment rate, the jobless rate for returning veterans remains high. Working opportunities significantly improve the emotional well-being of veterans. Yet getting a job is one of the greatest challenges facing men and women today as they leave active duty.

Military veterans struggle with transition issues as they return to civilian life. Securing a career is one way to ensure that veterans successfully transition back into civilian life. More importantly, obtaining a meaningful, satisfying job is a milestone toward supporting a veteran's emotional wellbeing. The connections between employment and good mental health and emotional resilience are documented facts. In William Julius Wilson's book, When Work Disappears: The World of the New Urban Poor, one of the underlying perspectives is that unstable work and low income diminishes self-efficacy and confidence to achieve valued goals, characteristics that are in line with good mental health.

Returning service men and women face an unemployment rate of nine percent which is higher than non-veterans in the same demographic group. When the poor economy is factored in, recent veterans have even greater challenges finding work. The disparity is daunting for female veterans who experience unemployment at nearly twice the rate of their civilian counterparts and higher rates than male veterans. Underemployment is another growing issue that forces many veterans to accept low-to minimum-wage jobs that don't capitalize on their skills. Without adequate attention to the problem, it will only become exacerbated as 22,000 members of

Kimberly Williams, LMSW

America's armed forces will be returning to civilian life, and their families, over the next several months.

Major reasons for the high unemployment among veterans include:

- Higher disability rates among returning veterans make it more difficult to find jobs that can accommodate their needs.
- Lack of civilian work experience makes them less likely to be hired, particularly in a slower economy, despite having many transferable and attractive qualities, including discipline, leadership and unique training.
- Barriers with veterans being able to translate their valuable military experience to the private sector, despite many support programs to assist veterans in obtaining civilian jobs.

Despite these obstacles, there is a compelling business case for hiring veterans. They are among the most talented and skilled members of America's workforce. Veterans have distinctive capabilities that make them great employees including performance-oriented backgrounds, strong work ethic, and an ability to thrive under pressure. They also have exceptional teamwork and problem solving skills that are transferrable to any work environment. Additionally, there are financial reasons to hire veterans, including a tax incentive of $9,600 per veteran employee.

A number of leading public and private sector entities have risen to the challenge by launching major initiatives to get veterans back into the civilian economy demonstrating not only their commitment to those who have sacrificed on behalf of our nation, but to their overall mental and physical well-being. First lady Michelle Obama and Dr. Jill Biden's "Joining Forces" initiative is confronting veterans employment challenges by promoting career development opportunities, highlighting the workforce potential of veterans and their spouses, educating employers, and working to reduce barriers to licensing and credentialing. Last year President Barack Obama challenged businesses to hire 100,000 veterans or their spouses by the end of 2013. Since then, businesses have hired and trained more than 380,000 veterans and military spouses. In the same spirit, 10 employers launched the "100,000 Jobs Mission," a coalition now of 131 companies that committed to hiring 100,000 veterans within a decade, which has exceeded its goal within only three years. As a result, they have now doubled their target to 200,000 veteran jobs by 2020.

In all of the efforts to employ veterans, hiring alone is not enough. Many of these companies are not only focused on hiring military veterans, but helping them develop a lasting future by providing on-the-job training, support to meet their educational goals, and opportunities for advancement. Retention is key to building lasting futures, but traditional retention mechanisms are not enough. Companies must also foster efforts to bridge the great divide between military veterans and civilians in this country. Because less than 1 percent of Americans have served in the military, civilians are increasing dissociated from veterans, their families, and an understanding of their service. However, there has been no opportunity in the civilian workplace for veterans to openly discuss the impact that war has had on their lives despite the great sacrifices they've made on our behalf. That is why MHA-NYC has launched Stories We Carry, an initiative to bring veterans and civilians together in various settings to share war's impact from every perspective. For far too long, veterans have shouldered the impact of war alone. It is time to transfer the weight of war back onto society, and employers hiring veterans are in a unique position to help make that happen. By bringing together veterans and civilian employees to openly share stories and misperceptions about war and military service, employee relationships can be enhanced and lead to deeper understanding, strengthened teamwork, and greater workplace retention and success.

MHA-NYC recognizes the importance and connections of gainful, meaningful employment and good mental health for veterans and their families. That is why in 2014 we are recognizing companies and leaders who are committed to employing and retaining veterans with the hope that we can spur others to follow their example. MHA-NYC's 2014 gala on Wednesday, October 1, at the Mandarin Oriental Hotel, will pay tribute to companies dedicated to hiring veterans, and to the men and women who braved the battlefronts of Iraq and Afghanistan, and now must brave the challenges they face back home as civilians.

MHA-NYC is delighted to honor Gregory J. Fleming, President of Global Wealth Management Group of Morgan Stanley, a true philanthropic leader and longtime advocate for veterans, and Staff Sergeant Salvatore A. Giunta, Medal of Honor Recipient Operation Enduring Freedom, the first living person since the Vietnam War to receive the nation's highest military award for heroism. MHA-NYC is also honored to have as their Dinner Chairs Frank Branchini, CEO of Emblem-Health, Ric B. Clark, CEO of the Brookfield Property Group, Kevin Dunleavy, Managing Director of Morgan Stanley, Laurence Fink, Chairman and CEO of BlackRock and Duncan Neiderauer, CEO of the New York Stock Exchange.

We hope you will join us in October to recognize companies that have made a commitment to help veterans build lasting, healthy civilian futures and in doing so promote the value of their dedication to their colleagues and to the veterans' community at-large. For more information, please visit www.mhaofnyc.org/gala2014.

Their mission was to protect us. Ours is to take care of them.

Founded in 2009 to confront the unmet mental health needs of veterans, service members, and their families, the Veterans Mental Health Coalition of New York City consists of 950 members who are dedicated to improving the lives of Veterans. VMHC works to improve access to quality mental health and substance abuse care through education, information, collaboration, and promotion of a comprehensive array of services. Membership is free so join VMHC and help us further our mission at **mha-nyc.org/VMHC**

MHA-NYC
Innovations in Mental Health

Veterans Mental Health
Coalition of New York City

VMHC

Second Chances

By Michele Fama
A Consumer in Recovery
Saint Joseph's Residential Services

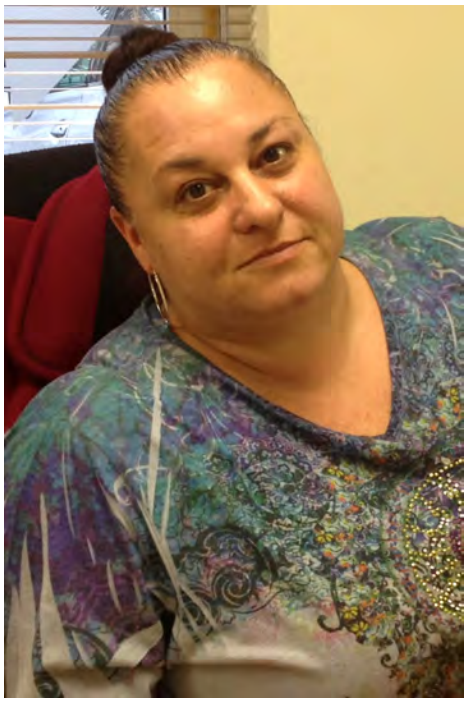
This is my story about my struggles with bi-polar disorder, substance abuse, and second chances. My journey began approximately 2 years ago. Between my undiagnosed mental illness and substance abuse, I was on a road of self-destruction. I was not capable of living a normal life. I couldn't get from A to B no matter how hard I tried. My mind wouldn't focus and I was a mess. My addiction and my lifestyle took me to some very dark places and introduced me to disreputable people. I lost most of everything that had meaning in my life.

One day I woke up to find myself homeless and living in the shelter system. I had lost my family and children. I had no money and no place to live, and I still thought in my mind that I was okay. At that point I had only my addiction and myself to worry about. I stayed in the shelter system for six months before I said "enough is enough". I was tired of feeling lost, lonely, and sick. It was time to get some help.

I reached out for help and spent the next 10 days in a detox program. From there I agreed to go to a rehabilitation center for 28 days. There I learned a lot about myself and my mental illness. I suffer from bipolar disorder, depression, and anxiety. The psychiatrists and the doctors prescribed medication to help stabilize my moods and monitored me for the first couple of weeks. It was then that I started seeing things so much clearer and brighter. I gained insight into the damage I had caused others in my life and began to recognize the things I had lost due to my illness.

The next step I had to face was my homelessness. With no place to go once I was discharged from the rehabilitation center, my counselor suggested a halfway house called Amethyst House. I went for the interview and was accepted into the program. Amethyst House is a place for women who have lost themselves and their ability to be able to live in the real world again, or just forgot how. It's an amazing program filled with rules and lots of structure, which scared me to death. It was the first step on my journey back into the real world. I had so many mixed emotions. The staff there was amazing. I learned so much about myself and was able to begin to make amends to those I had hurt. After a year I was set to graduate.

Starting over with no place to live, no money, food or furniture can be terribly overwhelming. It was then that my counselor introduced me to Saint Joseph's Medical Center. I found out their Residential Services department provided housing for people with mental illness. I couldn't believe places like that existed. After my interview they accepted me into their program. I was now overwhelmed



Michele Fama

with excitement and disbelief in how my life has changed. The program at Residential Services is set up to help men and women like me get a second chance.

I learned how to trust and believe again, but this program trusts and believes in me. They help set me up with a beautiful furnished apartment, helped me with food and utilities, and gave me a job. I work for their employment program called Rainbow, which is sponsored by Saint Joseph's Medical Center. The program is amazing and run by amazing people. The staff in Residential Services care about their clients and it shows in everything they do. The rewards and miracles of this program have made me grateful. Because of this program, no client of theirs (and there are over 700 clients) will ever go hungry, ever be alone, or ever be cold. My mother is and always will be my hero, but I could never be where I am today without the 3 ladies I admire and look up to, and I call them my " 3 Lady Bosses": Gigi Lipman of Amethyst House, and Elizabeth Woods and Marianne DiTommaso of Residential Services. I'm still on my journey and still continue to surround myself with these special women, positive people, and my support groups. I continue to live in my beautiful apartment and go to work every day. This program helps me give back to those who aren't as fortunate as I am.

Saint Joseph's Residential Services provides a full continuum of residential and housing options--from transitional community residences to permanent housing--so that persons with mental illness and other special needs can live as independently as possible. Residential Services manages 724 beds in four boroughs of New York City, as well as in Westchester County. For more information, visit www.stvincentswestchester.org.

A Rainbow of Opportunities

By Brian Rutledge
Assistant Coordinator
Saint Joseph's Residential Services

Employment is an integral part of confidence building, hope, self-esteem, and an essential portion of the recovery from mental illness. In 1991, the Residential Services department of Saint Joseph's Medical Center decided to pursue the development of a business which would provide vocational opportunities for the psychiatric clients of its residential programs. Rainbow Recycling was established to meet this goal.

Rainbow Recycling is an innovative business that provides recycling and paper shredding services to large businesses and institutions on Staten Island. The recipient of the 1995 American Psychiatric Association Significant Achievement Award, and the 1999 NYC Department of Mental Health, Mental Retardation and Alcoholism Services, Mental Hygiene Business Award, Rainbow Recycling provides meaningful, gainful employment for individuals with psychiatric and other disabilities who had previously been unable to attain or maintain employment and who often have become dependent on long-term psychiatric treatment due to the lack of job options.

What makes Rainbow effective as an employment alternative for those with mental illness? Special accommodations for employees are made, including flexible work schedules that take into account the need to schedule medical and psychiatric appointments and attendance at day programs. On-call employees are available to step in for regular employees who need a leave of absence due to a psychiatric or medical hospitalization.

In 1996, in an attempt to create more job opportunities for individuals with psychiatric disabilities, the services of Rainbow Recycling were expanded to include a general office-cleaning service called "Rainbow Brite." Now called "Rainbow Environment Services," these two divisions have grown throughout the years to include floor buffing, stripping and waxing.

In recent years the scope of employment criteria for Rainbow Environmental Services has broadened to include disabled individuals with dual diagnoses such as clients with both mental illness and substance abuse, as well as individuals with both mental illness and developmental disabilities.

In 2012 Rainbow Environmental expanded its services once again by providing painting, moving services, and apartment cleanouts. By 2013, Rainbow had ventured into the card-making business. This new division of the company focuses on making handmade cards for all occasions – holiday, birthday, etc. - including thank you cards, note cards and invitations. In 2014, Rainbow plans to expand even further to include the establishment of peer advocacy services.

Robert Harrell
A Longtime Rainbow Employee

In addition to being a source of hope for its workers, Rainbow offers stability and prosperity. Michele Fama, one of the more recent additions to the Rainbow family, has been employed as a receptionist since June of 2013. She answers the phones, coordinates time sheets, and provides general office help to the administrative staff of Residential Services. "The people I work with are special to me," said Michele. "Very special."

The longevity of its employees is a testament to the stability offered through Rainbow's services. Many members of the Rainbow staff have been long-time employees, such as Stephen Boyle and Charles Browne, who have been with Rainbow for 11 and 18 years, respectively. Steven currently provides computer training for clients in Saint Joseph's housing program along with a variety of other responsibilities. Charles paints apartments, strips and waxes floors, and is involved in moving projects. When asked what he likes best about working for Rainbow, Charlie replied "The people I work with are the BEST!"

With Rainbow's current services including shredding, cleaning services, painting, moving, cleaning apartments, and card making, as well as future peer advocacy positions, the future is certainly bright for Rainbow and its workers.

Editors note: Behavioral Health News applauds the courage and perseverance of all consumers engaged in their own recovery. It's a journey that may be fraught with many challenges and setbacks. There is no simple formula for success because each of us must find our own way based on our unique needs and abilities. We also salute the many treatment professionals and organizations that provide vital care in the community.

Housing and Employment, The Foundation for Recovery: Keeping The Focus in a Changing Environment

By Craig Stenning, Director, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)

Across the country, conversations are taking place about integrated, community- based employment for individuals with disabilities. There are also conversations about housing individuals with disabilities in the community, in the least restrictive environment. Traditionally, issues of housing and employment are addressed separately and left to compete as priority issues for purposes of funding. In Rhode Island, we are creating systems that are recovery oriented with the end goal of providing client choice. The Department has adopted the definition of recovery within the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Recovery Oriented System of Care : recovery is a unique journey through which an individual strives to reach his/her full potential; persons in recovery improve their health and wellness by taking responsibility in pursuing a fulfilling and contributing life while embracing the difficulties one has faced. This definition is the foundation on which our Housing First and Employment First initiatives have been established. And

Craig Stenning

when looking across disabilities, it directs us to continually challenge ourselves to create policies and practices that are person-centered.

The mantra of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) has been, "housing and employment is the foundation for recovery", but what does that mean? In order to create a person-centered, recovery oriented approach, we must overhaul our entire system. Person-centered services and client choice cannot be a mandate, but must be operationalized within the policies and practice of our system. Eight years ago, I attended a Supported Housing Leadership Forum sponsored by CSH (www.csh.org). The theme was Laying the New Foundation: The Key Components to Systems Change. The key elements included power, money, habits, technology and skills, ideas and values. In preparing for the kick off of our State's Employment First initiative, I reviewed these critical components and focused the work around them. State government is constantly vying to address critical needs and emerging crises in the shadow of the looming budget shortfalls. In order to successfully implement our strategies and to achieve our goals, it is critical to view our work in a holistic manner and, to the extent possible, look to reinvestment or cost- shifting.

We are working at several levels with our partners to address the elements of systems change through communications, leadership development, community education, outreach and organization. Research shows that housing is healthcare, and over the last 10 years especially in the homeless community, the benefits of housing for individuals experiencing long term homelessness, many with complex substance use and mental health issues, has not only changed lives but significantly reduced the cost to emergency systems (www.naeh.org). The Department has collaborated with the State's Continuum of Care to ensure that we are part of the housing conversation. The goal is to create an array of housing options from sober/recovery models to supported housing/Housing First with options for supportive services that focus on housing retention. BHDDH is looking at the service components and how to create a funding system that is flexible enough to engage community based organizations that have relationships with our vulnerable populations, but not necessarily the complex infrastructure typically needed to participate in mainstream Medicaid resources.

Employment is being approached in a similar manner. BHDDH is a part of the solution, and we are looking to our partners to develop the policy and financing mechanisms that allow individuals to obtain the services that meet their unique and individual needs. By creating an Employment First Task Force consisting of the Department of Behavioral Healthcare,

see Focus on page 36

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Realizing My Purpose

By Jerald Jenkins, Peer Specialist
Services for the UnderServed

I often wonder what my mom would think of the journey of my life and the man I am today. She raised me well, as a single parent to me and my older brother. She passed away when I turned 13, and my life began to spiral out of control. My brother and I were taken in by my aunt, but despite her best efforts the streets of Brooklyn claimed me and introduced me to drugs. To survive on the streets I had to show how tough I was. I became a thug, a menace to my neighborhood and a disappointment to my aunt who was also a victim of my recklessness.

By the age of 18 I was homeless and sleeping on the subways. At 20, a friend of mine who had also been homeless but had found an apartment after a stint at a men's shelter, encouraged me to do the same. I followed his advice, but instead of a shelter I was sent to a locked unit for substance abusers. By that time, I had explored every kind of drug from marijuana to crack cocaine and I knew I needed serious help.

During my 30-day detox, depression started to kick in and I became catatonic—totally withdrawn from everything and everyone, and most frightening of all, I started to hear voices. I was sent to a psychiatric hospital where I was diagnosed with major depression, schizoaffective disorder, and schizophrenia. I was offered Prozac, but being an addict, I feared further addiction. This probably was not the wisest decision. Soon the lack of medication and my drug withdrawal led to panic attacks. Now I needed a place that could provide me a home, treat my new diagnosis of mental illness and treat my substance abuse issues. Against my wishes I was given Haldol to manage my panic attacks and my behaviors.

I remember just being tired, just wanting to reconnect with my family and wanting to be well. I did not want to end up in jail and I certainly did not want to die. I landed in a supervised community residence, agreed to take medications for my psychosis, and made the decision to pursue my GED. In 1991 I moved on to a transitional treatment program at Services for the UnderServed (SUS) and shortly after, secured permanent housing in an SUS community apartment. I continued to work on my recovery and in 1994 after about 5 years clean, I was approached by a manager at SUS and offered a part-time position as a Peer Specialist. I readily accepted the offer and started as SUS' first peer specialist working in Intake.

It was my first real job and I felt proud of the work I was doing and the prospect of helping others. As a counselor, I made people whose situations I had once lived feel comfortable coming to SUS. I understood their challenges and by sharing my story, let them know that recovery was possible and they weren't alone. I was always taught that 'You can't keep it unless you give it away' at the self-help groups I attended, and that inspired me to contribute where I could.

I worked as a Peer Specialist at SUS with its Intake Department for three years, knowing then that I wanted to both give back and advance myself. Since then, I have continued my career in full-time positions serving as a Job Coach in SUS' Employment Services division for nine years, with its ACT team for five years and now, I am in my second year with SUS' Parachute Brooklyn Respite Center. I also helped to write the curriculum for SUS' Project P.R.E.P.A.R.E., a training program for individuals seeking positions as peer counselors.

My work defines who I am because I share it with my peers, giving me purpose and the opportunity to serve others. I want to see my peers reach their potential, especially the younger generation. Being a peer specialist at Parachute, a peer-supported crisis respite for young adults experiencing their first break, allows me to do that.

In working with my peers, it has been valuable to wear the label of both consumer and employee. While many people may want to lose the label of 'consumer' once they no longer need support services, it's a label I continue to wear proudly. It defines who I am, it keeps me humble and is what makes me great at what I do.

Having stable housing took a level of stress away so that I could pursue my employment goals. Employment helped me to gain a sense of hope and purpose. I enjoy being the consumer/the first peer counselor who stands as a testimony to others for what is possible. It is the powerful combination of housing and employment that supported my capacity to recover. This has made the biggest difference in my life.

I look forward to celebrating my 25th anniversary of being clean in October of this year. Since my days on the streets, I've rekindled my relationship with my aunt and keep in touch with my brother. I've always been a fan of music but now, finally, my DJ'ing business is really starting to take off. Today, I'm just living my life. Hey, I guess I don't need to wonder anymore...I know my mom would be proud.

Medicaid Redesign Team Updates

By Jorge R. Petit, MD, President Quality Healthcare Solutions Group, Chairman Elect, Mental Health News Education, Inc. (MHNE), and Jenna McCready, Research Associate

In 2012 the Medicaid Redesign Team (MRT) of New York State proposed an extension to their Partnership Plan Waiver—an action plan entitled "A Plan to Transform the Empire State's Medicaid Program"—that would extend their work for an additional five years and allow the reinvestment of money saved due the work of the MRT into implementing the remainder of the plan. If approved, the extension would allow the MRT to reinvest approximately $8 billion through December 31, 2019. Funds will be reinvested through the Delivery System Reform Incentive Payment (DSRIP), the State Plan Amendment, and Managed Care contract payments.[1]

In February 2014, Governor Cuomo released a statement that "an agreement in principle" was reached, and that New York State and the Department of Health were discussing the details of the waiver's terms and conditions with the Center for Medicare and Medicaid Services (CMS). In particular, discussions pertained to the implementation of the Delivery System Reform Incentive Payment (DSRIP) plan that proposes the incorporation of behavioral health benefits into managed care.

Jorge R. Petit, MD

The Final Health Budget details important provisions around the DSRIP, for example the establishment of an advisory panel, the submission of quarterly progress reports, and a state-wide inclusion clause, among others.[2] Over the final weeks in April, the DOH will hold public hearings across the state to inform residents of the extension details and gain insights and feedback from the public. The hearing in Buffalo, scheduled to occur on Monday, April 14th has been rescheduled to Wednesday, April 23rd. All other pubic hearings are expected to take place on their pre-determined dates.[3]

Workgroups

In March 2014, the DOH released an RFP for their Senior Supporting Housing Services Project, a project proposed by the MRT's Supporting Housing Workgroup. Organizations will receive government funds to establish housing services for "low-income, Medicaid-eligible seniors who are homeless or reside in the community and who are at risk of nursing home placement and senior transitioning out of nursing homes into community living who require long term care services." Up to eight projects will be selected to receive up to $250,000 for two years with no opportunity for renewal of the grant.[4]

Another RFQ was released in March 2014 for all mainstream plans for apply for qualification as a Managed Care Organization (MCO) and/or Health and Recovery Plan (HARP). Organizations located in New York City will be selected in round one—applications are due by June 6, 2014; selection will expand to statewide in round two—applications are due approximately by December 6, 2014. A conference will be held on May 2, 2014 for interested organizations eligible for round one selection.[5]

Footnotes:

1. https://www.health.ny.gov/health_care/medicaid/redesign/

2. http://www.hinmanstraub.com/newsletter/2014-15%20Final%20Health%20Budget.pdf

3. http://nyshealthfoundation.org/news-events/events/new-york-state-public-hearings-on-partnership-plan-extension

4. http://www.health.ny.gov/funding/rfa/1212230202/1212230202.pdf

5. https://www.health.ny.gov/health_care/medicaid/redesign/docs/behavioral_health_rfq_coverletter.pdf

Perspective on Recent Developments In New York State Behavioral Health Reform

By Peter D. Beitchman, DSW, LMSW Chief Executive Officer, The Bridge, Board Chairman, Mental Health News Education, Inc. (MHNE)

Since the last issue of *Behavioral Health News*, as summarized by the excellent update above written by Dr. Jorge Petit and Jenna McCready, the State has moved forward to aggressively implement managed behavioral health. This article presents a perspective on some of the developments.

RFQ for Behavioral Health Benefit Administration - Managed Care Organizations and Health and Recovery Plans (HARPS)

The broad outlines of the final RFQ follow the December draft. Happily, consumers, providers and advocates have discerned significant concerns for the stability of the behavioral health system throughout the final RFQ's 160-pages. Chief among these are three important clarifications: (1) HARPS and Managed Care Companies (MCOs) will be required to fund all behavioral health Medicaid services at current rates for a 2-year period beginning January 1, 2015; (2) To address immediate concerns about reduced access to services, the RFQ requires MCOs to contract with all behavioral health providers who serve a minimum of five of their enrollees; (3) MCOs are required to hire senior staff with behavioral health expertise. Taken together, these three elements will promote a reasonable transition period for MCOs, the provider community and consumers to develop the understanding, systems and relationships needed in the emerging managed behavioral care system.

Peter D. Beitchman, DSW, LMSW

HARP eligibility criteria are spelled out in detail in the RFQ. On the mental health side, the criteria are broad and inclusive (including all persons who reside in OMH-funded housing and all persons with SSI who have participated in any OMH-licensed program (including outpatient program such as Adult Mental Health Clinics, PROS, ACT, TCM and PMHP in the year prior to enrollment). On the substance abuse side, the criteria are more narrowly drawn, requiring two or more inpatient or outpatient detoxifications or one primary SUD inpatient stay within a year of enrollment or two or more inpatient admissions with SUD primary diagnosis and related medical diagnoses. Outpatient participation in 822s, for example, does not automatically qualify an individual for HARP enrollment.

1915(i) waiver services are described in the RFQ. These include a welcome list of rehabilitation services, including employment and vocational supports, peer and family support services, self-directed care services, residential supports and crisis and short-term crisis respite care and services. These services will be offered to HARP enrollees who meet specified eligibility criteria as assessed by a "neutral third party." Some from the advocacy, provider and consumer communities have expressed concern that, as presented in the RFQ, 1915 (i) services will not be available to non-HARP enrollees.

Four Related RFPs

In concert with the release of the MCO/HARP RFQ, four additional RFPs for related demonstration programs have recently been issued. Taken together, they target high need individuals, many of whom are heavy users of behavioral health services. Once again, they promote innovation to meet the behavioral, medical and social service needs of high need individuals to reduce health care costs and improve their health and living status.

Delivery System Reform Incentive Payments (DSRIP)

This multi-billion dollar Federal fund is being distributed by the State to encourage innovation that will result in a significant reduction of Medicaid hospital costs – both emergency room and inpatient. The behavioral health community has a key role to play in achieving the savings that the State envisions. While the final DSRIP RFP has not yet been released, in reading the preliminary material it is clear that behavioral health providers, in partnerships with hospitals and primary care programs, will create the kind of innovative programs that can impact hospital costs. The preliminary DSRIP description indicated that the Commissioners of Health, OMH and OASAS will have the authority to waive regulations in approving projects. We can expect that the behavioral health community to develop crisis intervention and hospital-to-community transition programs that will not only reduce costs but will also improve the lives of those we serve.

OMH and the Medicaid Redesign Team (MRT) have also issued an RFP for a *Crisis and Transitional Housing Pilot Initiative for Adults with Serious Mental Illness*. In this 2-year demonstration project, participating agencies will establish short-term crisis beds to divert consumers from emergency room and inpatient services. Each participating provider agency will establish three beds with a short length of stay. Providers will develop a mix of services designed to stabilize consumers so that they can return to their regular housing and services.

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Seven Tips for Teaching More Effective Job Skills

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

After fifteen years of modestly fulfilling our mission of teaching Computer Job Skills and securing employment for over three-thousand persons diagnosed with mental and physical disabilities, I regret how little we knew. We had the passion and heart for the work, but we lacked the expertise to be effective trainers for all our students.

Our wake-up call came from a mom who wanted to know why her son diagnosed with Autism wasn't learning in our traditional, instructor-led computer classes? We didn't know. "Chris" wouldn't look at us, he barely spoke. We didn't know how to communicate to learn what the issues were, much less to solve them. We did know our learning model and methods were failing "Chris" and most of the students on the Spectrum.

While they spent hours on the computer watching You Tube, T.V. and playing video games, we didn't know how to leverage their passion into $10-$12/hr job skills such as Microsoft Word, Excel, Publisher, keyboarding, internet searching and code proofing.

That was three years ago. Our students have taught us many things since then. Our problem was getting over ourselves

Donald M. Fitch, MS

and finding the courage to try new teaching methods. We hope the seven lessons below will help your students and staff to be more productive.

1) *Teach the Job:* A quick review of the job skills employers are looking for can be found on Craigslist.com;"proficient in Word, must type 45wpm etc." They are almost always looking for "hard skills". Yet, a review of vocational provider offerings and IEP's contain vague "soft skills"; "Johnny will become familiar with local job opportunities." Not, "Johnny will learn to type 30wpm at 98% accuracy on Mavis Beacon by the next quarter."

We suggest you invite employers/ personnel agency/business people to speak to your class/group on the skills they require. Review your curricula; is it "Employer aligned?" Check out the Department of Labor's O*Net online. It lists job skills for thousands of occupations. (www.onetonline.org). Once you've defined the job skill sets, you can begin your search for potential trainers, volunteers, parents, retirees (former secretaries are particularly valuable).

2) *Stop Talking so Much:* A major mistake we made with our students was over communicating the curriculum, both verbally and with hand out text. Students complained of being overloaded with information.

After testing a variety of media, we found a highly visual, minimalist comic book format and short fun You Tube videos combined with hands-on tasks and a one-on-one personal trainer to be the most effective and efficient training model. Class time was reduced by two-thirds, performance scores soared.

3) *Step Back:* We were unaware of the critical need of our student's personal space. Instead of standing behind the student, the trainer backs off, touring the classroom, responding to students who ask for assistance. Simple tasks like typing a letter in Word were completed in one-third the time and zero errors. This is particularly effective with our ASD students. However, we have found our students diagnosed with anxiety disorders prefer Instructors to remain close by.

4) *Diagnosis is Important:* Of some twenty variables studied, diagnosis accounts for most of the test variance. We plotted the student's job skills performance and the average time required to complete the task by their presenting DSM 5 (see chart on page 43). We were fortunate to have the same performance metrics for some seventeen job tasks across all ten populations. While the neurotypicals from One Stop were the gold standard, folks with physical disabilities (other than hand hand/arm) were next, then our ASD students. The least accomplished of our students were diagnosed substance/alcohol abusers. In our opinion, most of this population are quite capable of mastering the course work, they just weren't interested in doing so. We don't know (yet) how to motivate folks that don't want to learn. Last summer Leake & Watts totally tested our learning model by dropping off eight youth diagnosed with a variety of Intellectual & Developmental Disabilities for two hours a week (IQ's ranged from 60 to 40). To our surprise & delight, three students completed the Portfolio of Computer Job Skills, all mastered the Mavis

see Seven Tips on page 43

Court-Approved Settlement Gives New York Adult Home Residents Their Lives Back

By The Judge David L. Bazelon
Center for Mental Health Law

Nicholas Garaufis, U.S. District Judge, approved a comprehensive settlement agreement that will provide approximately 4,000 residents of 23 large "adult homes" in New York City the opportunity to live in their own homes. "Adult homes" are large board and care homes serving primarily people with serious mental illnesses.

Attorneys for the residents and the U.S. Department of Justice reached the landmark agreement with New York State, ensuring that residents with serious mental illnesses will receive the financial assistance and services they need to live in their own homes and to integrate into their communities.

The settlement will allow these residents "to blaze their own trails, pursue their hopes and dreams," as one resident told Judge Garaufis at the January 9, 2014, hearing on the settlement agreement.

"I miss cooking," another adult home resident told Judge Garaufis at the January hearing. "I miss hot chocolate in my microwave, and cut flowers that I could afford to buy every now and then, and when I feel stuck, and with support, I think I could go back to being where I was. I'd like the opportunity to do that."

Another resident testified that the adult homes have denied "basic rights that other people so freely enjoy."

"Thanks to this settlement, the plaintiffs, and other class members, can look forward to the life they deserve in their own community-which is what federal law requires," said Andrew Gordon, a litigation partner at Paul, Weiss, Rifkind, Wharton & Garrison LLP, which represented the adult home residents in this matter.

"We applaud Judge Garaufis for approving this model settlement agreement today, and the Cuomo administration for its leadership in ending the needless isolation and segregation of thousands of New Yorkers with mental illnesses in adult homes," stated Cliff Zucker, general counsel of Disability Rights New York (formerly Disability Advocates Inc.). "As Judge Garaufis noted, relief for adult home residents is long overdue."
"Virtually all adult home residents with mental illnesses can live in their own homes and thrive as full members of their communities," stated Ira Burnim, legal director of the Judge David L. Bazelon Center for Mental Health Law. "Many of these residents have waited years, some decades, to leave these institutions and lead lives like the rest of society."

"This is a great day for the civil rights and human dignity of people warehoused in adult homes," said Jota Borgmann, senior staff attorney at MFY Legal Services, Inc. "At the fairness hearing, one resident compared living in an adult home to being a 'farm animal,' and told the court that in an adult home you 'lose an edge of your humanity.'"

"Judge Garaufis' approval of this settlement agreement means New York City's adult home residents can finally take their lives back," stated Veronica S. Jung, senior staff attorney at New York Lawyers for the Public Interest. "This victory has been a decade in the making. The real test of our victory is in the state's implementation of the agreement, to quickly assess and move adult home residents into housing in the community. These residents are ordinary people who look forward to returning to jobs, families, and living independently in the community."

"We are pleased to see that this settlement has the approval of the court," said Mara Kuns, staff attorney at the Urban Justice Center. "The agreement seeks to realize the civil rights of adult home residents."

Led by Paul, Weiss, Rifkind, Wharton, and Garrison LLP, plaintiffs' legal team sought to resolve claims that New York State is violating the Americans with Disabilities Act (ADA) and the Supreme Court's *Olmstead* decision by failing to afford adult home residents an opportunity to live in the "most integrated setting" appropriate to their needs. The U.S. Department of Justice sought to resolve similar claims. After extensive negotiations, the residents, the U.S. Department of Justice, and the state reached this landmark agreement which will end the unnecessary segregation of thousands of people with mental illnesses.

Under the agreement, the state will provide as many scattered-site, supported housing units as necessary to afford all adult home residents with serious mental illnesses the opportunity to live in the most integrated setting appropriate to their needs, and will provide and maintain community services and supports including but not limited to: Care coordination; Psychiatric rehabilitation services; Employment services; Assistance with taking medication; Home health care; Personal assistance services; Assertive community treatment; and Crisis services.

The court appointed Clarence J. Sundram to serve as the independent reviewer to assess the state's compliance with the settlement. Sundram has a long history of working on behalf of people with disabilities. He founded and chaired for over 20 years the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities. More recently, he has

see Settlement on page 46

Ending Veteran Homelessness on Long Island

By Ralph Fasano, MEd, CRC
Executive Director
Concern for Independent Living

In 2011 President Obama, Department of Defense Secretary Eric Shinseki and HUD Secretary Shaun Donovan announced a five year plan to end veteran homelessness in the United States. The announcement was backed up by record funds to help achieve this goal. VASH vouchers (Veterans Administration Supportive Housing) were made available to serve as a rental subsidy for veterans so that they could afford housing. Case managers were assigned to the veterans to help them find the housing and services needed to remain housed. SSVF (Supportive Services for Veteran Families) were distributed in an effort to prevent veterans from becoming homeless. Halfway into this plan the results have been significant. Veteran homelessness has been reduced by 17.2 percent.

Earlier this year Concern for Independent Living together with the Long Island Coalition for the Homeless, United Veterans Beacon House, The Community Development Corporation of Long Island, Suffolk County United Veterans and the Northport Veterans Administration took part in a "Boot Camp" in Philadelphia. Six different regions from across the country came together to strategize on

Ralph Fasano, MEd, CRC

developing a plan to end veteran homelessness by December, 2015. We received training from the Rapid Results Institute and the 100,000 Homes Campaign. After three long days we came up with the Long Island Plan which is currently in the implementation stage.

The essence of the plan is simple. If you can house more people every month than the number of people who become homeless you can reduce the number of homeless by that number every month until no one remains homeless. Efforts can then focus on rapid re-housing to house any veterans who become homeless. Prevention activities are also key.

The creation of permanent affordable housing with flexible services is an important component of our plan. Concern is currently in the process of developing 60 units in Amityville and 59 units in Ronkonkoma. All of the units in Amityville will serve homeless veterans and their families. About half of the units in Ronkonkoma are for homeless veterans with the balance aimed at housing veterans who need affordable housing. Capital funding from the New York State Office of Mental Health, NYS Homes and Community Renewal, NYS Homeless Housing Assistance program, The Federal Home Loan Bank of New York and Suffolk County made this housing possible.

Concern has been working with the Northport VA, CDC of Long Island and United Veterans Beacon House to house homeless veterans who are given VASH vouchers. To date we have housed 47 veterans in permanent housing. Supportive services ensure that the veterans' needs are met. Two of the veterans have secured jobs and no longer need the vouchers to pay their rent. Others are in the process of receiving training that will help them get jobs. In several cases where rental housing was difficult to find, Concern purchased the sites and is renting them to the veterans. Home Depot donated $300,000 to help fund these acquisitions and The Long Island Community Foundation gave us a $25,000 start-up grant.

Another exciting development is the creation of a Community Resource Center alongside the Amityville housing. The Long Island Coalition for the Homeless is renovating a 40,000 sq. ft. building that will house approximately seven nonprofit agencies. United Veterans Beacon House, SUS, Family Service League, Suffolk County United Veterans, Concern and others will be joined together under one roof and will focus on coordinating our regional efforts to end veteran homelessness.

While there must be overall plans to achieve goals it always comes down to individuals and our ability to connect with them. For over a year now we have been working with a 71 year old veteran who spent many years living in the woods. After months of engaging him, he finally decided that he liked what we could offer him – an apartment in a safe, comfortable place where he could maintain his dignity and begin to rebuild his life. One year later his health has improved and he is working part-time. He was able to pay off debts and save money to purchase a

see Homelessness on page 41

Integrating Vocational Rehabilitation with Housing Support

By Donna Marcello, BA, CASAC
Career Services Program Director
East House, Rochester, New York

Entering a residential program for substance use can be very scary, a time filled with questions and learning to navigate the unknown. As service providers, we can make this time a little easier by answering questions, offering assistance, reassuring clients that all of their needs will be met. We can explain that the goal is not just to provide a bed to sleep in, but to help the individual to achieve sobriety, better physical health, improved mental health, economic self-sufficiency and independence. This is how we approach new clients at East House. And to make sure that all of their needs are met, East House makes vocational rehabilitation a priority.

Almost 25 years ago, East House realized the importance of providing education and employment services to complement its existing residential programs for individuals in recovery from mental illness and substance use disorder. So in 1989, it launched a program, now known as Career Services, to meet the vocational and education needs of its clients. Over those 25 years, we have seen the importance of meaningful activity to the rehabilitation of the individuals who we serve.

Currently, the Career Services program serves over 700 people annually in recovery from substance use disorder. These individuals come from East House's four OASAS-licensed halfway houses and one supported housing apartment program, or one of three other OASAS-licensed residential treatment programs in Rochester, NY that contract with East House for these services.

Counselors from Career Services are considered part of the team that serves clients. They work closely with house managers and counselors to ensure that education and employment services are addressed as part of the plan for clients. Every client residing in an OASAS-licensed facility is given an orientation to the Career Services program, and there is an expectation of involvement while the client is at East House. While we believe in the importance of involvement, we also believe in personal choice. So each client works on an individualized plan with his or her career counselor, choosing what services and goals are important to each of them.

Here's how it works: career counselors are assigned to each OASAS-licensed facility, allowing each program to have a point-person for vocational and education services and ensuring optimum collaboration between residential and vocational staff. As part of their assignment, career counselors attend community meetings at the halfway houses, as well as treatment team meetings and case reviews. Career counselors review client progress with residential and treatment staff on a regular basis to ensure that progress is consistent across programs. Depending on the client, the focus may be education, employment or both.

If the goal is education, clients have the opportunity to take classes to prepare for the TASC exam (Test Assessing Secondary Completion), formerly known as GED, at the East House Paul Wolk Learning Center, which is located at Career Services. In addition to TASC preparation, Career Services also offers adult basic education in math and reading as well as classes focused on computer skills, which are essential in today's job market. For those in need of assistance with memory, focus, or concentration, Career Services offers a cognitive remediation program called NEAR (Neuropsychological Educational Approaches to Remediation). NEAR is an evidence-based approach to cognitive remediation and has been successfully implemented in some outpatient and inpatient programs. NEAR classes are held in the East House Career Services computer labs and individuals have reported excellent gains following their 15-week course.

One client who completed NEAR is Dan. Dan was residing at an East House halfway house, and then graduated to the apartment program. He went through the NEAR program and also attended classes at the Paul Wolk Learning Center to prepare for and complete his TASC, which he obtained in 2013. He now volunteers at the Learning Center while searching for competitive employment. He has successfully graduated from the supported housing apartment program, but continues to utilize Career Services as an alumnus.

Career Services also assists clients with obtaining and retaining volunteer positions, which build skill level, job experience, and self-confidence; locating and registering for skills training or certification programs, as well as referrals to ACCES-VR. Contracts with ACCES-VR allow for work readiness skills training, vocational assessments, job readiness, job placement, and job retention services. Other employment-specific services include weekly groups which focus on job readiness skills, job seeking strategies and job retention. Clients also use two in-house computer labs to search for employment, complete online applications and create professional email accounts. Open interviews and panel discussions with Human Resources representatives from the business community are also available on-site. In 2013, 64 clients came to Career Services for assistance with a job search and 59 of those were placed in competitive employment.

Chad began working with his career counselor while he was living in one of the East House halfway house programs. Chad is deaf, and was able to work with a career counselor who is a sign language interpreter. He completed the halfway

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Safe, Affordable & Supportive Housing: Will it Remain an Elusive Dream?

By Ashley Brody, MPA, CPRP
Residential and Community Services Director, Search for Change (SFC)

Residents of the greater New York metropolitan area and others who are familiar with the regional real estate market understand residential property costs have become prohibitively expensive for renters and owners alike in recent years. In March, 2014 the Office of the State Comptroller released a report that confirmed and quantified these suspicions, and it portrayed a market that has become increasingly inaccessible to individuals and families of modest means. The past decade has delivered a marked increase in the percentage of New York State households with housing costs that exceed the affordability threshold as defined by the U.S. Department of Housing and Urban Development (HUD), and there is no indication this trend will abate any time soon. Data obtained via the U.S. Census Bureau's decennial Census and the American Community Survey, another gauge of socioeconomic and demographic trends, suggest 50% of rental households had monthly housing costs that exceeded the affordability threshold in 2012, and a quarter of these households were "severely housing cost burdened" inasmuch as they incurred costs that exceeded 50% of their monthly income (Office of the State Comptroller, 2014).

Social and economic challenges that afflict the general public are frequently magnified among the population of individuals with significant behavioral health issues, and the increasing inaccessibility of the housing market is no exception to this phenomenon. Furthermore, the proverbial "safety net" that was established to protect this population from the vagaries of the housing market has failed to fulfill its mandate. A review of programs funded by the New York State Office of Mental Health (OMH) reveals a marked erosion in funding due to inflation for licensed residential programs and supported housing units between 1991 and 2014. Funding for supported housing, a model that replicates the federal Section 8 Housing Choice Voucher Program via its provision of rental subsidies to individuals with limited income, has effectively dwindled by 20% in New York City, Westchester and Long Island. Upstate regions have seen a 40% reduction during this same period, and despite aggressive advocacy by stakeholders to augment funding during recent budgetary negotiations the newly-enacted state budget for 2014-2015 failed to include any adjustment for upstate regions. Furthermore, those who are "lucky" enough to receive housing subsidies represent an increasingly smaller segment of the broader behavioral health population as demand for such assistance continually outpaces supply. Those who do not receive it, including many who languish on lengthy waitlists, are essentially barred from the housing market altogether. In 2012 in New York, SSI recipients paid, on average, 133% of their monthly income to rent one-bedroom housing units. This fact alone suggests

Ashley Brody, MPA, CPRP

the acquisition and retention of affordable housing is a virtual impossibility for individuals with behavioral health conditions and other disabilities who depend on Social Security benefits to meet their financial needs (Technical Assistance Collaborative, 2012).

All of these trends are especially problematic for individuals with behavioral health concerns, many of whom experience comorbid physical health conditions and other challenges that are exacerbated by chronic residential instability and its attendant ills. Public policy has clearly failed to account for the impact of this housing crisis on vulnerable populations. According to the state Health Commissioner, Dr. Nirav Shah, and his associates, "social determinants" of health such as safe housing, nutritious food, and educational and employment opportunities are frequently overlooked by our social service infrastructure in its singular preoccupation with the medical determinants of health (Doran, Misa & Shah, 2013). In a review of epidemiological and survey data, Dr. Robert Manderscheid (2009) describes a decline in the availability of housing and community support services for individuals with mental illness during a period in which these services should be significantly enhanced to compensate for a diminution of inpatient resources. Other authors (O'Hara, 2007; Mechanic, 2007; Newman & Goldman, 2009) repeatedly cite failed housing policy as a predominant factor in our national mental healthcare crisis, and they suggest chronic homelessness and residential instability pose significant barriers to the overall health and community integration of individuals with mental illness. It should therefore come as no surprise that the Organization for Economic Cooperation and Development (OECD) found the United States ranks first in healthcare spending but 25th in social services spending. Perhaps this fact, as much as any other, betrays our nation's inefficient and misguided approach to the management of its social safety net. It is hardly surprising that an era of continuing deinstitutionalization without a commensurate enhancement of affordable housing or community support services should also produce a monumental increase in the population of individuals with serious mental illness entangled in our criminal justice system. Our nation's jails and prisons have effectively become the new "homes" for many for whom there is no longer an institution or a community. And sadly, the enactment of the Patient Protection and Affordable Care Act (PPACA), a seemingly auspicious development for millions of Americans who have been unable to access comprehensive and affordable health insurance, may do little to address the fundamental needs of this population. Freshly-minted health insurance cards will likely fail to improve the overall wellbeing of those who lack access to safe and affordable housing and the basic necessities essential to sustain health.

Notwithstanding these significant deficiencies in the social safety net, we are privileged to bear witness to some promising changes within of our behavioral health system and the manner in which individuals with mental illness and substance abuse conditions are housed within their communities. A movement that began in the early 1960s with President Kennedy's proclamation that institutions (specifically state-operated inpatient facilities for individuals with severe psychiatric or developmental disabilities) were essentially relics of an unenlightened past and should be dismantled and replaced by a more integrated and individualized continuum of services has acquired additional momentum in recent decades. In the past couple of years alone a confluence of events, including a proposal to close or consolidate several state-operated psychiatric centers, limit the placement of adults with mental illness in adult homes and nursing facilities, and curtail patients' lengths of stay in private hospitals and acute care facilities has necessitated a robust expansion of residential support services for those who were formerly housed in institutional settings. Such continuing deinstitutionalization is undoubtedly consistent with a moral and ethical imperative to accommodate individuals in need in the most integrated and least restrictive settings possible. It is also a legal requirement as established by a decision of the United States Supreme Court in Olmstead v. L.C. This decision effectively mandated the community integration of vulnerable populations via judicial decree and lent additional urgency to the deinstitutionalization movement.

In *theory*, the needs of vulnerable individuals emerging from institutional care will be fulfilled through a reinvestment of savings accrued through facility closures and the redesign of the state Medicaid program. In 2013, the OMH released a proposal to close or consolidate several of its facilities and to establish "Regional Centers of Excellence" wherein remaining facilities would deliver specialized inpatient services and an array of outpatient supports through community-based service "hubs." By some estimates, the state expends approximately $110,000 per bed annually in its inpatient facilities, so a significant reduction in service capacity presents a corresponding opportunity for reinvestment in housing and community support services (New York State Division of the Budget, 2014). In 2011, Governor Cuomo established a Medicaid Redesign Team (MRT) to conduct a comprehensive reevaluation of the nation's most expensive Medicaid program, and it produced a host of recommendations to reduce program costs through improvements in organizational efficiency and investment in community-based support services that would divert recipients from more costly inpatient and emergency medical services. Some of these recommendations emerged from the MRT Affordable Housing Workgroup and led to a reinvestment in housing and community support services during fiscal year 2013-2014. Similar items were included in the budget that was just enacted on April 1st. All of these investments *promise* to deliver additional supported housing and service opportunities for individuals in their communities of choice.

Theory. *Promise*. Terms that evoke memories of a previous era of deinstitutionalization during which individuals were discharged en masse from state-operated facilities with the expectation they would receive supportive housing, vocational rehabilitation, outpatient treatment, care management and a host of other services that would promote their safe and successful integration into their communities of origin. As the foregoing suggests, however, only some of these services and supports were available, and often for the select and fortunate few. Others endured homelessness, incarceration, repeated episodes of hospitalization in acute care facilities (i.e., the "revolving door" syndrome), or reinstitutionalization in homes for adults, board and care facilities and similarly substandard residential accommodations. President Jimmy Carter condemned this as nothing less than the wholesale neglect of the mentally ill in his sweeping review of national mental health policy (Bloom, 2010). This begs an obvious question. Have we learned from our past or are we condemned to repeat it?

Initiatives currently underway give rise to a certain optimism that we might avoid some of these mistakes. These initiatives share a conceptual elegance and common lexicon that identify such themes as preventive care, person-centeredness, community integration and comprehensive care coordination as hallmarks of sound behavioral health policy. The advent of Medicaid-funded "Health Homes" and the evolution toward universal Managed Care for even the most vulnerable populations are expected to fulfill the "Triple Aim" of the PPACA to reduce cost, enhance quality and improve outcomes within the healthcare delivery system. It is not unreasonable, however, for one to suspect more prosaic motives underlying these initiatives.

Section 2703 of the PPACA authorizes states to develop Medicaid-funded Health Homes for the management of vulnerable populations, generally those with serious mental illness or chronic or comorbid physical health conditions. These populations have historically received few preventive care services or relied heavily on costly inpatient or emergency care to

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Identifying Gaps in Employment and Vocational Supports

By Vinny Sceri, CPRP
Director of Vocational Services
Search for Change (SFC)

We must frame our services around the individual, not the individual framing themselves around a program. Perhaps that's easier said than done. I offer the following insights into this topic and hope to stimulate your thoughts and perspective and perhaps provide a foundation for understanding on how imperative "work" has become for those who are challenged daily with mental health issues.

As committed as we are in providing as amenable and efficacious an environment as possible to enhance all opportunities for vocational successes, ultimately it is the responsibility of the individual to achieve. This is challenging enough, but we can agree that sometimes the structure, politics, regulations and mandates in how we accomplish these goals is cumbersome at best. There are times when we may feel frustrated or at a loss for an answer.

Similarly, we would agree for those who have entrusted us with guiding their personal recovery have especially difficult challenges before them. I know for myself, it is easy to become distracted at times from their reality v. mine because 'its my job'. But in actuality, it is so much more.

Can you imagine what an individual coping with mental health issues daily is going through? We struggle at times with getting deadlines met, or writing service plans in a particular way, having our charts pass utilization reviews or audits, simply satisfying all of our "other" duties.

How do you combat this? How do we remain true to our mission, to the choice we have all made to have this profession as our vocation? At the same time, satisfy our professional responsibilities. What do you incorporate in practice to accomplish this? Flexibility, creativity, 'thinking out of the box,' perseverance, consistency and integration of our services and talents are some of the attributes we exhibit and need to exhibit in order to achieve some of the very difficult outcomes we strive to accomplish.

I witness flexibility and commitment on a regular basis as an integral part of the Recovery service system; that's great! One primary reason and / or motivator in remaining focused and diligent in safe guarding this responsibility, is the amazing accomplishments I so often observe from those receiving the supports. To hear the anecdotes and life stories of how a person climbed back from the depths of despair and hopelessness, to a vibrant, talented and contributing life style is all we should need to compel us to persevere. Employment has proven to be a vital part of so many in recovery; sustained recovery; health; hope; and self-worth. It ranks as the number one response to national surveys from those who are in recovery, as the most important value in one's life.

The Recovery and/or Psychiatric Rehabilitation Model, holds as its tenant philosophy, one which embraces person centered planning predicated on the *Skills, Values and Accommodations* an individual possesses and requires.

- Our interventions regardless if they are employment related or not, must facilitate the process of recovery.
- Assisting people in re-establishing normal roles in the community.
- Reintegrating into the community, which to date, work is still the number one survey response from our constituents.
- Identifying and developing personal support networks.
- Recognizing that all persons have the capacity to learn and grow.
- Allowing people to direct their own affairs, including the health related factors.
- Treating people with respect and dignity, eliminating labels and combating stigma wherever you find it.
- Assist individuals with developing achievable and realistic goals, ongoing; emblematic of their values, culture and ethnicity.
- Identify, teach and educate not only the client, but the employer to the strengths and talents that a person possesses. Demonstrating their worth and benefit to hiring such a person.

All of our services both with residential supports, as well as, vocational supports are designed to address the unique needs of each individual, consistent with that person's values and norms. All these things combined are necessary and lend themselves to the enhanced quality of life all people seek: a "piece of the pie" mentality.

Employment is one element in this journey for life, but is one of the most significant. As in the aforementioned section, "work" is still the number one consumer survey result. It encourages and helps protect the integrity of the recovery process. It does so by adding the intangible, human quest to be accepted, purposeful, needed and most of all *normal*.

Has our Current Service System Fallen Short on Delivery?

Since 2003 till today, the emergence of the "one stop shopping" mentality was born. PROS (Personalized Recovery Oriented Services), as well as, sub-contracting with the state clinics and hospitals commenced. In theory and in practice, these types of vocational and clinical services attempt to bridge the "Gaps" that are developing throughout the rehabilitation sector, especially for those suffering with mental health issues. For many, a PROS clinic, offers a more convenient way of surrounding oneself with the services one would need, without having to travel to multiple sites throughout the county or to enroll in multiple programs, etc.

Typically, when government tries to solve problems with large bureaucracy attached, someone is left holding the proverbial bag. Such is true in my observations in these past so many years, because one size often does not fit all.

In Putnam County New York for example, there are many who choose to work and want to work, but they require intensive long term supports on the job site for a very long time; years, in fact. Programs like the Vocational Program at Search for Change, Inc., operate a vocational support service, called Supported Employment. This is a wonderful match for many. However, the regulations and funding requirements attached to that county from the state, those who desire to receive long term supports are forced to go without, unless they are lucky to be eligible to be served through the state clinic and receive potential job coaching. Of course, there is the PROS clinic, which can provide similar support, but may not be able to provide the intensive and long term support necessary, especially on the job site where the real support is needed.

Additionally, programs like the Search for Change program are ACCES -VR (Adults for Continuing Careers and Educational Services - Vocational Rehabilitation) are contracted, whereas the state clinic and PROS are not. This in and of itself is a natural "Gap," because the individualized and intensive supports that ACCES may provide cannot be accessed if you are not receiving services from a ACCES sponsored provider. This has a direct negative impact on the long term work supports I mentioned prior.

In fairness, there are specific agreements between various provider agencies and the other county supports to attempt to provide the long term piece, but these are woefully inadequate.

There are many who have achieved successful and sustained employment and are well along in their recovery, no longer requiring such intensive daily support, but they are forced to consider choices, which limit their ability to continue to grow in the work place, because they are required to attend programs instead. Some have actually lost their jobs as a result.

This is a growing concern shared by many in all levels. Of course, here is where we need to be patient and not give up the ship. We must all continue to track and interview our constituents and advocate appropriately so that perhaps in the near future we will see the enhancements I believe are crucial to meet the needs of all.

The Good News

Shop around and become educated. I truly believe that the vast majority of people in the field are good caring people who want to assist those in need achieve whatever goals they hold for themselves. There are creative ways, collaborations amongst professionals and coordinated efforts to provide the variety of different services needed, which may not be

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Employment, Quality of Life and Recovery

By Cherene Allen-Caraco, BA, QMHP, QDDP, CPSS, CESP, Mental Health Quality Enhancement Specialist, CQL | The Council on Quality and Leadership

The notion that people who experience mental health challenges can and do recover has garnered a lot of attention in the peer, provider and policy making worlds; it is the subject of international research, practice change, and national efforts to reform our mental health system. In part, this reformation is being led by self-advocates who have shared their experience of recovery *despite* the services that they have received and are demanding that systems, organizations and practitioners embrace and utilize a truly person-centered, wellness and recovery-based approach to service provision. In response, many organizations have shifted their mission and vision statements to reflect recovery principles and have highlighted their commitment to promoting recovery in their marketing materials. On paper, recovery sounds good, but what does it actually *mean* and *how* do we do it? These questions are being debated and discussed at various levels within the field of mental health.

Traditionally, our mental health system and provision of services have been designed around the goals of stabilization, functioning and maintenance. Providers, community members, families and peers have been "taught" to have low expectations and that passivity and compliance are requirements for stability. The notion of thriving and healing have not been part of the equation, let alone recovering ones identity, confidence, and life. Through the courage of people who have shared their personal stories, and research validating that recovery can be the expectation, we have learned that services can either enhance or deter the individual recovery process. These pioneers have paved the way for people experiencing mental health and substance use challenges to create a better awareness and prompt fundamental changes in the way mental health is viewed, understood and treated. In short recovery goes well beyond compliance and symptom management and is all about quality of life.

For over four decades, CQL | The Council on Quality and Leadership has worked to understand, define and measure the key ingredients to quality of life from the perspective of people who are striving toward recovery and self-determination. Subsequently, CQL has led the effort to connect theory and practice, providing standards around services and supports that lead to recovery. CQL has developed and internationally implemented the use of Personal Outcome Measures®, a valid and reliable approach to defining and measuring quality of life. The tool looks specifically at 21 indicators and through focused conversations measures whether or not those things are present for people. Throughout the many years of speaking directly with people, learning how they define quality, understanding what helps and what hinders their recovery, CQL has learned that one of the key ingredients is employment.

Nationally, there are 3.1 million adults with mental health challenges who are unemployed (The NSDUH Report, March 25, 2014, SAMHSA). This is despite the fact that most people with mental illness express a desire to work. There are many factors that contribute to this statistic. Among them is the fear of loss of benefits and concern about relapse. Additionally, our historical "readiness approach" to employment that requires people to go through pre-vocational training, be treatment and medication compliant, be sober and deemed clinically ready to work has resulted in a large portion of people with mental health and substance use challenges being disqualified from employment services.

In fact "readiness" does not equate to successful employment. Rather, employment is a path to recovery. Policies such as Employment First initiatives, and approaches such as rapid job search, individualized placement and support and customized employment all have demonstrated effectiveness in improving quality of life and advancing recovery. If people are truly going to move beyond the illness identity and realize their own vocational recovery, we have a lot of work to do to re-educate ourselves and others and assist people in making informed decisions about work incentives. CQL's Personal Outcome Measures® offer information and data to support this shift in thinking. At the individual level, data about outcomes are linked directly to how the organization provides supports and services – person by person. At the organization level, organizations collect, analyze and use this measurement across groups of people ... for both program and organization improvement. CQL looked at 20 years of data and noted that the number of people reporting to have chosen their work was among the outcomes least present – hovering at 40% over the years. Having looked at the data and listened to people's stories, CQL began to dig deeper. We asked "which outcomes best predict achieving lots of different outcomes?" The analysis revealed the following outcomes to have the greatest degree of predicting many more outcomes for the person:

- Exercising rights
- Choosing where to live
- *Choosing where to work*
- Performing different social roles

Organizational efforts to provide supports that increase the presence of these outcomes, can have an even greater impact on recovery and overall quality of life for people.

There are a number of ways to design supports that promote employment and ultimately recovery. Among the advancements that are being made in employment services is the use of Employment Peer Mentors (EPM's) to provide outreach and engagement, share their stories of recovery through employment, and support others to navigate the internal and system barriers that keep people unemployed and in poverty. Among the states pioneering this effort is North Carolina who, as a part of a Department of Justice Settlement, has included the EPM role as a part of all state funded employment services for people with mental health and substance use issues.

As our community of providers and people who experience mental health and substance abuse issues come together, learn from and with one another, and strive toward improved emotional health and wellness, CQL remains dedicated to understanding and ensuring that personal quality of life remains at the forefront of promoting recovery-oriented supports in the behavioral health service system. For more information about CQL, please visit our website – www.c-q-l.org or email us at info@thecouncil.org.

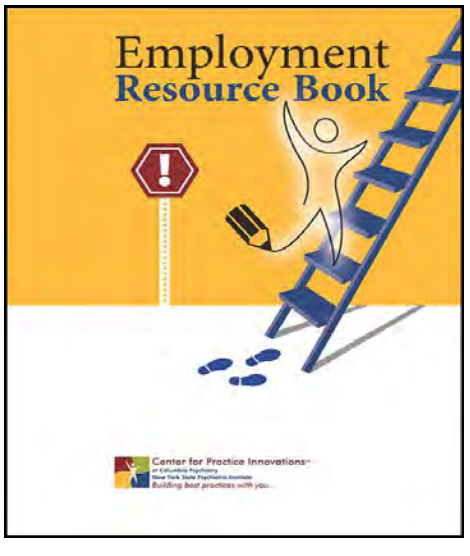
CPI's *Employment Resource Book* – Designed to Help Consumers Achieve their Employment Goals

**By Thomas Jewell, PhD,
Paul Margolies, PhD,
Anthony Salerno, PhD,
Gary Scannevin, Jr, MPS, CPRP,
and Lisa B. Dixon, MD, MPH**

The Center for Practice Innovations (CPI) supports the New York State Office of Mental Health's (OMH) mission to promote the widespread availability of evidence-based practices to improve mental health services, ensure accountability, and promote recovery-oriented outcomes for consumers and families. CPI serves as a key resource to OMH by spreading those practices identified by OMH as most critical to accomplish OMH's system-transformation initiatives.

Improving competitive employment outcomes for mental health consumers is a high priority for NYS, since these outcomes have historically been very low. For example, PROS programs across NYS have routinely reported competitive employment rates of less than 10% of program participants. NYS's experience has resembled experiences reported by other states.

For several years now, CPI has helped PROS programs across NYS to use the Individual Placement and Support (IPS) approach to supported employment. This evidence-based practice is considered the



gold standard; dozens of studies have shown the superiority of IPS compared to other approaches in helping individuals diagnosed SMI achieve competitive work,. CPI has used learning collaboratives to train PROS program employment staff members and to help program leaders with implementing this approach. These learning collaboratives include the use of online training modules, face to face training and consultation, and other resources.

One newly developed resource is CPI's Employment Resource Book. Informed by the principles of IPS, it is designed for use by consumers with employment staff members, other practitioners, peer specialists, with family or friends, and on their own. It consists of 32 topics and 10 appendices that cover important issues during three critical time periods: prior to the job search, during the job search, and after getting a job. The Employment Resource Book will be useful to consumers who:

- Aren't presently committed to working – by helping them to consider employment and engaging them into the job seeking process
- Aren't working but considering work at this time – by helping them to take the steps necessary to find meaningful jobs
- Are competitively employed and planning to stay with my current job at this time – by helping them with problem solving and identifying supports that can be helpful
- Are competitively employed and planning to find another job – by helping them to plan for the next job and consider developing a career path

The Employment Resource Book is not a curriculum that should be completed in order to become job ready. Instead, the consumer selects only the topic(s) that are relevant and that might meet his or her work-related wants and needs at any point in time. Examples of topics include:

- My decision to work
- My hopes and concerns about working
- Talking with family and supports about work
- My personal strengths and job preferences
- Important things to consider about my mental health
- What if I have had legal problems?
- Working and my benefits
- Figuring out what I would like to do for work
- Disclosure and deciding what to say about my background
- Preparing for the job interview—The basics
- How do I explain gaps in my work history? Or having several brief jobs? Or being an older worker?

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The Contract of Your Birth

By Kathy Brandt and Max Maddox
Co-Authors, "Walks on the Margins: A Story of Bipolar Illness"

"It was just before sunrise at the electric blue hour I had come to appreciate in the week since I had given up sleeping," writes Max in the opening chapter of Walks on the Margins: A Story of Bipolar Illness.

Finalist for the Iowa Review Award in Nonfiction, this fiercely candid story by a mother, Kathy Brandt and son, Max Maddox, creates a window into bipolar illness. Says Pete Earley (author of *Crazy*), *Walks on the Margins* will make you angry. It will make you cry. It will also inspire you! Ultimately, it is testament to the unconditional love of a parent and a son's determination to overcome a serious mental illness. Writing in tandem, they have not only told their personal story, but have told the story of thousands of other American families who are everyday heroes."

Max was twenty and a junior in college when he began his manic journey through the small college town of Grinnell, Iowa. He was picked up by the police, transported to the hospital, and diagnosed with Bipolar I. Kathy took him home where soon the other half of manic depression hit him hard.

Kathy Brandt and Max Maddox

Writes Max, "Quick was the rant and rattle of suicidal ideation to snuff out completely any lingering hope for a normal life. The question of how and where I could end the agony soon turned into a habit of minute-by-minute thinking, like the compulsion to open and close a door."

Something had to be done. More mood stabilizers, fewer antipsychotics, a different family of anti-depressants, a new one, a proven one, an experimental one, a conservative one. Slowly Max began to stabilize and returned to college the next semester. A year and a half later while on spring break, Max disappeared in Chicago.

"I feared the worst," writes Kathy, "pictured him sleeping under a bridge, bleeding in a back alley, or laying unidentified in a Chicago morgue. I kept my phone in my pocket and when it rattled against my hip, I prayed someone would tell me Max was okay. The call finally came. Max had been admitted to a Chicago hospital. I told myself he would get through this episode just as he had the last, that his dreams would not be buried under the rubble of manic-depression, that every page studied, paper written, canvas painted wouldn't seem like a lie."

Max had an episode every year after that. He disappeared among the big city homeless, ended up handcuffed in the back of police cruisers, and came within inches of jumping from a shattered eighth floor window in Philadelphia. By the time he was twenty-six, he'd earned a dozen commitments to psychiatric institutions.

For Kathy the homeless pushing grocery carts scrawled with intimations of the second coming became encounters too close to home. She struggled to come to terms with my changing role as parent and confidant. Stymied, bullied, blindsided by doctors, hospitals, and the law. She chased Max's collapsing dreams and feared he wouldn't live through the next crisis.

"I'm so sorry," a doctor once said to her. "Max is never going to get well. He can never live on his own. You'd better start planning for his future."

Kathy could not, would not, accept the prognosis. She is clear-eyed about the illness and its implications, but determined not to fall into the trap of assuming incurable means hopeless. She is deeply involved in NAMI (National Alliance on Mental Illness) and has become a vocal advocate for those with mental illness and their families, imparting the message that, with adequate support, "people with mental illness can and do succeed. They live fulfilled lives, working and developing significant relationships. They engage in the process of recovery, knowing that recovery doesn't mean cure."

Max, too, is realistic about his struggle and knows the invaluable gift of family support. When his mother arrived at his apartment during a bout of suicidal depression, he writes: "And yet, my mom was there with me still, sitting on the bed next to me in my basement cave, when I opened my acceptance letter to graduate school, the application for which she did a wonderful job.

'Thank God,' she and I said in the same breath. She had ushered me back into life once again. What can I say without resorting to cliché? I can't. Really though, you don't have to bring everyone down with you. But, of course, this means not going down at all. And so there is the contract of your birth."

Learn more about Kathy and Max at: www.kathybrandtauthor.com and at www.maxmaddox.net. To order the book go to http://www.amazon.com/Walks-Margins-Story-Bipolar-Illness/dp/0989141403/.

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Developmental Disabilities and Hospitals, the Department of Labor and Training, the Office of Rehabilitative Services and the Rhode Island Department of Education, we are able to look at policies and funding models across these departments and determine how to, more efficiently and effectively, provide employment and day services. We have also created "Advisory Workgroups" that invite our community partners (advocates, providers, consumers, businesses and State and local government) to provide guidance on barriers, gaps, and best practices. Employment First is running parallel to the Housing First work, with similar needs to realign the system to produce the outcomes desired to improve the quality of life that research shows is connected to individuals with disabilities becoming employed. The impact goes beyond increasing income and provides the community connections, self-worth and sense of purpose that is critical to the recovery concept.

In conclusion, I would like to reiterate the fundamental learning from the Department's experience in promoting Housing and Employment for individuals with disabilities. The concepts behind the Building Blocks mentioned above: collaborative planning/consensus-building, (re)investment and leveraging of resources, coordination, streamlining and integration of funding, building provider capacity, quality assurance, research and data, and finally, communication and advocacy, are critical components to structural systems change. True partnerships need to be formed, not simply through memorandums of agreement among organizations, but through building trust and shared values. Data collection is often addressed, however, we must move beyond collecting data and begin to share data and create common indicators and outcomes to ensure we are implementing programs that move the work forward. Bringing the unusual suspects to the table, such as business leaders to housing and housing leaders to employment, promotes collaborative conversations; builds buy in among the necessary parties; and establishes political will. It really does "take a village," and as we begin to expand our network, we bring more resources, expertise and innovation to the table.

There will never be the ideal time to change the system. The days of budget surpluses are atypical; however, there is room in the system for change. We need our leaders to step up, our systems to be permeable and our advocates to push government to bend toward innovation.

Rhode Island's system is by no means the ideal: the unemployment rate is still one of the highest in the country. Housing needs to be elevated to meet the need for affordability of Rhode Islanders, and we are under the spotlight of the Department of Justice. However, we have a plan which entails taking down the silos and working with the grass tops and the grass roots angle to transform our system. The key is to identify the importance of the holistic approach and not allow one issue to be prioritized to the detriment of the other – Housing and Employment are the foundation.

NIMH Director's Blog: A New Research Agenda for Suicide Prevention

By Thomas Insel, MD
Director, National Institute of Mental Health (NIMH)

More than 38,000 Americans died by suicide in 2010, the most recent year for which we have national data. This makes suicide, once again, the tenth leading cause of death for all ages; the second leading cause of death for young adults ages 25 to 34.[1] Despite changes in recent decades that might reasonably have been expected to reduce suicide rates—increased awareness about mental disorders, the availability of treatment, and community-based public health efforts aimed directly at preventing suicide—U.S. rates of suicide deaths have not decreased. In fact, suicide has proven stubbornly difficult to understand, to predict, and to prevent.

This grim reality contrasts with the successes achieved in other areas of medicine and prevention. Death rates from heart disease, cancer, traffic accidents, and homicides are all declining. For heart disease and cancer, research has identified risk factors as well as new pathways to prevention and treatment. Changes in automobile design along with road safety measures have contributed to an ongoing reduction in traffic deaths. Homicides

Thomas Insel, MD

now number less than half the annual total of deaths by suicide in this country.

Why is suicide different? There are a number of public health approaches, from redesigned bridges and buildings to firearm safety, that need the kind of aggressive engineering and policy approaches we have seen with automobile safety. And, learning from heart disease and cancer, we can do better detecting and helping individuals at risk. Despite our best efforts, it remains very difficult to predict who will attempt suicide and, thus, difficult to intervene. The presence of mental illness is a risk factor, but it is not universally present or identified in those who attempt suicide. Treatment can be effective, but too many high-risk individuals are not getting the effective care they need. Suicide remains one of the top five sentinel events (unanticipated events resulting in serious injury or death) for health care systems.[2] To reduce suicide, we need to know how to target our efforts: to be able to reliably identify who is at risk, how to reach them, and how to deter them from acting on suicidal thoughts.

In a blog post last September, I talked about a newly updated *National Strategy for Suicide Prevention* and the research agenda being developed by a task force of the National Action Alliance for Suicide Prevention . This week, the Research Prioritization Task Force (RPTF) released *A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives*.

The stated goal of the *Research Agenda* is to reduce suicides by 20 percent in five years and 40 percent in the next ten (assuming all recommendations are fully implemented). The *Research Agenda* bases its recommendations on the impact of currently known interventions and the potential number of suicide attempts and deaths prevented. For instance, it was estimated that in 2010 there were 735 suicides from motor vehicle carbon monoxide inhalation.[3] One model illustrated the hypothetical effect of shut-off devices in cars linked to carbon monoxide sensors, a technology that could be inexpensive per vehicle and is currently feasible. The results suggest that installing devices the way we install seat belts could prevent most suicides from carbon monoxide poisoning in automobiles.

What are we doing to jumpstart this agenda? Two new initiatives will focus on priorities of the *Research Agenda*. First, NIH recently announced funding opportunities calling for research on violence with particular focus on firearm violence. This call for proposals was developed in response to the Presidential memorandum in January 2013 directing science agencies within the U.S. Department of Health and Human Services to fund research into the causes of firearm violence and ways to prevent it. The resulting research will help us understand the risk factors for firearm violence and prevention opportunities, directed at self as well as others.

In 2010, suicide was the third leading cause of death for adolescents. It remains a challenge to predict individual risk, and

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Suicide in the Military: Army NIH-Funded Study Points to Risk and Protective Factors

By The National Institute of Mental Health (NIMH)

The largest study of mental health risk and resilience ever conducted among U.S. military personnel today released its first findings related to suicide attempts and deaths in a series of three JAMA Psychiatry articles. Findings from The Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS) include: the rise in suicide deaths from 2004 to 2009 occurred not only in currently and previously deployed soldiers, but also among soldiers never deployed; nearly half of soldiers who reported suicide attempts indicated their first attempt was prior to enlistment; and soldiers reported higher rates of certain mental disorders than civilians, including attention deficit hyperactivity disorder (ADHD), intermittent explosive disorder (recurrent episodes of extreme anger or violence), and substance use disorder.

"These studies provide knowledge on suicide risk and potentially protective factors in a military population that can also help us better understand how to prevent suicide in the public at large," said National Institute of Mental Health (NIMH) Director Thomas R. Insel, M.D. NIMH is part of the National Institutes of Health.

Although historically, the suicide death rates in the U.S. Army have been below the civilian rate, the suicide rate in the U.S. Army began climbing in the early 2000s, and by 2008, it exceeded the demographically matched civilian rate (20.2 suicide deaths per 100,000 vs. 19.2). Concerns about this increase led to a partnership between the Army and the NIMH to identify risks.

The articles reflect different strategies to evaluate information on suicide risk and potentially protective factors. An article by lead author Michael Schoenbaum of NIMH examined the suicide and accident death rates in relation to basic sociodemographic and Army experience factors in the 975,057 regular Army soldiers who served between Jan. 1, 2004 and Dec. 31, 2009. This study found that the suicide rates increased during this time period, even among those who had never deployed, and also found that being deployed increased suicide risk for women more than it did for men. However, suicide risk still remained lower for deployed women than for deployed men. Additionally, the study identified a correlation between demotion and suicide risk: soldiers who had been demoted in the past two years experienced increased suicide risk, compared to those without such demotions. There was also increased risk in soldiers without at least a high school diploma or a GED certificate, compared to soldiers with similar or higher degrees. The data suggest that being male, white, or a junior enlisted rank put individuals at the highest risk of suicide.

The second article, by lead author Matthew Nock, Ph.D., at Harvard University, Cambridge, Mass., explains the findings from a survey of more than 5,000 non-deployed soldiers, designed to shed light on suicidal thoughts, plans, and attempts before and after entering the Army. Recruitment interviews revealed that 13.9 percent of soldiers considered suicide at some point in their lifetime, 5.3 percent made a suicide plan, and 2.4 percent attempted suicide, with between 47 to 60 percent of these outcomes first occurring prior to joining the Army. Researchers found that soldiers attempting suicide appeared to be lower-ranking, enlisted, female, and to have been previously

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Disclosure: The Right Decision?

By Kathy Burns, Employment Coordinator, Human Development Services of Westchester, HOPE House

I work with individuals diagnosed with a mental illness, as an Employment Coordinator at HOPE House. Not only am I challenged in this economy with assisting our folks with finding the "perfect job," but also help them decide if disclosure about their disability would be beneficial. I always tell my clients that it is a personal choice, and I try to guide them to make the best decision in meeting their individual needs. I also advise them that if they do choose to disclose, it is confidential information which cannot be shared with other staff, unless some accommodations are needed.

When reviewing the type of work an individual wants, it is really important to understand the expectations and requirements for that chosen field. If one of my clients chooses to disclose, then they also need to decide at what point they would like to discuss it with their employer. Some individuals I work with like to bring it up during the interview, which creates a level of comfort for them in case anything comes up during the time they are employed. They may also like to have a job coach on site to help learn and perform the job as mapped out by their job description. Another option for disclosure is after the individual is offered the position and working, and this alternative may first help the client prove their abilities to the employer.

Disclosure can be a very forbidding decision for a client to make, taking the risk of being accepted for who they are and not being stigmatized by staff for revealing their disability. I applaud all of those individuals who make the choice to find employment and better their lives. To disclose or not to disclose is one of those life decisions which we as helping professionals can point out both the pros and cons, and try to guide our clients in making the best decision for them. We also need to continue to educate our employers about mental illness and how our clients can become some of their best workers if only given that opportunity.

HOPE House and Employment

By Paulus March Jr., Client Human Development Services of Westchester, HOPE House

I joined HOPE House and became a member in 2011. It is a social club, but I was surprised to find out that it also offers employment services. Kathy B., is the employment coordinator and she was a big help. Through her hard work I was able to find suitable employment.

The process of getting a job was a journey. Though it took a long time, Kathy promised it would happen. First, I had to make sure I became stable on my medications. I was experiencing symptoms (mania etc.) which made it difficult to fully operate at work. After that, then my ACCES-VR case was opened again. I was then assigned a vocational counselor to develop my employment plan. Over a lapse of time ACCES-VR referred me to Goodwill for a job evaluation to see if I was ready for work. Kathy finally helped me to start looking for a stock clerk job. It came to pass that I was hired at Joyce Leslie, a women's clothing store where I met George my new boss. I was excited when I finally was hired, especially since Kathy helped me adjust to the job.

HOPE House offers many services, but I am glad they offer vocational opportunities. Kathy B. even runs a job club group. It doesn't matter how long you haven't been working you can find suitable work. Since I have a job now I have been able to cope better with my symptoms.

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wanted this opportunity to continue with inpatients very much indeed.

As of March 12th, 2014, I've been working for HHC Central Office for one year. One year of a job I love, a job that gives me as much as I strive to give our clients. Probably more. The personal evolution rooted in this job is a deeply appreciated, ongoing gift.

These days, I also get to go home to a new apartment, in a location that assists me in building a good record of work attendance and being on time.

On March 25th, I told some group members that I'd been staying healthy and out of the hospital for exactly ten years that day. There were no better people to grin with, no individuals I would rather have shared this with.

After work I went home to supportive housing. I hung up my suit. I put my work materials away. I ate some dinner. I slept in safety and privacy. The alarm was set for work the next day. A home, a career, a miracle.

Overcoming the Stigma Of Mental Health in Housing

By Camille Webb, Assistant Director of Housing, The Guidance Center of Westchester

The stigmatization of mental illness continues to be the primary and most significant problem facing participants who are in search of affordable housing options. Persons with mental illness have long experienced stigma from society impacting their pursuit of employment opportunities, housing, adequate health care, and accessing community resources to name a few. Individuals with serious mental and persistent illnesses require a wide array of services, yet they face enormous hurdles in obtaining access to these services, resulting in poor life outcomes. Stigma and discrimination towards people with mental illness is existent and widespread throughout our society; however, until stigma is properly defined, it may be difficult to approach or decipher the problem. For this reason, the continuing social stigma attached to mental illness is one of the biggest obstacles housing providers face when helping their residents find and secure a permanent home.

What is Stigma?

Although there are many definitions to describe stigma, a common theme is the idea that it is a negative judgment based on a personal trait, or a display of social unacceptability against a person or particular group perceived to be outside the mainstream. It was once a common perception that having a mental illness was due to some kind of personal weakness. We now know that mental health disorders have a biological basis and can be treated like any other health condition. Even so, there is still a long way to go to overcome the many misconceptions, fears, and biases people have about mental health.

Stigma can be displayed in many ways from subtle, for example, assuming that one could be violent or dangerous because they have a mental health condition, or in a flagrant manner by explicitly denying the provision of services because of their race or nationality. The consequences of stigma in a mentally ill person can be devastating and is sometimes the primary barrier to the achievement of wellness and recovery as well as full social integration. Feelings of anger, frustration, shame and low self-esteem as well as discrimination at work, school, and in other areas of a person's life leads to a feeling of hopelessness. The prevalence of mental health stigma seriously undermines an individual's ability to get the help they need because of their fear that their confidentiality will be violated or fear being ridiculed by society.

Throughout our society, people from different ethnic, cultural, and racial backgrounds have been influenced by stereotypical biases and misconstrued perspectives consequently displaying harsh stigmatization towards the field of mental health. Without knowing it, people interact on a daily basis with individuals who are living productive lives while managing their mentally illnesses. However, it is the few that are not engaged in treatment, homeless, and exhibiting psychotic symptoms that are stereotyped and profiled as what represents mental illness. As a result, people with mental illness face many challenges such as exacerbated symptoms as they struggle to create a balance in coping with their diagnosis and the fallacies and misconceptions that society has about their illness.

The Impact on Housing Opportunities

In the area of wellness, research has shown that having a stable home is an important component in the life of a mentally ill person. It is not uncommon for individuals with serious and persistent mental illnesses to face difficulty when pursuing affordable housing options. Many live below the poverty level and cannot afford fair market rent. In addition some do not have the capability to negotiate leasing contract or navigate the system of obtaining housing. Consequently they are forced to live in substandard conditions exposing them to unsafe surroundings and high risk behaviors.

During the last twenty years, the emergence of supported housing programs became a key undertaking in offering affordable housing and social support for individuals with psychiatric disabilities. However, in an effort to maintain inequality in housing, stigma has been used to justify the underprivileged position of certain groups within our society. In the county of Westchester, New York, housing providers such as The Guidance Center of Westchester located in Mount Vernon, works incessantly to provide optimal housing services to individuals who are disabled. However, while dealing with their disability is a constant battle for those who are diagnosed with mental illness, the fight for housing equality is unending for both the housing participant and the housing providers. All too frequently, providers encounter barriers such as: landlords and some neighborhoods refusing to provide service to individuals with disability, landlords often refusing to accept subsidized rent payment, overpriced rent barring providers out of particular jurisdictions, low vacancy rates, and poor housing conditions due to limited financial resources. While many housing providers have partnered up with

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benefit amount when returning to work.

2) Affordable Housing: For many formerly homeless people, stable housing has served as a springboard from which to take steps toward competitive employment and increased self-sufficiency. Since the 1980s, New York City has been at the forefront of developing supportive housing for people who have been homeless and have a mental illness. DOHMH oversees thousands of units of supportive housing, working with each provider to help tenants achieve their goals.

Staff in supportive housing face many demands and understand that helping people pursue employment is a process that can be complicated and time consuming. To support housing providers to help tenants gain employment, DOHMH works with its 200 supportive housing programs to educate staff about the impact of employment on tenants' benefits. We have trained staff in 50% of the programs, and will continue until all programs have the capacity to help residents with employment and benefits. To provide ongoing support and information, we also created and disseminated a toolkit for housing providers.

3) Supported employment can help people to navigate employment challenges and gain competitive work. There are a host of challenges related to securing employment. For example, if an individual with mental illness leaves the workforce for periods of time due to illness, they may have to choose between appearing to be an unreliable employee who leaves without warning for periods of time or disclosing their illness and facing the potential stigma.

DOHMH oversees a portfolio of Assisted Competitive Employment (ACE) programs that provide supported employment services to obtain and retain jobs at or above the minimum wage. The goal of these programs is long-term competitive employment; DOHMH is currently transforming the reimbursement of these services to "pay-for-performance" where providers will be paid according to how many people they place in jobs and how long they retain them. This major change will occur this July.

4) Finally, we are deeply invested in integrating peers into the workplace and expanding the peer workforce in New York City. Hiring individuals with lived psychiatric experience is critical to changing the paradigm and making all services – housing, employment and everything else we do, a more responsive and successful system. Through Parachute NYC, a crisis intervention program and NYC Start which facilitates young adults experiencing their first psychotic break to reintegrate back into the community after hospitalization, we have created more than 65 peer positions. Our annual spending on peer services is $20 million and growing. With a trained peer workforce and fair payment structure for their work responsibilities, peer-delivered services will be successfully integrated into all facets of service delivery.

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College Drinking Facts

By The National Institute on Alcohol Abuse and Alcoholism (NIAAA)

College Drinking

Virtually all college students experience the effects of college drinking – whether they drink or not. The problem with college drinking is not necessarily the drinking itself, but the negative consequences that result from excessive drinking.

College drinking problems

College drinking is extremely widespread:

- About four out of five college students drink alcohol.
- About half of college students who drink, also consume alcohol through binge drinking.

Each year, drinking affects college students, as well as college communities, and families. The consequences of drinking include:

- Death: 1,825 college students between the ages of 18 and 24 die each year from alcohol-related unintentional injuries.
- Assault: More than 690,000 students between the ages of 18 and 24 are assaulted by another student who has been drinking.
- Sexual Abuse: More than 97,000 students between the ages of 18 and 24 are victims of alcohol-related sexual assault or date rape.
- Injury: 599,000 students between the ages of 18 and 24 receive unintentional injuries while under the influence of alcohol.
- Academic Problems: About 25 percent of college students report academic consequences of their drinking including missing class, falling behind, doing poorly on exams or papers, and receiving lower grades overall.
- Health Problems/Suicide Attempts: More than 150,000 students develop an alcohol-related health problem and between 1.2 and 1.5 percent of students indicate that they tried to commit suicide within the past year due to drinking or drug use.

Preventing Drinking in College

Research strongly suggests that prevention strategies geared towards specific groups and used in combination with each other can help reduce the frequency and quantity of college drinking. These groups include:

- Individual students
- Student body as a whole
- College and surrounding community

Learn more about College Drinking at http://pubs.niaaa.nih.gov/publications/CollegeFactSheet/CollegeFactSheet.pdf.

HUD from page 12

they can be used to support affordable and integrated housing opportunities for individuals with disabilities. HUD's resources include tenant-based housing vouchers, public housing, subsidized/assisted housing developments, and community development block grant funding, among many others. In addition, all recipients of federal financial assistance from HUD have the obligation to administer programs and activities in the most integrated setting appropriate to the needs of individuals with disabilities.

As part of its efforts to support *Olmstead's* implementation, HUD is working with housing providers, states, and its federal partners to better align policies and practices in the creation of new housing to meet the needs of individuals with disabilities. As an example, HUD is encouraging public housing agencies to partner with State and local governments to provide additional community-based, integrated housing opportunities for individuals with disabilities transitioning out of, or at serious risk of entering an institution. Further, to assist states and housing providers, in 2009, Congress appropriated funding to HUD's Housing Choice Voucher program specifically targeted to individuals with disabilities to help them more quickly transition from an institution to the community. HUD is also allowing grantees, in certain cases, to implement preferences to individuals with disabilities who are transitioning out from or are at risk of entering an institution.

see HUD on page 47

Suicide Prevention from page 37

once a young person screens positive for suicide risk, there are few, if any, strategies to guide matching of individuals to the appropriate intervention. As a second initiative, NIMH released a request for applications to support research that addresses both issues: developing and testing screening approaches for use in emergency departments (EDs) to identify children and adolescents at risk for suicide; and developing methods to help assign youth who screen positive to appropriate interventions. Given the numbers of young people who may be at risk, and the high number of them who visit the ED, developing effective screening and assessment approaches to gauge the level of risk can give providers the tools they need to better use limited resources.

A friend who lost his son to suicide told me that every suicide has at least 11 victims: the person who dies and at least ten others who will never be the same. This is a problem that sooner or later, unfortunately, touches us all. Developing the *Research Agenda* was a 3-year effort by the RPTF, chaired by Phillip Satow, chair of the board at the Jed Foundation, and myself. The RPTF called on more than 60 national and international research experts and more than 700 individuals representing stakeholders in this research to identify priorities. We believe the *Research Agend*a gives us a roadmap to save lives.

Read Dr. Insel's Blog on the NIMH online website: www.nimh.nih.gov/about/director/index.shtml.

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Homelessness from page 31

vehicle. He spends part of his free time engaging homeless veterans who can benefit from some guidance from one who has been there.

Another veteran celebrated his 42nd birthday this month with his 16 year old daughter in his two-bedroom condo that he rents through HUD VASH. His daughter attends high school and she is doing well in school for the first time in years. He began a self-designed weight loss plan in November, has lost 15 pounds, and recently decided to start using the gym at his condo complex to get back into shape. He has been adding "decorative touches" – artificial flower arrangements, framed pictures, candles, and a blue and white runner for his dining room table – to his new home for the last month. He's saving for a washer and dryer; a car for his daughter is next. He planned and enjoyed cooking holiday meals at Thanksgiving and Christmas time, and served his Concern case manager his "special" brewed tea on Christmas Eve. Despite suffering from severe anxiety, he is happy, feels secure and safe in his home and is starting to venture out to public places after being a virtual hermit for several years. He has recently begun receiving financial compensation from the VA for his service-related disabilities, and combined with his social security disability benefits earned during all the years he worked as a truck driver, he has a monthly income sufficient for his needs.

Ending Veteran homelessness on Long Island will take a concerted effort using all of the resources available in the best manner possible. We are determined to work with our partners to help make this happen.

Photos Below:

Photo #1: 60 units of housing for homeless veterans in Amityville will open in mid-2014.

Photo #2: In cases where finding rental housing for veterans with VASH vouchers proved difficult, Concern purchased sites and is renting them to the veterans.

Photo #3: Adjacent to the 60 units of housing that Concern is developing will be a large Community Center where a number of non profits will provide support services to homeless veterans.

#1


#2

#3

Supportive Housing from page 6

Substance use disorders programs have extensive experience with outreach, motivational counseling, and successful referral to health and social services, especially with homeless people and individuals with histories of criminal justice involvement. These agencies are uniquely situated to provide transitional housing and supports to persons recently discharged from inpatient surgical or medical services. Many of our intensive residential programs have on-site Article 28 primary care clinics and many of our upstate community residential services providers have strong partnerships with hospital and community health center primary care and specialty service clinics.

Peers in recovery are increasingly used in work with persons in treatment or early recovery in community-based health care settings. Peer advocates, Recovery Coaches, and Health Navigators can make a significant contribution to supportive housing residents as they get jobs and become fully integrated into the community.

ASAP strongly supports the inclusion of Supportive Housing programs as an integral component to Medicaid Redesign and Health care transformation. ASAP is convinced that "Supportive Housing Builds Recovery" for individuals, for families, and for communities that have been battered by substance use, homelessness, and lack of economic opportunities.

Dignity from page 14

becoming homeless and hospitalized, Felicia started living at the Riveredge Community Residence and attending FEGS Bronx PROS program in March of 2013. Her participation in ISTP proved to be integral in her recovery. Felicia took pride in her kitchen assignment. Felicia approached her assignment with zeal and was always on time. She made great progress during her stay and in the fall of 2013 was ready to seek greater independence. Working with staff, she completed her resume, conducted research on job opportunities and applied to several companies. She was selected for an interview with Macy's and successfully obtained a job working in the housekeeping department. Felicia also transitioned to a more independent living situation, moving into FEGS Manhattan Apartment Treatment Program. She is very focused on her recovery and she continues to do everything possible to ensure that she is on the right track.

By leveraging employment resources for people with serious mental illness, FEGS is promoting the culture of work as integral to recovery and leading a fulfilling life.

Gerardo Ramos, is Assistant Vice President of Community Residences and Homeless Services; Martin Sussman, is Assistant Vice President of Specialized Housing; Ellen Stoller, is Assistant Vice President of Professional Development and Consumer Affairs; and Jerold Scott, is Senior Director, of Data Analysis at FEGS.

Gaps from page 33

available at the "one stop shop." Hopefully, the powers that be will recognize these growing "gaps" and fill them with adjunct services meeting the direct need of those who just want to work!

If I have fashioned any concepts or perspective to recovery services, then I have achieved a modest level of success and purpose to sharing my experiences.

Every day I learn something about recovery, how important work is, as well as, the need for independence from the very people I am humbled to be entrusted to serve. It is inspiring and motivating. I hope this is your experience as well.

NYSPA from page 20

Q: Parity mental health benefits for New Yorkers are based on our state's Timothy's Law and on the federal Mental Health Parity and Addiction Equity Act. The latter relies to a great extent on state level enforcement. What role do you envision OMH playing in assuring 'parity' for New Yorkers either directly or in collaboration with other state agencies?

A: It is critical that OMH does all it can to ensure parity in mental health treatment for all New Yorkers. Our regional offices play an important role in keeping

see NYSPA on page 43

Older Adults from page 8

people with psychiatric disabilities leave adult homes.

- In addition, as OMH's housing system has grown over the past decade by approximately 5000 beds, both the number and proportion of adults 65 and older has grown from about 1350 (5.6%) to 2100 (7.1%).[2]

- In addition, all OMH housing programs have been encouraged to develop wellness programs and pay more attention to the health of their residents.

- And, NYS's Medicaid reform efforts include recognition of the importance of stable housing for people with disabilities.

However:

- It is not clear how many older adults, especially older adults with physical as well as psychiatric disabilities, will benefit from additional supported housing for people now in adult homes.

- Despite the increasing numbers of older adults in mental health housing, older adults are under-represented—less than half of their proportion of the population. This may reflect the fact that people with serious mental illness sometimes experience recovery over the course of their lifetime. Or it may reflect the facts that they are likely to die younger than the general population or that they tend to shift from the mental health system into the long-term care system as they develop physical disabilities. Still, it is striking that older adults are nearly 15% of the population of NYS but just over 7% of the population in residential care in the mental health system.

- Despite the increasing number of older adults in mental health housing, there has been no increase in the number of beds specifically designed to serve older adults (less than 10% of the beds occupied by older adults.)

- According to the Association for Community Living (ACL), no additional resources have been provided to support on-site wellness programs and increased attention to physical health.

- ACL also reports that even the residential programs specifically designed for older adults generally struggle to respond adequately to the chronic physical disorders that are increasingly common as people age, because resources are not built in to do this.

- ACL has long argued that a higher level of care needs to be put in place to meet the needs of older adults with co-occurring psychiatric and physical disabilities within the mental health system.

- It is also worth noting that the growth of 5000 beds over the past decade is well below the 35,000 additional units of housing that The Campaign for Mental Health Housing identified as needed in 2004.[3]

- Despite recent recognition in New York State of the importance of providing stable housing for the people who are likely to be the most costly Medicaid cases—usually people with co-occurring, severe, physical and behavioral disorders, it is not at all clear that housing being developed as part of Medicaid reform will be of much help to older adults with psychiatric disorders. The Requests for Applications (RFAs) to establish housing for "senior supportive housing" [4] and for "nursing home to independent living supportive housing" [5] released in March *do not mention people with psychiatric disabilities*. Since a considerable number of seniors in and out of nursing homes have both physical and mental disabilities, some older adults with psychiatric disabilities might qualify. Whether there would be appropriate design is another question.

- In addition, the funding for new housing units coming out of the recent RFAs is remarkably small. $250,000 per year for two years with no refunding for eight supportive housing projects and $2 million per year for two years with no refunding for two nursing home transition housing projects. This is not very encouraging given the rapid growth of the elder population over the next quarter century.

- Despite the fact that thousands of older adults with psychiatric disabilities live in adult homes, nursing homes, supportive housing, and prisons, so far as I know no one has gathered meaningful data about their numbers, where they are, how they are treated, and what changes are necessary so that they get humane and clinically appropriate care as well as a real opportunity to live where they would prefer in the community.

So, it appears that there has been a bit of progress since 2008 when the Geriatric Mental Health Alliance pointed out vast need to enhance housing for older adults with psychiatric disabilities. But it also appears that that progress has been exceedingly limited.

For both humane and economic reasons, we need to find out whether Medicaid reform and other efforts to "transform" the physical and behavioral health service systems are responsive to the housing needs of older adults with psychiatric disabilities. And we need to know before the elder boom is so far advanced that there will be no possibility of catching up with it.

This is exactly the sort of issue that The NYS Geriatric Mental Health and Chemical Dependence Planning Council should take up. Hopefully, they will make it their business to identify the extent and nature of the need and then develop a plan so that older adults with psychiatric disabilities will have adequate community housing before it's too late.

Michael Friedman retired as Director of the Center for Mental Health Policy, Advocacy, and Education in 2010. He continues to write frequently on mental health policy issues. His writings are collected at www.michaelbfriedman.com. He can be reached at mbfriedman@aol.com.

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Military from page 37

deployed. Certain pre-enlistment mental disorders, including panic disorder and post-traumatic stress disorder, linked to increased rates of suicide attempts after joining the Army. In fact, approximately one-third of post-enlistment suicide attempts tied back to pre-enlistment mental disorders. Pre- and post-enlistment mental disorders accounted for 60 percent of first suicide attempts in the Army. The soldiers' pre-enlistment patterns of suicidal thoughts and behaviors remained lower than suicidal thoughts and behaviors reported by a demographically matched civilian group. However, once in the Army, the onset of suicidal thoughts and planning became more common than among comparable civilians. Both groups had similar rates of suicide attempts.

The last article, by lead author Ronald C. Kessler, Ph.D., at Harvard Medical School, Boston, Mass., describes a comparison of the same set of non-deployed soldiers and a group of similarly aged civilians. Rates of common mental disorders in the U.S. Army are compared with a demographically-matched civilian population from the National Comorbidity Survey Replication, a national household study that assesses mental disorders. The Kessler study estimated how common certain mental health disorders are among Army soldiers, and whether the disorders developed prior to entering the Army. The most common disorders in soldiers included ADHD and intermittent explosive disorder. Almost 85 percent of those who self-identified as having had a mental health disorder reported that the problem began prior to joining the Army. For some of the disorders—including ADHD, intermittent explosive disorder, and substance use disorder—an early age of onset occurred more among soldiers than in civilians. The study also looked at role impairment, which is whether the disorders seriously affected the soldiers' home life, work performance, social life, or close relationships. Severe role impairment was found to be substantially more common among soldiers with a mental disorder, than those without.

Although the root causes for the rise in Army suicides still remain unknown, these three studies point to risk factors, which may help identify potential protective factors, focus existing prevention programs, and foster the development of novel efforts to reduce suicide and suicidal thoughts and actions among service members at higher risk.

The Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS) is funded by the U.S. Army and the National Institute of Mental Health. The study is led by co-principal investigators Robert J. Ursano, M.D. (Uniformed Services University of the Health Sciences), and Murray B. Stein, M.D., M.P.H. (University of California, San Diego), with site investigators Steven G. Heeringa, Ph.D. (University of Michigan), and Ronald C. Kessler, Ph.D. (Harvard Medical School), and with collaborating scientists Lisa J. Colpe, Ph.D., M.P.H. (NIMH), and Michael Schoenbaum, Ph.D. (NIMH). Contact us at <http://www.armystarrs.org/media_room>

The mission of the NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. For more information, visit <http://www.nimh.nih.gov>.

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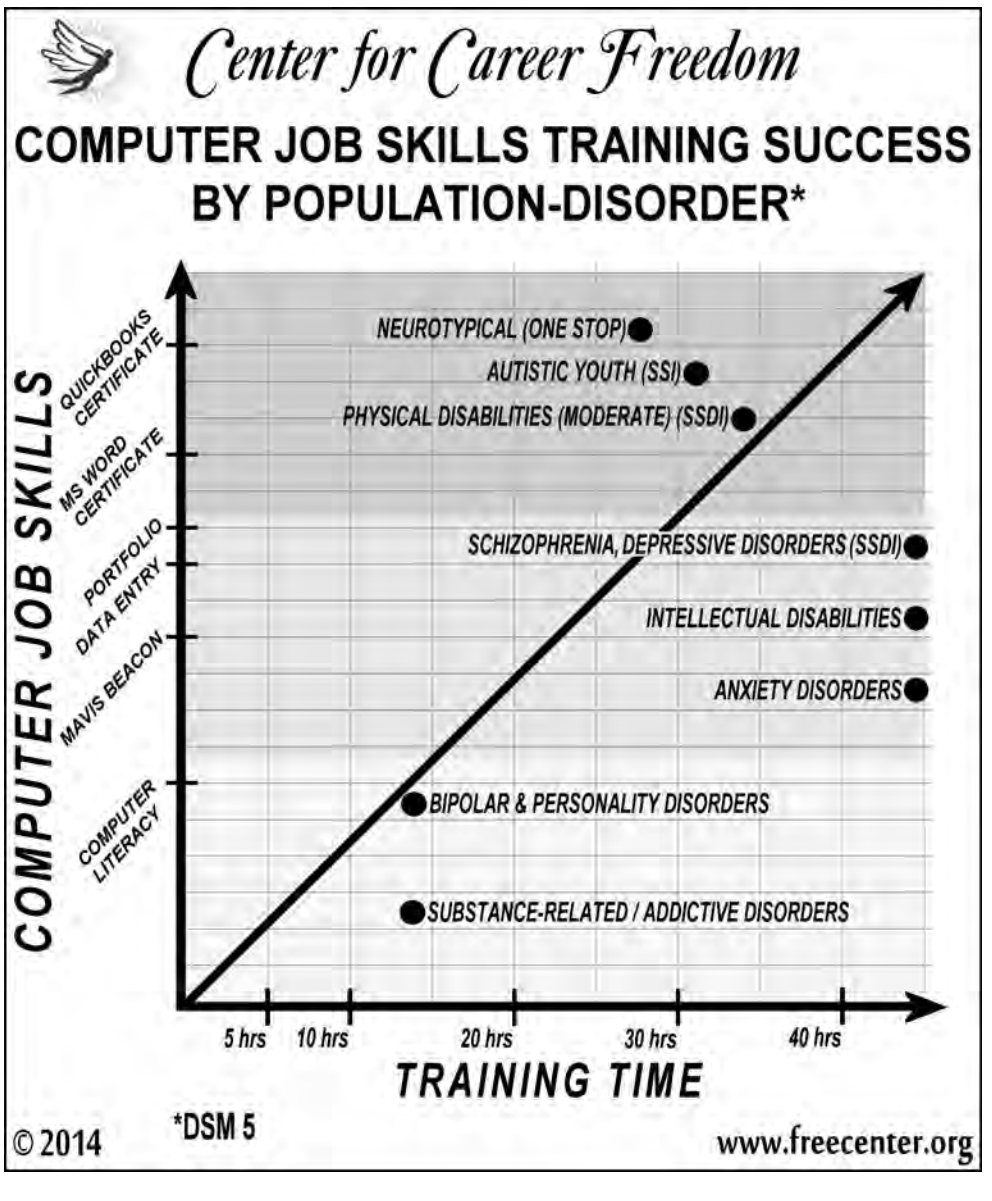
NYSPA from page 42

an eye on the system of care and alerting us to any possible parity violations. We will work with all the appropriate state agencies and the community to make sure parity is real.

In closing, I thanked Dr. Sullivan for making time for our interview and took the opportunity, on behalf of her colleagues and all New Yorkers, to wish her every success in her new position, as her successes would benefit all of those in our state confronting the challenges of recovering from mental illness.

Dr. Perlman is the Director of the Department of Psychiatry at Saint Joseph's Medical Center in Yonkers, New York and a past president, New York State Psychiatric Association.



Service Model from page 18

hope and recovery and when people across New York have access to and choice among the supports and services that fosters self-determination for living, working, learning and participating fully in their communities."

As treatment services evolve to support individuals within their communities, we are developing housing and outpatient services that complement and extend the efficacy of residential treatment. Our evidence-based services provide a continuum of care proven to offer the best return on investment as measured by reduced recidivism, emergency medical visits, and shelter stays.

In its mission statement OASAS endorses "nonprofit-operated affordable housing, supported by on-site services … (as) the means by which New York State is able to give hope to individuals, families and communities in recovery." We couldn't have said it better ourselves.

For further information on Odyssey House treatment and housing services, please speak to an Admissions Specialist by calling: 212-987-5100, or send us an email at: info@odysseyhouseinc.org.

Seven Tips from page 30

Beacon Typing System.

5) The Jobs are Hiding in Plain Sight: In Westchester County, New York, the non-profit sector; private hospitals, clinics, colleges, schools, social service providers, museums, etc. account for over fifty-thousand jobs, more than local government (49k) or retail trade (48k) (Non-profit Westchester, March 2014). While most of the non-profits have experience with the populations we all serve, we have found many do not employ more than a token of their own clients. This sector is drowning in government mandated paperwork and offers a growing opportunity, for folks with Computer Job Skills.

6) It's Bottom-Up Not Top-Down: Fear of failure stops many Providers & schools from trying something new. They wait for a multi-signature memo from an official source before acting. They believe innovations must come from above. Better to be safe than sorry.

Sadly, none of our disruptive innovations in job skills training came from official sources – they all sprung from the trenches of direct care in response to the student's needs. They taught us how they like to learn. Our challenge was to find the courage to pilot test a "flipped classroom", "peer instruction", "comic book curriculum", "employer-defined content", "personnel space", remote training via SKYPE, etc. (a small computer "learning lab" can be an inexpensive and "safe" place to observe your students/clients skills).

7) *The SSI Earning Cap is Not a Myth:* Social Security deducts one-half of all gross earnings over $85/month from the checks of recipients of SSI (Not to be confused with SSDI). Recipients are virtually all youth with disabilities with little or no work experience. To address this, the Center created an Employment Program where students are paid $8/hr to apply what they have learned to real world work assignments from fellow NGO's; business cards, flyers, Google look up & mailing labels, small mailings, IPad/IPhone Life Skill App Tutorials, peer instruction & Train-the-Trainer, etc.

Help is on the way, Senators Brown & Warren have recently introduced a bill which would help these SSI Recipients by:

- Disallow counting in-kind support as income,
- Raise the allowable assets from $2,000 to $10,000,
- Raise the earned income cap from $85/month to $357/month

Please email your representatives with your support of S2089 & HR 1601. Thank you.

Integrating from page 31

house program and graduated to the supported housing apartment program. Shortly thereafter he was referred to ACCES-VR with East House Career Services support and guidance. He renewed his CDL-B license, started job searching via the ACCES-VR and East House contract services, and is now employed full time and living independently.

Perhaps the most unique education program is the East House Enrichment Program at RIT. Every summer since 1996, Career Services has organized this two-week college experience program at Rochester Institute of Technology. Through the program, 40 East House clients have the chance to experience college life first-hand and determine if school is an attainable goal for them. Every step of the program mimics a college experience, from applying and acceptance, through orientation and class scheduling to fundraising to support the costs. Transportation to and from campus, as well as daily lunches, are provided. A graduation ceremony on the last day with friends, family, treatment team and counseling staff closes the program.

In 2012, Mary was residing at one of the community residential programs that contracts with East House Career Services. Mary was excited to apply for, and be accepted to, the Enrichment at RIT program. She excelled on campus and decided to continue utilizing the offerings at Career Services. After the completion of the Enrichment program, she came to the job readiness classes offered at Career Services, and volunteered at the Paul Wolk Learning Center. She was provided with job search and placement assistance. She is now employed full time as an Office Administrator and part of her position involves supervision of other staff and volunteer personnel.

In October of 2012, East House opened Darn Good Cookie Company (DGCC), its first affirmative business, which provides training and employment opportunities to East House clients while they are living in one of our residential programs. Darn Good Cookie Company makes and delivers cookie arrangements for customers who are looking to send a delicious and unique gift. The cookies can be also ordered for wedding favors, special occasion favors, holiday baskets, birthday parties, or thank you gifts to corporate customers. East House clients are involved in every portion of the daily operations: taking customer orders over the phone or internet, baking, cleaning, inventory, delivery assistance, decorating and arranging baskets. Since its inception, eighteen clients have worked at Darn Good Cookie Company.

The Career Services program has changed and grown over the last 25 years and currently provides a greater number of services to more clients than at any time in the past. One thing hasn't changed, and that is our commitment to providing person-centered goal planning and vocational rehabilitation to individuals in recovery. The partnership between the residential treatment staff, and the vocational staff, has proven to be effective in the success of our clients. East House strives to meet the whole needs of the person, and move lives forward to independence.

Resource Book from page 35

- Dealing with my concerns when I'm starting a new job
- Contacting supports when the job becomes challenging

Examples of appendices include:

- Basics of benefits counseling
- Sample resumes
- Interview tips
- Starting the new job and preparing for the first day of work
- Using supports

Each topic has three parts:

- *Important information:* Each topic contains several "Important Information" sections that introduce the topic and provide important facts for thought and discussion.
- *Personalized activity:* After many of the information sections, the individual will be presented an activity to help her/him think through the information and how it applies to her/his life. Activities may consist of worksheets, checklists, questions for consideration, or other exercises.
- *Next steps:* This section allows the individual to decide on next steps for moving closer to the employment goal.

We believe that this resource will inspire and empower consumers to pursue competitive employment, as well as help them to keep a job once they have obtained it. It will be especially useful to consumers who aren't presently committed to working, helping them to consider employment and engaging them into the job seeking process.

You can obtain the Employment Resource Book through the CPI website (http://practiceinnovations.org/) by clicking on the "Purchase CPI Products" tab on our home page. You will be asked to register and to select a password for your account. Once your account has been established, you will be able to download an electronic version for free or purchase bound paper copies.

For additional information, contact Paul Margolies at margoli@nyspi.columbia.edu.

Thomas Jewell, Paul Margolies, Gary Scannevin, Jr. and Lisa Dixon are with the Center for Practice Innovations. Anthony Salerno is with New York University.

NYC from page 39

The Way Forward

DOHMH will continue to support affordable housing, competitive employment, and a peer workforce as key elements in promoting recovery and community integration for people with mental illness. DOHMH supports these key elements through oversight and delivery of effective services, advocacy to inform policy change, and training and education for individuals and community-based organizations. Medicaid reform and the imminent reimbursement of mental health rehabilitation services such as supported employment and residential supports are bringing yet new opportunities to incorporate these critical supports for substantial health outcomes and recovery into the health system.

Cornerstones from page 1

housing is one of the cornerstones necessary to build a system of care that truly supports recovery.

The second cornerstone in our efforts to create a holistic and comprehensive system of resources is employment. OMH uses employment as a clinical intervention, a needed step in the journey to recovery. In fact, a recent study from Mathematica Policy Research showed that the use of Medicaid services decreased by nearly 50% for people with disabilities who are working. Additionally, competitive employment provides consumers with more personal freedom and independence through increased income. Employment also provides meaning and purpose, socialization and integration into the community.

One program that our agency operates, Personalized Recovery Oriented Services (PROS), is a comprehensive recovery oriented program for individuals with serious mental illness. The goal of the program is to integrate treatment, support, and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program may include developing needed skills, decreasing unnecessary use of inpatient and emergency room services, reducing contact with the criminal justice system, increasing competitive employment, attaining higher levels of education, and securing preferred housing. The PROS program has become one of our most successful initiatives, as more and more New York residents achieve recovery within the community.

John, a PROS consumer from the Hudson Valley region, experienced some of this recovery first-hand. Four years ago, John had a tough time finding and remaining in a job. He described himself as someone for whom social interactions and relationships were "like a foreign language." Through the PROS program, using New York State's ACCES-VR employment system, he started training to become an electrician at his local Board of Cooperative Educational Services. Through this training he increased his self-esteem, his sense of competence and ultimately his success at his job. In less than two years, John began working part time at a local business, a position he still holds today. He is considered by his supervisor to be an "excellent employee" and is nearing graduation from his electrician training program.

However, John's success story was not a straight path; he frequently struggled with re-emergence of depressive symptoms as well as suicidal thoughts. By continuing to use PROS services, such as clinical treatment and wellness self-management, John has been able to successfully overcome each obstacle in his path to recovery. With the support he needed, John has been able to craft a life for himself that now includes friends, employment and personal emotional growth.

John is now proud of what he has created these last few years, going from "suicidal" to a student and model employee. He has created a life which allows him to take on more and more responsibilities, independently. While his recovery is an ongoing process, he has learned that he possesses the ability to recover and has the support to sustain a happy, healthy life.

It is the goal of the staff at OMH to make it possible for all individuals living in New York State with mental illness to have their own unique opportunity for recovery and success in their lives. We are not there yet but we will continue to work with individuals with mental illness, their families and supporters to make it a reality.

Dr. Ann Marie Sullivan was appointed as Acting Commissioner for the New York State Office of Mental Health on November 18, 2013. Previously, she was the Senior Vice President for the Queens Health Network of the New York City Health and Hospitals Corporation. As Senior Vice President, she was responsible for Elmhurst and Queens Hospital Centers, two public hospitals which serve a community of over 2 million New York City residents.

Along with ensuring the seamless integration and coordination of services across the Network, Dr. Sullivan has aligned and helped to implement key corporate programs such as the Care Management Initiative on the inpatient units and in the emergency services; the development of Breakthrough; the launching of best practices to improve patient safety; and the integration of behavioral health and medical sciences.

Dr. Sullivan grew up in Queens, New York City. She graduated from NYU and its School of Medicine and completed her Psychiatric Residency at New York University/ Bellevue Hospital in1978. She has served as Associate Director of Psychiatry and Medical Director of Ambulatory Care at the Gouverneur Diagnostic and Treatment Center and joined the Queens Health Network as Regional Director of Psychiatry in 1990, overseeing the administrative, budgetary, and clinical aspects of the psychiatric services of both Network hospitals. She has enjoyed an extensive career in public psychiatry and has lectured and published on best practices in community care.

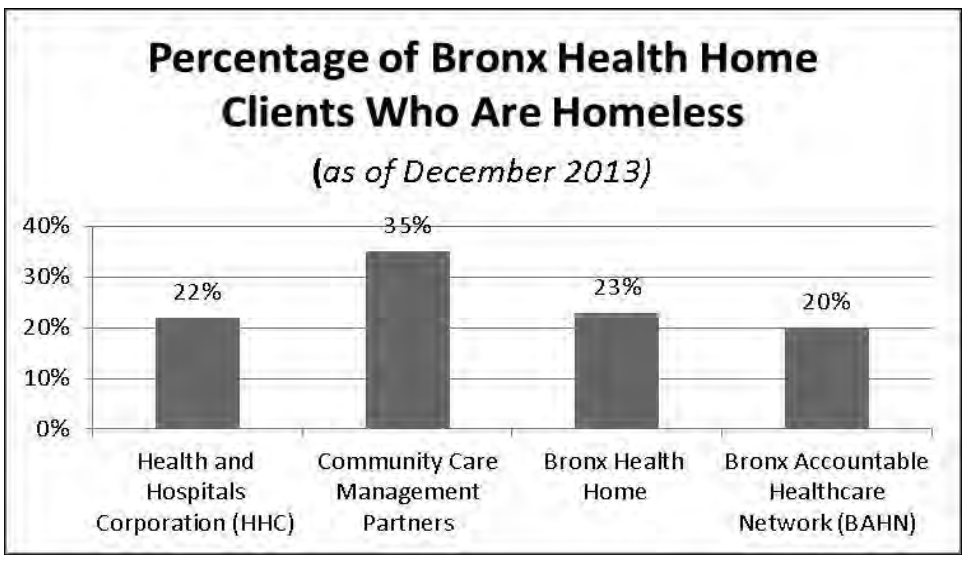
Dr. Sullivan is an active advocate for her patients and her profession, is a Distinguished Fellow of the American Psychiatric Association and has served as the Speaker of the American Psychiatric Association's Assembly and on its Board of Trustees. She is a fellow of the New York Academy of Medicine, a member of the American College of Psychiatrists and the Group for the Advancement of Psychiatry.

Housing Needs from page 12

housed clients, and provide policy and systems change recommendations for strengthening the housing system to meet their needs.

The Bronx Health and Housing Consortium, with assistance from the CSH, collected and analyzed data between December 2013 – January 2014 concerning the obstacles facing Health Home service providers in the Bronx in obtaining housing for their clients. At the annual Bronx Health & Housing Consortium meeting in December 2013, the four Bronx Health Homes reported the percentage of enrollees who answered "Yes" to the NYS Assessment form question: "Are you Homeless?"

As of December 2013, an average of 21% of Bronx Health Home clients were self-reported homeless. At the same Consortium meeting, the NYS Department of Health reported 7,743 people enrolled in Bronx Health Homes. Thus, 21% of 7,743 translates to 1,626 Bronx Health Home participants homeless or unstably housed. Even if the actual need for units is half this figure, there would still be a need for almost 800 units in the Bronx for Health Home participants. Last year, there were about 50 MRT permanent supportive housing units allocated to the Bronx, all scatter-site and for single adults.



Data

We also asked the Health Homes to supply the following data from this sample that identified as homeless: demographics, entitlements, medical diagnoses, service utilization and housing situation. This second data source, which includes information on 428 Health Home enrollees, was collected from three of the four Bronx Health Homes. All of this self-reported data is included in the assessments performed by case managers at the Health Homes. Our final source of data is a select qualitative sample comprised of thirteen case studies completed by Health Home care coordinators. Here, care coordinators were asked to select cases that they believed highlighted the obstacles that they face in their attempts to acquire stable housing for their clients. We use this data to illustrate the work required on the part of care coordinators to support Health Home enrollees with complex needs. All three sets of data were made anonymous before our review.

Findings

Our study found that the Health Home population is both medically frail and facing precarious housing situations. Our demographic snapshot indicates that Health Home enrollees are a diverse group, with varying and complex needs that are not currently being met. The median age of our Health Home enrollee is 48 years old, and 20% of our sample is over the age of 60. While much of the MRT housing in the Bronx, and a substantial portion of NY/NYIII housing (NY/NYIII is a New York City supportive housing initiative), is intended for single adult occupancy, our study sample size found that 28% of the participants are not single: 15% have minor children, 4% live with children over the age of 18, and 9% live with their partner in childless, 2-adult households.

Their living arrangements are often unstable. Thirty percent (30%) live with friends or family; 28% live independently in rental apartments but are at risk of eviction; 23% live in shelters; 7% live in houses referred to as ¾ housing; 6% live in SROs; 3% live in public housing; 2% live in residential facilities, and 2% are homeless living on the street.

The qualitative case studies demonstrate that for those who do experience unstable housing conditions or homelessness, care coordinators face numerous obstacles in attempting to find them more stable housing. Care coordinators report that:

- Clients living with friends or family are at risk of being asked to move out, or are living in untenable physical conditions;
- In some cases clients have been on the New York City Housing Authority waiting lists for 2-3 years;
- Supportive housing eligibility requirements are so narrow that clients do not qualify
- In attempting to find housing for their clients, they often go to great lengths, including one case where a worker made 300 contacts with various agencies and housing providers over the course of one year.

Policy Recommendations

Health Home participants have serious housing needs. One-fifth of all Bronx Health Home participants are unstably housed/homeless. This need is not currently being met by MRT, NY/NY III or any other source of affordable housing. While the present study has several limitations including the sample size and the self-reported data source, the study does find some compelling evidence for bringing housing to scale for some of the state's most vulnerable people. Below is a summary of a few of the challenges identified from the Bronx Health Home study:

Challenge #1: Scarce affordable housing options for individuals with fixed incomes and special needs.

Recommendations: New affordable housing must include units that are accessible to physically disabled participants and supportive housing for the aging to keep them out of costly nursing and adult homes. Broader housing eligibility criteria are needed for high need frequent users of health and other public resources (public assistance, criminal justice, shelter, etc.). Future affordable housing endeavors such as new MRT initiatives, a new NY/NY agreement and Mayor DeBlasio's affordable housing initiative should target individuals in this high utilizing category.

Challenge #2: Lack of diversity in unit sizes offered, along with narrow eligibility criteria. This leaves clients ineligible for housing or relegated to long waiting lists.

Recommendation: Increase capital investment for housing and incentivize the creation of larger units so that families as well as single adults can access housing

Challenge #3: Care Coordinators have limited time and resources to dedicate towards finding housing.

Recommendations: Sufficient training on Health Homes and housing integration and where possible, funding for housing specialists to serve as intermediaries should be provided. Lastly, a centralized (state/ citywide) coordinated assessment and referral (or placement) system is needed to identify and prioritize frequent users and coordinate their intake, assessment and provision of housing referrals to ensure the right person is getting into the right bed in a timely manner.

Research has well-documented the inextricable link between housing and health. Health Homes are not able to fully address the health needs of their high-need frequent user participants, nor are policymakers able to reap the full benefits of this innovative coordinated care approach, until high-need individuals are living in stable, suitable conditions.

Perspective from page 29

The Division of Long Term Care of the New York State Department of Health has issued *The New York State Balancing Incentive Program Innovation Fund (BIP)*. The primary goal of this 16-month demonstration program is to increase the number of Medicaid recipients served in non-institutional settings by either helping them transition from long-term institutional care back to community-based services, or to prevent increasingly fragile individuals currently in community-based services from having to move to long-term care institutions. Again, a premium is placed on innovative approaches to achieve the desired outcomes. With a large and growing cohort of aging recipients, this RFP is another opportunity to address significant needs in the behavioral health community.

Finally, the Medicaid Redesign Team has issued an RFP for a *Supportive Housing Health Home Pilot Project*. The purpose of this two-year demonstration is to assist homeless and unstably housed health home enrollees in obtaining affordable and stable housing. Funding can be used to pay for rental subsidies directly or for the services needed to help recipients qualify for such housing. An initiative of the MRT Affordable Housing Workgroup, this pilot program clearly envisions stable housing as a key element in reducing health care costs.

Proposed Revised OASAS Regulations

In the midst of all of this activity, OASAS has released new Draft 822 regulations for outpatient treatment programs. The draft contains a number of suggested changes that may be of concern to the substance use community. It is easily accessed on the OASAS website; comments are being accepted until May 1st.

Conclusion

While this article has focused on recent developments in the transition to managed behavioral care, it is crucial to understand that beginning in January of 2015 behavioral health is being subsumed into an overall managed healthcare system. The recent action of the Department of Health and the Offices of Mental Health and Alcoholism and Substance Abuse Services should be viewed in this context as the State realizes its vision of an integrated and responsive healthcare system. Clearly the transition offers both challenges and important opportunities.

Dream from page 32

manage their conditions. Health Homes are designed to deliver a package of comprehensive services and supports to recipients whereby "care managers" develop and monitor care plans in consultation with other members of recipients' support networks. In theory, improved communication and collaboration among service providers will promote recipients' timely use of preventive services and enhance their access to other supports (e.g., housing, vocational services, etc.). Such an approach should have a salutary effect on the overall health and wellbeing of individuals who were previously disengaged from treatment or had failed to access the supports necessary to ensure their lasting stability. It must be noted, however, that the PPACA offered a seemingly irresistible incentive for states to adopt the Health Home option through a substantial enhancement in federal funding for this initiative, and this financial enticement likely provided the foundation on which programmatic rationales were subsequently erected. Many states, including New York, typically receive a federal contribution (i.e., "Federal Medical Assistance Percentage" or "FMAP") of approximately 50% toward Medicaid-covered services. States and localities bear fiscal responsibility for the balance. The PPACA authorizes an enhanced FMAP of 90% for Health Home services for the first eight quarters (two years) following adoption of the Health Home option. In view of New York's exorbitant Medicaid expenditures and the Cuomo Administration's desire to contain its ever -increasing costs, anything less than the rapid and wholesale adoption of Health Homes in the face of such an incentive would have been unthinkable. Whether such an approach would prove superior to existing programs, such as Targeted Case Management (TCM), Managed Addiction Treatment Services (MATS), etc., for which no enhanced FMAP was available, was all but academic. Under the Health Home funding model, care management agencies receive a capitated monthly rate for the delivery of required services. These rates are established via an actuarial methodology that considers regional and case-specific acuity factors, and the fiscal viability of care management agencies now depends on a robust client enrollment that frequently alters the care manager-to-client ratio. Care managers that previously served 12 or 24 clients per month under the TCM model of care now serve several times as many, and their clientele includes individuals with an increasingly diverse constellation of psychiatric, substance use and physical health conditions. Can such a model achieve the Triple Aim? Will it be proven superior to the TCM model and its predecessors? It is undoubtedly too early to tell. But a preliminary report from the Assistant Secretary for Planning and Evaluation for the U.S. Department of Health and Human Services (ASPE) has cast some doubt on the efficacy of the Health Home model and exposed predictable shortcomings in its implementation that warrant additional scrutiny. In a survey of early adopters of the model the ASPE identified deficiencies in communication among recipients' service providers, inefficient or inoperable information technologies and enduring challenges in recipient engagement as obstacles to successful implementation (U.S. Department of Health and Human Services, 2012). There is some reason to believe these challenges will be overcome in time but one should not assume as much. Moreover, there is nothing inherent in this new approach to service delivery that directly addresses the scarcity of affordable housing or its role in sustaining the health of its recipients.

In a similar vein, the widespread implementation of Medicaid Managed Care for populations that were previously "carved out" of it promises to reduce costs and improve healthcare outcomes. Medicaid recipients with serious mental illness, in particular, will soon have all of their services funded through private Managed Care plans authorized by OMH and the Department of Health (DOH). These plans establish capitated payment rates for contracted providers and effectively shift the financial risk for service provision from the state to providers and recipients. By some accounts the most vulnerable (i.e., the seriously and chronically ill) members of this population will bear the greatest risk should capitated payment rates limit their access to essential treatment and support services. Although such limitations will ostensibly be offset by plans' promotion of preventive services and their integration of primary and behavioral healthcare, such claims warrant considerable skepticism. Indeed, it is not unreasonable to assume managed behavioral healthcare of the seriously mentally ill will encounter many of the same obstacles to successful implementation that afflict Health Homes, and it will likely do even less to directly address our affordable housing crisis or the other social determinants of health and stability for vulnerable populations.

One would hope the foregoing portrays both a cautionary tale and another opportunity for governmental and private stakeholders to "get it right," and there is cause for tempered optimism. The OMH has recognized the potential repercussions of a poorly executed capitated payment system on the health and stability of its most vulnerable recipients, and it is in the process of calibrating payment rates accordingly. It recently issued a Request for Qualifications (RFQ) through which managed care plans may apply to deliver services to the "mainstream" behavioral health population or enhanced services to individuals with serious mental illness or more extensive behavioral health concerns. These specialized Health and Recovery Plans (HARPs) may award higher capitated payments for the delivery of a broad array of medical, behavioral health and social support services to this population. The OMH also continues to explore and incentivize the redesign of its existing residential support services and to develop new approaches to housing its recipients. These include an expansion of crisis respite services, hospital diversion and similar resources for which demand will likely increase in response to dwindling inpatient resources. These developments, however, are largely contingent on a continuing reinvestment of savings accrued through facility closures, Medicaid redesign and the *effective* replacement of a costly fee-for-service system with Managed Care. Care management agencies, many of which continue to navigate a tumultuous transition from a TCM to Health Home service modality, are uniquely positioned to identify pitfalls in this transition and the potential repercussions for service recipients. And it is incumbent on housing and residential service providers, healthcare professionals, recipients and their families to seize this opportunity to collaborate with their Health Home partners and other stakeholders in the governmental and private sectors. In the absence of such focused and coordinated advocacy, access to safe and supportive housing and the many other determinants of health and stability will likely remain an elusive dream.

Stigma from page 39

the Department of Community Mental Health and other agencies such as Westchester Residential Opportunities in advocating for fair and affordable housing, the struggle continues.

The insufficient financial resources of individuals with serious and persistent mental illness, combined with the limited and affordable housing opportunities in Westchester's county, have made access to decent housing a continuous challenge, and have led some mental health service providers to become direct developers of housing and partners with other housing agencies. Too often the expansions of supported housing opportunities are compromised or faced with opposition from community members who fear devaluation to their property and neighborhood standards. Housing providers who operate within the same area or jurisdiction, constantly compete for the same vacant units which are often few and far in between. It is no wonder that individuals with limited resources are more likely to live in less desirable poverty ridden areas or deal with excessive overcrowding in confined locations. This distribution of substandard housing shows an obvious disparity in housing opportunities in the area of mental health.

Differences in housing opportunities based on stigma can be reduced if providers are vigilant in ensuring that the services and program they offer do not inadvertently stigmatize the individuals for whom the services and programs are intended. There needs to be an increase in public awareness in order for society to understand which groups are more vulnerable to stigma and the importance of enforcing corrective action in addressing housing disparity. Additionally proper education of mental health issues is crucial to reducing the stigma attached to mental disability. All too often the facts are skewed and misrepresented when we educate individuals about mental health.

As providers, it is important that we first recognize and understand what stigma is, its origins, and the prejudices that influence it. We should not shy away from confronting it, assuming that it is beyond the reach of our capabilities. Society needs to understand that individuals with mental illness can and do recover and are able to live productive lives.

If we continue to ignore the effects of stigma and its prejudices, then we are justifying further inequality and encouraged repudiation to those individuals in search of life improvement opportunities.

Settlement from page 30

served as the Governor's Special Advisor on vulnerable persons.

The plaintiffs are represented by Disability Rights New York, the Judge David L. Bazelon Center for Mental Health Law, MFY Legal Services, Inc., New York Lawyers for the Public Interest, Urban Justice Center and Paul, Weiss, Rifkind, Wharton & Garrison, LLP.

Disability Rights New York is the state's designated Protection and Advocacy System for people with disabilities. Its mission is to protect and advance the rights of adults and children with disabilities so that they can freely exercise their own life choices, enforce their rights, and fully participate in their community life.

The Judge David L. Bazelon Center for Mental Health Law (www.bazelon.org) is a national legal-advocacy organization representing people with mental disabilities. It promotes laws and policies that enable people with psychiatric or intellectual disabilities to exercise their life choices and access the resources they need to participate fully in their communities.

MFY Legal Services envisions a society in which no one is denied justice because he or she cannot afford an attorney. To make this vision a reality, MFY provides free legal assistance to residents of New York City on a wide range of civil legal issues, prioritizing services to vulnerable and under-served populations, while simultaneously working to end the root causes of inequities through impact litigation, law reform and policy advocacy.

The Urban Justice Center serves New York City's most vulnerable residents through a combination of direct legal service, systemic advocacy, community education and political organizing.

New York Lawyers for the Public Interest (NYLPI) advances equality and civil rights, with a focus on health justice, disability rights and environmental justice, through the power of community lawyering and partnerships with the private bar. Through community lawyering, NYLPI puts its legal, policy and community organizing expertise at the service of New York City communities and individuals. NYLPI's partnership with the private bar strengthens its advocacy and connects community groups and nonprofits with critical legal assistance. NYLPI is the recipient of the 2010 New York Times Awards for Nonprofit Excellence.

Paul, Weiss, Rifkind, Wharton & Garrison LLP is a firm of more than 800 lawyers who collaborate with clients to help them solve their most challenging legal problems and achieve their business goals. The firm has an unwavering dedication to representing those in need, and its pro bono efforts continue to benefit individuals and society.

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Innovative from page 16

for the PhotoVoice project was a painting that had been created while she was in the hospital. This was dark colored picture with entangled lines and confusing images.

The next picture selected by the individual in this example was the front door of her new apartment. This was a rather plain photo, but it had an image of a solid door on the front and it looked secure. She was able to describe how the peer support counselor from the PORCH program met with her and helped identify the ideal apartment for her needs. This included locating a place to live that was convenient and accessible to resources for her behavioral health needs and for everyday living (e.g., grocery stores and public transportation). The participant described how the peer counselor was able to assist her in completing the necessary paperwork for the Housing and Urban Development program that currently supports her rent.

The final picture in this PhotoVoice series was from the inside of her apartment. This was a well-organized picture of a table that included a laptop computer and books, and an inspiring poster. She articulated that she is attending a local community college and with the assistance of her peer counselor working on a degree in community services. She was able to articulate that as a result of the PORCH program, with secure housing and safe living environment she was able to begin her recovery journey. This included the support of her peer counselor, and the necessary supports to improve her health along with her education and community involvement.

The PhotoVoice project allows PORCH participants to easily give voice to their experiences within the program through pictures. Like the example above, the personal expressions are usually creative, personal and powerful — and are well-received by the participants, their peer counselors, and the community.

All too often, care for those with behavioral health conditions is focused on symptom management. Optum recognizes that in order to improve the health of those we serve there is a corresponding need to also address their overall social well-being. A safe and stable place to live is essential to achieving this goal. In collaboration with diverse community stakeholder groups, Optum strives to promote supportive housing and healthy community environments in which individuals are able to develop and maintain their own recovery.

Optum does not recommend or endorse any treatment or medications, specific or otherwise. The information provided is for educational purposes only and is not meant to provide medical advice or otherwise replace professional advice. Consult with your clinician, physician or mental health care provider for specific health care needs, treatment or medications. Certain treatments may not be included in your insurance benefits. Check your health plan regarding your coverage of services.

1. Substance Abuse and Mental Health Services Administration, SAMHSA's Working Definition of Recovery Updated, March 23, 2012. Available online at http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated.

HUD from page 40

HUD continues to fund single site supportive housing that is statutorily permitted to house and provide voluntary supportive services to individuals with disabilities in some or all of the units. Examples include the Housing Opportunities for Persons With AIDS (HOPWA) program, Section 202 housing developments for non-elderly persons with disabilities funded Prior to 1991, certain McKinney-Vento homeless assistance programs, and HUD-VASH vouchers, among others. Some of these programs offer housing settings occupied exclusively by individuals with disabilities, some offer housing opportunities in integrated settings, and some may offer both.

HUD continues to explore how it can fund additional integrated housing units scattered throughout communities. The Frank Melville Supportive Housing Investment Act of 2010 expanded HUD's Section 811 Supportive Housing for Persons with Disabilities program. Among other reforms, this Act authorized a new Project Rental Assistance program that was first implemented through a demonstration program in FY 2012. Under this program, state housing agencies that have entered into partnerships with state health and human services and Medicaid agencies can apply for Section 811 Project Rental Assistance (PRA) for new or existing affordable housing developments funded by LIHTC, HOME, or other sources of funds. Under the state health care/housing agency partnership, the health care agency must develop a policy for referrals, tenant selection, and service delivery to ensure that this housing is targeted to a population most in need of deeply affordable supportive housing. To learn more about this program, visit: http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/grants/section811ptl. (Please note that applications are due May 5, 2014, for the FY 2013/2014 Section 811 PRA Notice of Funding Availability)

HUD also encourages housing developers and providers to explore state-specific conditions to assess the different housing options that promote integrated, community-based housing for individuals with disabilities. As states and localities continue to transition individuals from institutions and other segregated settings into communities, HUD stands ready to assist its partners so as to maximize meaningful choice and self-determination for individuals with disabilities. For more information on HUD's role in accomplishing the goals of *Olmstead*, visit: http://portal.hud.gov/hudportal/documents/huddoc?id=OlmsteadGuidnc060413.pdf.

References

1. *Olmstead*, 527 U.S. at 607.

2. 56 Fed. Reg. 35694 (1992), codified at 28 C.F.R. pt. 35, app. B.

3. DOJ Olmstead Statement, http://www.ada.gov/olmstead/q&a_olmstead.htm

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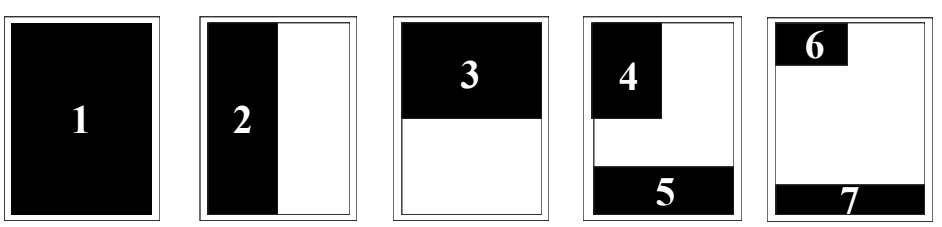

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