

Mental Health

Technical Assistance Brief (2003-01)

"A Vision for Recovery, Rehabilitation and Rights involves a dedication to the belief that all people can grow, change and gain desired opportunities and roles in contrast to perspectives that view some people as 'too sick' to reach a vision of recovery. This vision includes recognition for a world free of barriers where all people with psychiatric disabilities enjoy equal rights and opportunities to achieve their maximum potential. A world where equal access, freedom of movement and civil liberties are guaranteed and a world where individuals coping with psychiatric disabilities can freely pursue their goals and aspirations unfettered by the dual burden of stigma and discrimination. Values inherent in this vision of recovery are self-determination, choice, growth, and hope."

(Adapted from NYAPRS' Vision for a Recovery-Centered Mental Health System, September 2000)

Contents

- Introduction
- Key Points Summaries
 - Section I Key Points
 - Section II Key Points
 - Section III Key Points
- Section I: Definition and Description of Mental Illness
 - Definition of Mental Illness
 - Description of Mental Illness
 - DSM IV-R
 - Stigma and Discrimination
 - Medication
- Section II: Recovery, Research and Rehabilitation
 - A Vision for Recovery
 - Research on Recovery
 - Connecting MH with ACCES-VR
 - Practical Rehabilitation Strategies for Facilitating Employment Services
 - Addressing Additional Personal Challenges to Employment
 - Peer Support/Self Help Groups
- Section III: Related Resources for ACCES-VR Staff
 - MH Advocates
 - ADA and NYS Human Rights Law
 - Benefits Counseling
 - Supported Education
 - Transition of School Age Youth
 - Mental Illness and Chemical Abuse (MICA)/Dual Diagnosis
 - Mental Illness and Deafness

- Cultural Diversity
- IPRT Took Kit
- Existing Program Service Models in NYS for Employment of Individual with Psychiatric Disabilities
- Appendices
 - A. DSM IV-R Axes and Disability Categories
 - B. Medications and their Classifications
 - C. Practical Solutions and Possible Practical Job Accommodations to Common Side Effects
 - D. Additional Readings and Research Based Principles
 - E. Local ACCES-VR/MH Program Liaisons
 - F. Map of OMH Regional Territories
 - G. Frequently Used MH Abbreviations and Acronyms
 - H. Statewide Resources with Web Sites
 - I. Questions that may be Asked by Community Stakeholders

Introduction

The Technical Assistance Brief on Mental Health (MHTAB) is intended to:

- Enhance access to ACCES-VR services for individuals with mental illness;
- Improve employment outcomes for individuals with mental illness; and
- Assist in training ACCES-VR Counselors, mental health providers and other stakeholders to promote effective employment services through increased collaboration and mutual understanding.

The format is designed to present information with links to additional resources. The “Key Points” are abbreviated summaries that highlight the main points of each section. You may also link to a more detailed discussion of each main point. For issues related to ACCES-VR Policy, the Vocational Rehabilitation (VR) Manual should be consulted. The Technical Assistance Brief is not vocational rehabilitation policy or meant to be a single prescription for services.

Key Point Summaries

Section I Key Points: Definition and Description of Mental Illness

Definition:

Mental disorders are health conditions that are “characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.” (American Psychological Association). Section I provides additional information on the definition of mental illness.

Description:

Consumers with mental illness have demonstrated the ability to benefit from VR services, even in the presence of symptoms. Vocational involvement is essential to successful recovery, while the recovery process in turn aids the consumer in

maintaining employment. Section I provides additional information on the description of mental illness.

DSM IV-R:

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised is the reference used by mental health professionals to differentially diagnose mental disorders. A person's DSM IV-R diagnosis is not a predictor of recovery or employment success. Vocational planning should be based on all employment factors (strengths, resources, priorities, concerns, abilities, capabilities, as well as interests and informed choice), rather than a diagnostic category. Section I provides additional information on the DSM IV-R.

Stigma and Discrimination:

Stigma and discrimination are major factors that affect individuals with mental illness and their vocational rehabilitation efforts. Stigma and discrimination may influence employment outcomes more than the disability itself. Stigma and discrimination is not just the use of the wrong word or action. Stigma and discrimination are primarily about disrespect and fear. This must be consciously addressed in the vocational rehabilitation process, especially for individuals with psychiatric disabilities. Section I provides additional information on stigma and discrimination.

Medication:

To understand mental illness and rehabilitation, it is also important to understand the potential benefits and precautions regarding medication treatment. Medication, often combined with various recovery-oriented services and other personal supports, assists individuals in their rehabilitation and recovery efforts. Clear and continuous communication between vocational staff and the individual treatment team regarding medication issues is critical to the success of the vocational rehabilitation process. New medications are being discovered every day and it's essential to access the most up-to-date information regarding medications and their side effects. Vocational Rehabilitation Counselors should be familiar with possible practical solutions to common medication side effects. Section I provides additional information on medication and side effects.

Section II Key Points: Recovery, Research and Rehabilitation

Vision for Recovery:

Dedication to the vision that all people can grow, change and gain desired opportunities works best when there is close MH/ACCES-VR collaboration in providing strong mental health supports along with vocational rehabilitation supports. In this way, it is never too early or too late to begin the recovery process. See Section II for additional information on a vision for recovery.

Research and Recovery:

There has been a shift in mental health from maintenance and stabilization to rehabilitation and recovery. There are at least ten workable research based principles

and strategies instrumental to employment success. See Section II for additional information on research and recovery.

Connecting MH with NYSED :: ACCES :: VR :

The ACCES-VR/OMH 1999 MOU urges ACCES-VR and MH Providers to identify “Points of Contact” (POC) or liaisons to address local system issues and concerns. To successfully provide services for individuals with psychiatric disabilities requires a strong collaboration among services and a continuous focus on recovery. See Section II for additional information on the ACCES-VR/OMH MOU and identifying local and state POCs.

Rehabilitation Strategies:

Engagement through rehabilitation counseling; exploration of options; exposure to work preferences; and experience to confirm employment goals; are some recommended practical rehabilitation strategies that can be used to assist the individual throughout the vocational rehabilitation process. See Section II for additional information on counseling strategies to facilitate successful employment.

Addressing Additional Personal Challenges:

Individuals with psychiatric disabilities typically have additional personal challenges (including undeveloped employment goals, additional functional limitations, alcohol and drug abuse, legal issues and fear of loss of benefits) that impact success on the job and may require counselor intervention. See Section II for additional information on personal challenges and strategies.

Peer Support/Self Help:

There are several good reasons why ACCES-VR consumers should be encouraged to utilize peer support/self-help services throughout the vocational rehabilitation process. See Section II for additional information on peer support/self-help group resources for individuals with psychiatric disabilities.

Section III Key Points: Related Resources for ACCES-VR Staff

Mental Health Advocates:

Mental Health Advocates can play an important and at times an essential role in assisting a consumer with a psychiatric disability in making certain decisions. See Section III for additional information on the role of MH advocates and additional resources regarding advocates.

ADA and NYS Human Rights Law:

Consumers may not understand their rights under ADA. Psychiatric disabilities are examples of hidden disabilities that may be covered under ADA and NYS Human Rights Law. We need to assure that consumers understand when it may or may not be appropriate to self-disclose to an employer that they have a disability. See Section III for additional information on the ADA.

Benefits Counseling:

The cyclical nature of many mental illnesses makes it essential to address a consumer's fear of losing benefits. Benefits Counseling can help the individual make informed choices regarding working and earnings impact on entitlements. See Section III for additional information on benefits counseling and work incentives.

Supported Education:

Supported Education is a service that can provide individualized instruction and support to assist individuals in recovery to succeed in postsecondary education. See Section III for additional information on supported education programs and resources.

Transition of School Age Youth:

Because there may be some reluctance to label kids in school with emotional disorders, legitimate eligible applicants for ACCES-VR services may be overlooked. See Section III for additional information on transition planning for youth.

Mental Illness and Chemical Abuse and Dual Diagnosis:

The existence of a mental illness and a chemical abuse diagnosis requires an integrated treatment service approach addressing both disabling conditions in order to achieve vocational success. See Section III for additional information on resources for MICA and other dual diagnosis.

Mental Illness and Deafness:

There are few specialized psychiatric treatment services for consumers who are deaf. See Section III for additional information on accessing special deaf resources.

Cultural Diversity:

Being knowledgeable and sensitive to possible cultural implications of mental illness can be important to success in vocational rehabilitation. See Section III for additional information on cultural diversity and resources.

IPRT Tool Kit:

The IPRT (Intensive Psychiatric Rehabilitation Treatment) Tool Kit is an instrument widely used by MH programs to assess overall rehabilitation readiness. See Section III for additional information on the IPRT Tool Kit.

NYS OMH Program Service Models:

Assisted Competitive Employment (ACE), Intensive Psychiatric Rehabilitation Treatment (IPRT), Affirmative Business/Industry, Peer Advocacy, Self-Help Programs and Continuing Day Treatment Programs are examples of NYS MH program models. See Section III for additional information on MH program model descriptions.

Section I: Definition and Description of Mental Illness**Definition of Mental Illness**

Mental Illness is a term that refers collectively to all diagnosable mental disorders. There are many terms used to define mental illness. Mental disorders are health conditions that are “characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.” (American Psychological Association) The terms mental illness, mental disorders, psychiatric disability and psychiatric disorders are used interchangeably.

Description of Mental Illness

Researchers and mental health professionals have identified many psychiatric disorders. Some are extremely rare such as schizophrenia with a prevalence of less than 1% of the population, and others occur relatively frequently such as depression with a prevalence of greater than 10% of the population. Some of these disorders reflect acute episodes that occur once or infrequently for the individual, and others present as more long-term in nature.

Symptoms of mental illness are often cyclical in nature. Even when individuals may experience long periods of symptom remission, there may be times when they experience an exacerbation of symptoms that require additional supports, a medication adjustment, time off from work, and/or hospitalization. The ability to provide vocational rehabilitation services despite symptoms is key to successful recovery. (An individual does not have to be free of symptoms to participate in ACCES-VR sponsored services)

Additional information on specific mental disorders can be found at:

- NAMI: <http://www.nami.org>
- Surgeon General’s Report on MH:
<http://www.surgeongeneral.gov/library/mentalhealth/home.html>
- NMHA: <http://www.nmha.org/infoctr/factsheets/index.cfm>

DSM IV-R

Mental health professionals use a reference developed by the American Psychiatric Association (APA) called the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), in order to select a specific diagnosis based on a pattern of symptoms. However, a person’s diagnosis does not determine their prognosis. The DSM IV-R diagnosis is not predictive of rehabilitation success. People with severe mental illness often work successfully while experiencing symptoms.

The DSM IV-R diagnosis does not describe or predict the extent of the disability. Individuals diagnosed with the same disorder can be very different from one another. Furthermore, the same individual may function differently at different points in time. It is important to look beyond the diagnosis to evaluate the specific individual’s strengths and limitations. An individual’s employment plan should not be based on a diagnosis.

As stated in the ACCES-VR/OMH MOU, a DSM IV-R diagnosis, if available, should be provided to ACCES-VR as part of the referral, but it is not mandated. ACCES-VR utilizes a four-digit code for tracking impairments, not a DSM diagnosis. A current

diagnosis or referral information can indicate the presence of mental illness (ACCES-VR/OMH MOU). It is more important, however, for ACCES-VR to have information to document functional abilities and limitations, than it is to have a diagnosis. A good rehabilitation plan, vocational or otherwise, focuses on assets, while eligibility requirements include an objective listing of functional limitations.

See Appendix A for the DSM IV–R, Axes and Disability Categories.

Stigma and Discrimination

Research has indicated that psychiatric disabilities are the most negatively perceived of all disabilities. Recovery often begins with finding someone who believes in you. The ACCES-VR Vocational Rehabilitation Counselor is often that person who can provide the hope the individual needs in order to regain their role in society and validate their identity through work.

The stigma and discrimination connected with mental illness promote inaccurate beliefs about the abilities of individuals with psychiatric disabilities to benefit from vocational rehabilitation services to be successfully employed. Stigma-related discrimination can even result in the exclusion from the very services that will enable an individual with a psychiatric disability to be successful. Stigma and discrimination, which include the use of inappropriate labeling of individuals, is a major factor that affects the success of employment efforts. It can occur in any setting.

Bias, distrust, stereotyping, embarrassment, fear and anger toward individuals with mental illness are manifestations of stigmatization of people with mental disorders. These attitudes and behaviors perpetuate low self-esteem, isolation, and hopelessness.

Addressing barriers resulting from stigma and discrimination involves a commitment to the belief that all people can participate in recovery. This includes recognition that individuals with mental illness enjoy equal rights and opportunities to achieve their potential with equal access and civil liberties.

The negative effects of stigma and discrimination may impact outcomes (including employment) more than the disability itself. Fear, resulting from myths regarding mental illness, is a paramount factor that perpetuates stigma and discrimination. Education and the dissemination of accurate information about psychiatric disabilities are key to challenging stigma and discrimination. Mental health and ACCES-VR staff can be instrumental in reducing stigma and discrimination by maintaining the assumption that people who are diagnosed with mental illness can recover and can work.

For more information on how to eliminate discrimination against people with psychiatric disabilities, click on:

- www.mentalhealth.org/stigma/about.asp
- www.intentionalcare.org/index_2.html

Medication

Medication can be essential in rehabilitation and recovery. Medication is used to treat symptoms, but by itself is usually not sufficient to effect recovery. New medications are continuously being discovered and recommended drug treatments are changing regularly. Rehabilitation efforts to enhance all areas of a person's life can have a dramatic influence on the effectiveness of prescribed medications. It is important for ACCES-VR staff to communicate with the consumer regarding medications and their potential effect on employment. A brief summary of medications, their classifications and side effects, can be found in Appendix B.

Three recommended Web Sites for the most up-to-date information on medications include:

- www.medlineplus.gov/
- www.nimh.nih.gov/health/publications/index.shtml

Medication Side Effects:

The consumer should be encouraged to discuss possible side effects with the treatment provider and/or physician and their treatment team. ACCES-VR staff should work with the consumer and the treatment team regarding any issues or concerns related to medication that may be impacting the employment plan.

ACCES-VR staff can enhance treatment efforts by assuring that observation of side effects are accurately documented and reported. Not all side effects require immediate medical attention. Many of them can be alleviated through techniques that can be taught and that individuals can use on the job.

Some Common Medication Side Effects:

- Tardive Dyskinesia: This is a pronounced involuntary movement, often of the mouth and tongue. Tardive Dyskinesia can become permanent.
- Anticholinergic effects: These include dry mouth, tachycardia (rapid heartbeat), blurry vision, and constipation.
- Extrapyrimal effects: Refers to disorders related to motor control, including:
 - Pseudoparkinsonism: stiffness, shuffling, tremors, motor rigidity
 - Dystonias: twisting and contractions of muscle groups
 - Akathisia: motor restlessness
 - Rabbit Syndrome: fine tremor of lower lip
 - Pisa Syndrome: leaning to one side

Questions ACCES-VR Counselors Should Ask Consumers Regarding Medications:

1. If you are taking medication, how does it affect you?
2. Do you require any reasonable accommodation as a result of taking medication?
3. Do you require flexibility in your employment to attend appointments with your physician or others?
4. Do you require assistance taking medication? If so, what is it?

For "Practical Solutions to Common Side Effects and Other Job Accommodation Ideas," click here for Appendix C.

Section II: Recovery, Research and Rehabilitation

A Vision for Recovery

In the last century it was believed that people with severe mental illnesses could not recover. Recent research underscores the reality that people, even those on the back wards of state hospitals three decades ago, can and do recover when offered the opportunity to focus on self-determined goals, choice, growth in skills, and have, above all, hope. Current research helps correct the perception that some people are too "sick" to recover. Core values inherent in recovery should include self-determination, consumer choice, personal growth, and hope. A Vision for Recovery, Rehabilitation and Rights involves a dedication to the belief that all people can grow, change and gain desired opportunities and roles in contrast to perspectives that view some people as "too sick" to reach a vision of recovery. (Adapted from NYAPRS' Vision for a Recovery-Centered Mental Health System, September 2000)

It is never too early or late to begin the recovery process. Understanding the recovery process emphasizing consumer empowerment and applying it to the vocational rehabilitation process are essential to confronting the devastating effects of stigma.

(adapted from Center for Psychiatric Rehabilitation *Areas of Expertise*. For more information:

<http://www.bu.edu/cpr/expertise/recovery.html>)

Research on Recovery

There has been a shift in the mental health system from traditional beliefs that focused on maintenance and stabilization to rehabilitation and recovery. This shift has been accompanied by an emphasis on improved medications and treatment, the self-help and empowerment movement, and advocacy efforts championed by consumers and families. Pivotal to this move towards self-sufficiency and independence is the recognition that employment for persons with psychiatric disabilities is an achievable role, which fosters financial security, personal identity and an opportunity to make a meaningful contribution to community life.

Recently, a NY statewide survey of consumers of mental health services was conducted to identify their most important priorities. In all regions of the state, the first ranked response was "Increasing the opportunities and skills training programs necessary to getting and keeping a job."

Currently, more than 85% of individuals with psychiatric disabilities are unemployed and less than 25% are currently receiving vocational services. The success of various employment program approaches, such as transitional and supported employment,

have developed into evidence-based practices which demonstrate that effective employment interventions can promote recovery.

Click below for the latest information for research on recovery.

- <http://www.bu.edu/cpr/>
- <http://www.bu.edu/resilience/>
- <http://www.power2u.org/>
- <http://www.mhselfhelp.org/>
- www.intentionalcare.org/index_2.html

For further recommended readings and "Research Based Principles" published by Judith Cook Ph.D. and other publications, see Appendix D.

Connecting MH with ACCES-VR

Guidance for increasing access to services can be found in the Memorandum of Understanding between NYSED/ACCES-VR and OMH (October 1999).

A key recommendation in the MOU is for ACCES-VR and OMH to encourage their field offices and programs to establish a liaison or point of contact to facilitate service delivery, foster interagency cooperation and address local systems issues.

It is strongly believed that providing appropriate services for individuals with psychiatric disabilities can be facilitated by having a local agency and program listing of "liaisons and POCs" (Points of Contact). It is highly recommended that each region inserts this important local reference or guide and that it is made readily available to all stakeholders and be widely disseminated. See Appendix E for additional information.

Also, Appendix F provides a map of the OMH 5 Field Offices and counties covered with names, addresses and telephone numbers of OMH Field Office Directors and Rehabilitation Liaisons.

Practical Rehabilitation Strategies for Facilitating Employment Services

The table below provides a framework with some practical activities that promote positive employment outcomes. The framework, while outlining phases of a process, is not meant to be a step by step, sequential process, but a list of strategies that can be used to assist the individual as needed, throughout the vocational rehabilitation process.

Engagement (focus is to establish trust, rapport, and information sharing)

- Have conversations that support work as an option, including conversations with people who have already made the transition to work.
- Reinforce the value of previous work or training experiences, no matter how brief or limited.
- Help the person to identify and accept strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice to set an employment goal.

Exploration (utilize motivation counseling techniques to help consumers move through stages of change)

- Meet and talk with peers about how employment services have made a positive difference.
- Read and discuss written materials on training and placement programs and job information.
- Visit employment and training programs or work sites and talk with workers and supervisors.
- "Job shadowing" that pairs a consumer with a staff person for a short period of time, enabling the consumer to observe, and possibly assist, in a real work setting.

Exposure (to employment at the earliest opportunity to test job options)

- Participate in short or part-time work try-outs or situational assessments.
- Discuss factors that contributed to past job or other successes and reinforce those factors in current efforts.
- Identify factors that have interfered with job success and develop plans to address.
- Enhance awareness of alternative job options through information sharing, visits to other work sites, and developing plans to acquire a more preferred job.

Experience (assist consumers in gaining skills & experience & test job goals)

- Facilitate supported work experiences, defined as jobs in integrated work environments that assist participants in gaining skills and experience, and test job goals.
- Provide supports for retaining the work experience gains.
- Use the experiences to reinforce employment goal planning and direction of vocational efforts.

Addressing Additional Personal Challenges to Employment

Although "empowerment" is used often in discussing the needs of disenfranchised groups of people, few programs and services enable people with psychiatric disabilities to make fundamental decisions regarding one's own career future. ACCES-VR is committed to applying the principle of informed choice and providing tangible assistance to meet job and career goals.

Challenge	Impact on Work	Strategy
Undeveloped vocational goals	Lack of awareness of personal skills related to available jobs.	Use involvement in work experiences, transitional or volunteer work to learn about skills and job demands and to develop goals.
Functional disabilities caused by psychiatric symptoms or other physical	Difficulty meeting the physical and cognitive demands of work or managing work-related interpersonal	Ensure access to integrated treatment and rehabilitation that includes medications, mental health counseling and support services, and case management. Cognitive remediation

health conditions	relationships, e.g. supervisor.	and physical therapy may also be needed.
Alcohol and drug dependency	Increases absences from work, impairs physical and cognitive functioning and increases errors or injury on the job. Provides just cause for termination.	Ensure access to alcohol/drug treatment, recovery/motivation support groups and peer and family support networks. Include joint case management (VR, MH, SA) as part of an integrated planning strategy that addresses the individual's needs at various stages of recovery.
Criminal justice system involvement	Criminal record can exclude eligibility from some jobs and questions regarding past criminal involvement in the hiring process are not precluded under ADA.	Vocational case management that builds motivation for change, addresses recovery, and focuses on acquiring and retaining work to rebuild an acceptable work history. Enrollment in job training or educational programs that provide credentials which employers need and indicate the person's motivation to succeed.
Fear of losing entitlements	Decision not to work, or to limit hours worked per week, or reluctance to accept wage increases.	Make benefits counseling available on an ongoing basis. Utilize options that retain health care benefits.

Peer Support/Self Help Groups

Peer self-help employment groups can dramatically contribute to recovery and can support ACCES-VR efforts to assist the consumer to regain and maintain a desired employment role. Peer support provides people with an opportunity for meeting on a regular basis to discuss on-going needs related to employment issues with others who have similar struggles. Peer support also offers a safe and confidential place to share concerns outside of the work place. People can communicate more openly, view problems more objectively, and find more effective coping strategies based on the experience of others. Peers can serve as role models to each other. Utilizing peer advocacy can effectively reduce the need for conflict resolution and mediation. For more information on peer support for people with psychiatric disabilities:
<http://www.mhselfhelp.org/>

Why Self-Help Works

Self-help for individuals with psychiatric disabilities aids in the process of symptom reduction in several ways:

- Self-help provides a social network based on common experience. Recipients of mental health services are often isolated due to stigma and discrimination within and outside of the mental health system. In this situation, lack of socialization becomes an acute problem. When recipients come together in a self-help setting, they share common experiences, which lead readily to the formation of social relationships.
- Self-help facilitates people moving from the role of always being helped to helping. Always being helped makes one feel helpless. It is a demeaning role in our society, which leads to low self-esteem and a poor self-concept, which in turn may lead to increased anxiety. The role of helper is valued in our society, and leads to higher self-esteem and self-concept, thus providing a buffer from anxiety and repeated crises.
- In self-help groups people share specific ways of coping, based on experience.
- Those who successfully cope serve as role models for people who less successfully cope.
- Self-help provides some structure for people which is not imposed from the outside but self-generated from the members themselves.

The Mental Health Empowerment Project, as part of its self-directed rehabilitation series, teaches many of these things to recipients and ex-recipients. Many recipients and ex-recipients find them helpful. A recommended reference:

OMH Bureau of Evaluation & Services Research, "The Meaning to Self-Help"
Investigators: Sharon Carpinello, Ed.D., Edward L. Knight, Ph.D., 1993

Section III: Related Resources for ACCES-VR Staff

MH Advocates

Mental Health Advocates can play an important and at times necessary role in assisting a consumer with a psychiatric disability in making certain decisions. This can be especially important in the ACCES-VR application/group orientation process for individuals with a significant psychiatric disability. Best practice has confirmed the value of having an advocate accompany an applicant with a significant psychiatric disability, if they desire.

Some additional recommended resources:

- NYS Commission on Quality Care for the Mentally Disabled: www.cqc.state.ny.us
- NYS Office of Mental Health: www.omh.state.ny.us/omhweb/about/index.html
- Mental Health Association in NYS (MHANYS): www.mhanys.org
- Mental Health Empowerment Project (MHEP): (mhepinc@aol.com)
- NYS Association for Psychiatric Rehabilitation Services (NYAPRS): www.nyaprs.org

Americans with Disabilities Act (ADA) and Human Rights Law

It is important for employment specialists to remember that psychiatric disabilities are examples of hidden disabilities that may be covered under ADA and the NYS Human Rights Law. Rights are essential to a good rehabilitation process. However, many employers have grievance procedures to resolve disputes and this option should always be explored with the consumer first.

There are various risks to disclosing or not disclosing to an employer that a person has a psychiatric disability. Disclosure can allow the worker to involve the employer, an employment services provider, a job coach or other third party in the development of accommodations. Disclosure can also set clear expectations in otherwise difficult situations. However, there are also some valid reasons why it would not be advantageous to disclose. This is especially true if the person may not require a specific accommodation. Disclosure should not occur without a full discussion of resulting issues with the psychiatric consumer.

- ADA for People with Mental Health Disabilities, Cornell University Participant Handbook, 2000. (607/255-2906)
- "Mental Health Issues in the Workplace. How the Americans with Disabilities Act Protects You Against Employment Discrimination" written by the MATRIX Research Institute (2nd edition, June 2000) (www.matrixresearch.org)
- Equal Employment Opportunity Commission Web Site, for specific psychiatric assistance: (www.eeoc.gov)
- Bazelon Center for Mental Health Law Web Site: <http://www.bazelon.org>
- NYS Human Rights Law: <http://www.nysdhr.com/>

Click below for an interactive and informative web site for people with a psychiatric condition that address issues and reasonable accommodations related to work and school. Remember that there are some good reasons why someone should disclose one's disability to an employer and some good reasons why someone should not disclose. This is the only site designed exclusively to provide information about ADA and other employment and education issues for people with psychiatric disabilities. <http://www.bu.edu/cpr/jobschool/>

Benefits Counseling

Many consumers who receive SSDI or SSI fear that going to work will result in a loss of benefits. Fortunately, many recent changes in Social Security regulations encourage people with disabilities to go to work and to retain health care and other benefits. This is crucial since mental illness tends to be cyclical.

Benefits counseling is a resource for an individual to obtain benefits and/or to understand and use work incentives available through the Social Security Administration and other public or private programs. Benefits counseling provide reliable information on the impact of earned income on cash benefits and entitlement programs that the person may depend on for overall income.

Benefits counseling can also help the individual to make informed choices regarding working and earnings, applying work incentives to manage benefits and the costs associated with going to work, and developing a plan that leads to greater economic self-sufficiency. It reduces the risk of losing essential entitlements and helps the person establish a secure financial situation. This service is often available through independent living centers, legal services offices, SSA-funded Benefits Planning, Assistance and Outreach providers (1-888-224-3272); and other qualified community providers.

One excellent resource for SSA work incentives is the Social Security Redbook SSA Pub. No. 64-030. (www.ssa.gov/work click on "Resources Tool Kit")

Supported Education

Supported Education is a service that can assist the consumer with a psychiatric disability to access when pursuing postsecondary education. It is available on many college campuses and provides individualized instruction and support to assist people with psychiatric disabilities to obtain educational goals that will enable them to achieve an employment outcome. The purpose is to help current or potential students with disabilities to select, enroll in, and graduate from an educational or training site of their choice. While there are several different program models (on-site support, self contained classroom and mobile support model), most Supported Education Programs include the following program services:

- Coordination of services on campus
- Direct on-campus assistance
- Referrals to resources on and off campus
- Financial assistance advisement and advocacy
- Coordination of services with mental health providers
- On-going support
- Public relations
- Crisis resolution on campus
- In New York State, Supported Education is a relatively new concept in mental health services and is funded through a variety of possible sources (ACCES-VR may or may not be directly involved in funding this service). New programs, however, are being developed on a regular basis. The best way to find out about Supported Education Services in local communities is to contact the County Mental Health Director's Office (Directory and Index: MHANY (518) 427-8676) and/or the Disabled Student Services Office located on college campuses.

Transition of School Age Youth

ACCES-VR staff need to assure that they are getting referrals on students with an emotional disability in a timely and appropriate manner. Because there may be some reluctance to label kids with a psychiatric disabling condition, legitimate eligible applicants may not be referred to ACCES-VR. There are often special education supports available for those youth that choose to self-disclose and plan to attend some type of postsecondary education. Sometimes there is reluctance to authorize additional

testing and evaluations to confirm psychiatric diagnoses. If the CSE (Committee on Special Education) determines that further assessment is not necessary to fulfill the requirements of the IEP (Individualized Education Program), then it is ACCES-VR's responsibility to arrange and pay for any additional testing needed to establish ACCES-VR eligibility or to adequately develop an IPE. (Individualized Plan for Employment) Accessing additional information on "Student Transition" can be found at the ACCES-VR Web Site: www.acces.nysed.gov/vr.

Mental Illness and Chemical Abuse (MICA)/Dual Diagnosis

"Mental Illness and Chemical Abuse" (MICA) is an example of a dual diagnosis. Research indicates that over 50% of the mentally ill population also have a substance abuse problem. Two disorders require an integrated treatment approach. It is not mandated that MICA consumers complete substance abuse treatment or have a certain length of abstinence in order to apply or be eligible for ACCES-VR services. ACCES-VR staff should be sensitive to other types of dual diagnoses. One good resource: National Alliance for the Mentally Ill Web Site: www.nami.org/helpline/dualdiagnosis.htm

Mental Illness and Deafness

There are few special deaf resources for intensive psychiatric intervention across the state. The ACCES-VR Counselor/s in each local ACCES-VR district office that specialize in serving consumers who are hearing impaired or a local ILC (Independent Living Center) advocate are the best resources for recommending local "specialty" psychiatric counseling services related to deafness. The normal mental health referral route with the assistance of a qualified interpreter may be the best course of action for immediate counseling intervention.

A good statewide resource is the Coalition of Organizations Serving the Deaf and Hard of Hearing (COSDHH). To access the best local resource person to help address issues related to effective treatment of mental illness in people who are Deaf, can be obtained through the NY Society for the Deaf: nysd@aol.com

Cultural Diversity

There are significant differences among cultures as to what is considered "normal" behaviors and the perception of mental illness. For example, American Indian, Asian, and Hispanic cultures have both a wider tolerance for communication with voices, dead spirits, etc. At the same time, the broader culture can be intolerant of members of the culture who appear to be different. Vocational Rehabilitation Counselors should explore the cultural implications of the individual's disability. Working with the consumer, family members and significant others are necessary to gather accurate insights related to cultural dynamics. In addition, by acquainting people with others of the same culture and who have faced and overcome the same challenges, aids success in achieving employment goals.

More information on cultural diversity can be found in the Surgeon General's Report (www.surgeongeneral.gov/library/mentalhealth/home.html)

OMH IPRT Took Kit (Rehabilitation Readiness Determination)

This instrument is widely used in MH to help determine rehabilitation readiness. OMH requires its completion to determine readiness for Intensive Psychiatric Rehabilitation Treatment (IPRT) Programs and vocational rehabilitation services. Psychiatric rehabilitation readiness determination is a process developed at Boston University that assesses to what extent a consumer is ready to make a change in their life in one of four environments: living, working, educational, social. This readiness to set an "Overall Rehabilitation Goal" is based on the consumer's perceived need and commitment level to making a change in their life. Other considerations include awareness of themselves, awareness of possible goal environments and the consumer's ability and willingness to work with a service provider. This assessment does not indicate whether a person has the skills necessary to make a change in their life, but does assess whether or not a person has the need, motivation, awareness and perceived support to undertake the steps necessary to set and achieve an "Overall Rehabilitation Goal". Copies of the Readiness Assessment Forms can be obtained at the OMH website: www.omh.state.ny.us under "Resources;" then "Print Shop Catalog;" enter Form # 346 to view form.

Existing Program Service Models in NYS for Employment of Individual with Psychiatric Disabilities

- **Psychosocial Club:** The objective is to assist individuals disabled by mental illness to develop or establish a sense of self-esteem and group affiliation; to promote their recovery from mental illness and their reintegration into a meaningful role in community life through the provision of two or more of the following: 1. Recipient and self-help empowerment interventions; 2. Community Living; 3. Academic; 4. Vocational and/or 5. Social, leisure, time rehabilitation, training and support services.
- **Assisted Competitive Employment (ACE):** The objective is to assist individuals in choosing, finding, and maintaining satisfying jobs in the competitive employment market at minimum wage or higher. When appropriate, ACE provides these individuals with job related skills training as well as long-term supervision and support services, both at the work site and off-site.
- **Intensive Psychiatric Rehabilitation Treatment (IPRT):** The IPRT program is time-limited, with active psychiatric rehabilitation designed to assist a recipient in forming and achieving mutually agreed upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies, to overcome functional disabilities and to improve environmental supports. The IPRT program shall provide the following services:
 - Readiness Determination. (IPRT tool kit)
 - Goal Setting
 - Functional Assessment
 - Service Planning

- Skills and Resource Development
- Discharge Planning
- **Affirmative Business/Industry:** The objective is to provide vocational assessment, training, transition or long-term paid employment, and support services for persons disabled by mental illness in a less restrictive/more integrated employment setting than sheltered workshops. Affirmative programs may include mobile contract services, small retail or wholesale outlets, and manufacturing and service oriented business.
- **Peer Advocacy:** Peer Advocacy Services are, by definition, provided by current or former service recipients who have been trained in such areas as negotiation and mediation skills, recipient's rights, mental hygiene law, and access to entitlements and local resources. Peer advocacy programs may provide individual advocacy, systems advocacy, or a combination of both types.
- **Self-Help Program:** The objective is to provide rehabilitative and support activities based on the principle that people who share a common condition or experience can be of substantial assistance to each other. These programs may take the form of mutual support groups and networks, or they may be more formal self-help organizations, which offer specific educational, recreational, social, or other program opportunities.
- **Continuing Day Treatment:** A continuing day treatment program (usually a MH prevocational service) shall provide active treatment and rehabilitation designed to maintain or enhance current levels of functioning and skills, to maintain community living and to develop self-awareness and self-esteem through exploration and development of recipient strengths and interests. A continuing day treatment program shall provide the following services:
 - Assessment and Treatment Planning
 - Discharge Planning
 - Medication Therapy
 - Medication Education
 - Case Management
 - Health Screening and Referral
 - Psychiatric Rehabilitation Readiness Development
 - Psychiatric Rehabilitation Readiness Determination
 - Referral
 - Symptom Management
 - The following additional services may also be provided:
 - Supportive Skills Training
 - Active Therapy
 - Verbal Therapy
 - Crisis Intervention Services
 - Clinical Support Services

Appendices

Appendix A: DSM IV-R Axes and Disability Categories

1. **Diagnosis Axes:** Five axes are used to diagnose a person, each reflecting an important aspect of that person's current condition. The five axes are:
 - Axis I** Clinical Disorders, and Other Conditions That May Be a Focus of Clinical Attention.
 - Axis II** Personality Disorders, and Mental Retardation.
 - Axis III** General Medical Conditions.
 - Axis IV** Psychosocial and Environmental Problems.
 - Axis V** Global Assessment of Functioning.

Mental disorders are characterized by specific symptoms, which generally result in difficulties for the individual. These symptoms can be seen in the individual's behavior, emotions, perceptions and/or thinking. Different disorders are characterized by different symptoms, which are identified very clearly in the DSM IV-R. Remember that diagnoses are not a valid predictor of vocational success.

2. **Categories of Disorders:** Each section of the DSM IV-R reviews a different category of disorders. The following outline provides a sense of the variety and complexity of the mental disorders:
 - A. Disorders usually first diagnosed in infancy, childhood or adolescence (e.g., mental retardation, learning disorders, pervasive developmental disorders)
 - B. Delirium, dementia, and amnesic and other cognitive disorders
 - C. Mental disorders due to a general medical condition not elsewhere classified
 - D. Substance related disorders (e.g., alcohol abuse, cocaine dependence)
 - E. Schizophrenia and other psychotic disorders
 - F. Mood disorders (e.g., depressive disorders, bipolar disorders)
 - G. Anxiety disorders (e.g., panic disorder, agoraphobia, post traumatic stress disorder)
 - H. Somatoform disorders (e.g., pain disorder, hypochondriasis)
 - I. Factitious disorders
 - J. Dissociative disorders (e.g., dissociative identity disorder)
 - K. Sexual and gender identity disorders
 - L. Eating disorders (e.g., anorexia nervosa, bulimia nervosa)
 - M. Sleep disorders
 - N. Impulse-control disorders not elsewhere classified
 - O. Adjustment disorders
 - P. Personality disorders (e.g., borderline personality disorder, antisocial personality disorder)
 - Q. Other conditions that may be a focus of clinical attention

Easy to understand information on specific disorders can be found at the NIMH web site: <http://www.nimh.nih.gov/publicat/index.cfm>

Appendix B: Medications and their Classifications

Medications are often less effective than they could be because many clients do not regularly take them or have access to them. Vocational counselors need to have a basic knowledge of medications to effectively communicate with the treatment team regarding medication treatment effects relative to successful employment.

1. **Antipsychotic Medications:**

These medications are used to treat individuals who have psychotic illness primarily schizophrenia. They help to lessen the symptoms but are not cures. Many on these medications will sometimes experience side effects. These may affect someone's ability to work and it is important to discuss with the consumer their particular situation. There are two classifications: typical and atypical.

The typical are the older drugs and include: thiorazine (chlorpromazine), taractan (chlorprothixene), permitil and prolixin (fluphenazine), haldol, haloperidol, daxolin, loxitane (loxapine), serentil (mesoridazine), lidone and moban (molindone), trilacon (perphenazine), orap (pimozide (for tourette's syndrome), mellaril (thioridazine), navane (thiothixene, stelazine (triflupromazine), and vesprin (triflupromazine)

Atypical neuroleptics were developed starting in 1990. These drugs have proven helpful for individuals who have not responded well to the typical anti-psychotic drugs. They have fewer side effects (particularly tardive dyskinesia), although there is a greater likelihood of weight gain. One drug Clozaril (clozapine) requires close monitoring because of the possibility of a blood disorder. Weekly or bi-weekly blood testing is required. Other atypical neuroleptics are risperdal (risperidone), zyprexa (olanzapine), seroquel (quetiapine) and geodon (ziprasidone).

2. **Anti-Manic Medications:**

These medications are used to treat bipolar disorder (manic depression). The medications are used to even out the mood from the extreme highs or lows. Medication often takes time to build up in the system. The most common medication used is lithium. Possible side effects include drowsiness, weakness, nausea, vomiting, fatigue, hand tremor, or increased thirst and urination. There is a very small therapeutic window, so close blood level monitoring needs to be done. Lower levels of sodium in the body can also increase the toxicity of lithium. Lithium can also effect the thyroid and kidneys. People being treated with lithium also tend to have weight gain as one of the side effects of this medication.

Anti-seizure medication has been found to be useful for some people who do not benefit from lithium. Two medications that fit this class are tegretol (carbamazepine) and depakote (divalproex). Other anti-manic medications include Neurotin (garapentin), Lamital (lamotrigine), Cibalith-S (lithium citrate), and Topomax (topiramate).

3. **Anti-Depressant Medications:**

These medications are used to treat people with depression. Generally someone will need to experience symptoms for at least 2 weeks and they interfere with their functioning before medication is prescribed. Someone who is depressed may also have psychotic symptoms. These medications can also be used to treat anxiety disorders. There are 3 main classifications of antidepressant medications: tricyclic; newer antidepressants (SSRI's) and the monoamine oxidase inhibitors (MAOIs). Each of the classes of these drugs can have various side effects. Other side effects with tricyclics may include blurred vision, dry mouth, constipation, weight gain, dizziness when changing position, increased sweating, difficulty urinating, changes in sexual desire, decrease in sexual ability, muscle twitches, fatigue, and weakness. Examples of tricyclic drugs include elavil (amitriptyline), asendin (amoxapine), norpoamin (desipramine), Pamelor (nortriptyline) adapin (doxepin),

tofranil (imipramine), ludiomil (maprotiline), surmontil(trimipramine), and vivcatil (protriptyline). Drugs that are similar to the tricyclic but have different side effects are deseryl (trazodone), wellbutrin (bupropion), and Serzone (nefazodone).

The newer antidepressants have side effects that are gastrointestinal and headache. Insomnia, anxiety and agitation also occur. There are also potential drug interactions with other medications. Examples of the SSRI's include Prozac (fluoxetine), Luvox (fluvoxamine), Paxil (paroxetine), Celexa (citalopram), and Zoloft (sertraline).

The MAOI's have similar side effects to other antidepressants but also interact with certain foods so that anyone using these drugs needs to be on a restricted diet, Examples of these drugs include: Marplan (isocarboxazid), and parnate (tranylcypromine), nardil (phenelzine).

4. **Anti-Anxiety Drugs:**

These drugs are used to treat symptoms of anxiety that include "butterflies in the stomach," sweaty palms, irritability, uneasiness, jumpiness, feelings of apprehension, rapid or irregular heartbeat, stomach ache, nausea, faintness, and breathing problems. Besides generalized anxiety, other anxiety disorders are panic, phobia, obsessive-compulsive disorder (OCD), and posttraumatic stress disorder. Anti-anxiety medications help to calm and relax the anxious person and remove the troubling symptoms. There are a number of anti-anxiety medications currently available. Benzodiazepines are usually used although there is also a non-benzodiazepine, buspirone (*BuSpar*), is used for generalized anxiety disorders. Antidepressants are also effective for panic attacks and some phobias and are also used. For more generalized forms of anxiety, especially when it is accompanied by depression. The medications approved by the FDA for use in OCD are all antidepressants clomipramine, fluoxetine, and fluvoxamine.

The most commonly used benzodiazepines are xanax (alprazolam) and valium (diazepam) followed by Librium, Librax, Libritabs. (chloridiazepoxide). Other benzodiazepines are azene (clorazepate), paxipam (halazepam), ativan (lorazepam), serax (oxazepam) and centrax (prazepam). Benzodiazepines are relatively fast-acting medications; in contrast, buspirone must be taken daily for 2 or 3 weeks prior to exerting its anti-anxiety effect. Benzodiazepines have few side effects. Drowsiness and loss of coordination are most common; fatigue and mental slowing or confusion can also occur. These effects make it dangerous to drive or operate some machinery.

With benzodiazepines, tolerance, dependence and abuse can occur. This is why they are usually prescribed only for brief periods of time or intermittently. There are occasional situations where one of the following medications may be prescribed: antipsychotic medications; antihistamines (such as Atarax, Vistaril, and others); barbiturates such as phenobarbital; and beta-blockers such as Inderal or Inderide (propranolol). Propanediols such as equanil (meprobamate) were commonly prescribed prior to the introduction of the benzodiazepines, but today rarely are used.

For additional information on medications link to:
<http://www.nimh.nih.gov/publicat/medicate.cfm#index>

Appendix C: Practical Solutions and Possible Practical Job Accommodations to Common Side Effects

SYMPTOMS	SOLUTION
Eyes sensitive to strong sun or light	<ul style="list-style-type: none"> • Use sunglasses, a hat or visor • Avoid prolonged exposure
Dryness of lips and / or mouth	<ul style="list-style-type: none"> • Increase fluid intake • Rinse mouth with water • Keep hard candies or sugarless gum handy
Occasional indigestion / upset stomach	<ul style="list-style-type: none"> • Drink small amounts of <i>clearsoda</i> water • Eat dry saltine crackers or toast • Do not provide or encourage antacids without a physician's permission
Occasional constipation	<ul style="list-style-type: none"> • Increase water consumption • Increase physical exercise • Increase consumption of leafy green vegetables or bran cereals • Drink lemon juice in warm water
Fatigue / Sleepiness	<ul style="list-style-type: none"> • Take a brief rest period during the day • Speak to physician about switching entire daily dose to bedtime
Dizziness when upright	<ul style="list-style-type: none"> • Practice getting up slowly from a sitting or reclining position
Mild extra-pyramidal symptoms (restlessness, muscle stiffness, slowed movements)	<ul style="list-style-type: none"> • Increase regular exercise • Take short walks • Learn stretching exercises for muscles • Use music to relax
Dry Skin	<ul style="list-style-type: none"> • Use mild shampoos and soaps • Use lotion after each bath • Wear seasonal protective clothing
Weight gain	<ul style="list-style-type: none"> • Increase regular exercise • Watch diet and reduce overeating
Skin Discoloration	<ul style="list-style-type: none"> • Wear clothing that covers skin
Sunburn	<ul style="list-style-type: none"> • Use sunscreen

	<ul style="list-style-type: none"> • Use sunglasses, a hat or visor • Avoid prolonged exposure
--	--

Other Ideas for Job Accommodations that may be Related to Medication Side Effects or the Disability

Potential Barriers	How to Cope/Possible Solutions
<p>Inability to screen out environmental stimuli, such as sounds, sights, or smells, which distract. For example, an individual may have a hard time working next to a noisy printer or in a high-traffic area.</p>	<ul style="list-style-type: none"> • Move the noise source away from the work area or vice versa whenever possible. • Wear headphones playing soft music while working. • Install high partitions around the work area. • Change spatial arrangements, noise and lighting levels as needed.
<p>Inability to concentrate. Feelings of restlessness, having a short attention span, being easily distracted, or having a hard time remembering verbal directions. Difficulty focusing on one task for an extended period of time.</p>	<ul style="list-style-type: none"> • Break large projects into smaller tasks; • Assign tasks in writing or tape record instructions. • Take short, frequent breaks to stretch or walk around whenever attention is slipping. • Provide access to private space.
<p>Lack of stamina. Not having enough energy to work a full day or drowsiness from medication.</p>	<ul style="list-style-type: none"> • Request part-time schedule. • Request flexible schedule or job sharing to be sure the individual is working only during high-energy hours. • Take a mid-day rest break. • Change medication times, if allowed by M.D. • Access to water in workspace. • Review diet and exercise lifestyle with physician.

<p>Difficulty handling time pressures and multiple tasks. Having trouble managing assignments, setting priorities, or meeting deadlines. For example, not knowing how to decide which tasks to do first in order to complete a project by its due date.</p>	<ul style="list-style-type: none"> • Break larger projects down into manageable tasks. • Meet regularly with the supervisor or job coach for help prioritizing or estimating how long it will take to meet a deadline. • Use written instructions (or tape recorder) and a daily "To Do" list. • Provide a co-worker "buddy" or mentor.
<p>Difficulty interacting with others. For example, being too shy to talk with co-workers at breaks, or having trouble figuring out "how things go around here".</p>	<ul style="list-style-type: none"> • Pair the individual with a co-worker who can introduce him/her around and show him/her the ropes.
<p>Difficulty handling negative feedback. Having a hard time understanding and interpreting criticism. For example, getting defensive when someone says, "work isn't up to standards." Having difficulty figuring out what to do to improve, or believing that trying to change is worthless.</p>	<ul style="list-style-type: none"> • Ask that a job coach be present when there is a meeting with the employer for feedback. • Permit calls to job coach as needed. • Encourage the worker to offer their own perspective on individual strengths and weaknesses. • Request specific ways to improve. • Ask to receive feedback in writing with an opportunity to discuss later.
<p>Difficulty responding to change. Unexpected changes at work, such as new rules, job duties, or supervisors and co-workers, may be unusually stressful. For example, it may take a long time to learn new tasks, or the person may feel especially anxious around new co-workers.</p>	<ul style="list-style-type: none"> • Ask for advance notice of job changes. Introduce tasks gradually. Minimize changes to job description over time. • Make a special effort to introduce the worker to new co-workers. Ask the employer to notify new supervisors of the individual's needs. • Exchange tasks with

	<p>others.</p> <ul style="list-style-type: none"> • Limit supervisory or staff changes, if possible.
Difficulty with Scheduling Demands	<ul style="list-style-type: none"> • Allow time off for medical appointments and time off without pay when needed. • Allow use of vacation and personal leave for medical needs. • Allow for more frequent breaks.

Appendix D: Additional Readings and Research Based Principles

Research Based Principles

The following are a summary of principles that research studies have confirmed to be critical to recovery for individuals with psychiatric disabilities. These principles appear simple and obvious on the surface, but are tantamount to achieving successful employment. Based on current research by Judith Cook, Ph.D.:

1. People with serious mental illness can be successfully engaged in competitive employment.
2. Vocational rehabilitation services should involve employment in integrated settings for minimum wage or above.
3. Consumers should be placed in paid jobs as quickly as possible according to their preferred pace.
4. Ongoing vocational support should be available as needed and desired.
5. Consumers should be helped to find jobs that match their career preferences.
6. Vocational rehabilitation services should explicitly address financial planning and provider education/support around disability benefits and entitlements.
7. Vocational and mental health services should be integrated and coordinated.
8. Vocational service providers should work collaboratively with consumers to address issues of stigma and discrimination, and to help negotiate reasonable accommodations with employers.
9. Vocational rehabilitation services should be made available to all mental health consumers.
10. Vocational services should involve family and friends in supporting consumers' efforts to work.

"Does Rehabilitation Really Make a Difference in the Long-Term Outcome of Schizophrenia?" Courtenay M. Harding, Ph.D., Michael J. Desisto, Ph.D., Takamaru Ashikaga, Ph.D., George W. Brooks, M.D., Rodney V. McCormick, Ph.D. and Shiva Gautam, Ph.D.

"Ten world studies have found that the long-distance outcome for schizophrenia is widely heterogeneous. The question remains: 'Does rehabilitation contribute to a more

positive outcome for these seriously ill patients?' To examine this crucial inquiry, 269 patients with severe and persistent mental illness were taken from the back wards of Vermont State Hospital given a ten year pioneering model rehabilitation program both in the hospital and in the community (Office of Vocational Rehabilitation SP#180)."

"Recovery and the conspiracy of Hope" Patricia E. Deegan, Ph.D. Presented at: The Sixth Annual Mental Health Services Conference of Australia and New Zealand. Brisbane, Australia.

"...Recovery is a process. It is a way of life. It is an attitude and a way of approaching the day's challenges. It is not a perfectly linear process. Like the sea rose, recovery has its seasons, its time of downward growth into the darkness to secure new roots and then the times of breaking out into the sunlight. But most of all, recovery is a slow, deliberate process that occurs by poking through one little grain of sand at a time."

Appendix E: Local ACCES-VR/MH Program Liaisons

(*This resource should be developed and disseminated locally to enhance collaboration among ACCES-VR, OMH and MH Provider Programs.

MH Program Name:

Description of Services:

ACCES-VR Liaison: Name, Address, Telephone #, e-mail Address

MH Liaison: Name, Address, Telephone #, e-mail Address

Appendix F: Map of OMH Regional Territories

Appendix G: Frequently Used MH Abbreviations and Acronyms

AA: Alcoholics Anonymous

AC: Before Meals

ACT: Assertive Community Treatment

ADA: Americans with Disabilities Act

ADL: Activities of Daily Living

AIP: Annual Implementation Plan (of the Health Systems Agency)

BID: Twice a Day (usually 12 hours apart)

BOCES: Board of Cooperative Education

CAC: Credential Alcoholism Counselor

CAMERA: Case Management, Evaluation, Referral, and Assessment

CARES: Consortium of alternatives Residences and Essential Services

CAT: Clinical Assistance Team

CCSA: Community Client Services Assistant(Case Manager)

CMHC: Community Mental Health Center

CMI: Chronically Mentally Ill

COPS: Comprehensive Outpatient Program
CPEP: Comprehensive Psychiatric Emergency Program
CR: Community Residence
CRC: Certified Rehabilitation Counselor
CSP: Community Support Program
CSS: Community Support System
CSW: Certified Social Worker
DRG: Diagnosis Related Group
DSS: Department of Social Services
DMH: Department of Mental Hygiene
DSM IV: Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition)
DT's: Delirium Tremens
ECT: Electro-Convulsive Therapy
EPE: Extended Period of Eligibility (for SSDI and SSI)
HHS: U.S. Department of Health and Human Services
HMO: Health Maintenance Organization
HRF: Health Related Facility
HS: At Bedtime
ICF: Intermediate Care Facility
ICM: Intensive Case Management
IJD: Independent Job Developer (Job Coach)
IM: Intramuscular Injection
IPE: Individualized Plan for Employment
I&R: Information and Referral
IPRT: Intensive Psychiatric Rehabilitation Treatment
ISP: Individual Service Plan
MI: Mental Illness
MICA: Mentally Ill Chemical Abuser
MMPI: Minnesota Multiphasic Personality Inventory
NA: Narcotics Anonymous
NYCRR: New York Codes, Rules, and Regulations
OBS: Organic Brain Syndrome
OCD: Obsessive Compulsive Disorder
OD: Overdose
OMH: Office of Mental Health
OWPCE: Office of Workforce Preparation and Continuing Education
PC: After Meals
PDR: Physicians Desk Reference
PINS: Persons In Need of Supervision
POWER: Peer Outreach with Evening Recreation
PRN: As Needed (When Necessary)
PSC: Personal Service Coordinator
Q: Every Day
OD: Once a Day
QID: Four times a day (usually six hours apart)
RTF: Residential Treatment Facility

SA: Substance Abuse
SE: Supported Employment or Supported Education
SOCR: State Operated Community Residence
SPMI: Severely and Persistently Mentally Ill
STAT: Immediately
TANF: Temporary Assistance for Needy Families
TEP: Transitional Employment Program
TID: Three times a day (usually 8 hours apart)
TWP: Trial Work Period (for SSDI or SSI)

Appendix H: Statewide Resources with Web Sites

- Commission on Quality Care: *In NYS, this is the primary protection and advocacy system for MI: www.cqc.state.ny.us
- Coordinated Care Services Initiative (CCSI): www.ccsi.org
- ILR Program on Employment and Disability, Cornell University: <http://www.ilr.cornell.edu/ped/ada>
- Independent Living Centers (ILCs): www.acces.nysed.gov/vr Under "Lifelong Services Network".
- Mental Health Association in NYS: (MHANYS): <http://www.mhanys.org>
- Mental Health Empowerment Project: (MHEP): mhepinc@aol.com
- New York Association of Training and Employment Personnel (NYATEP): www.nyatep.org
- New York State Association for Psychiatric Rehabilitation Services (NYAPRS): www.nyaprs.org
- New York State Office of Mental Health (NYSOMH): www.omh.state.ny.us/omhweb/about/index.html
- New York State Rehabilitation Association (NYSRA): www.nyrehab.org
- Office of Alcohol and Substance Abuse Services (OASAS): www.oasas.state.ny.us
- Regional Rehabilitation Continuing Education Program (RRCEP): www.gse.buffalo.edu/org/rrcep
- Adult Career and Continuing Education Services - Vocational Rehabilitation (ACCES-VR) www.acces.nysed.gov/vr

Appendix I: Questions that may be Asked by Community Stakeholders

The following are frequently asked questions (FAQs) by advocates, consumers and mental health service providers. These FAQs may be adapted and expanded for use locally to assist in service coordination efforts.

Frequently Asked Questions:

1. Is there a written agreement between ACCES-VR and OMH that describes the recommended referral process between MH and ACCES-VR?
Yes. The ACCES-VR/OMH October 1999 MOU outlines interagency considerations to enhance the services provided by each agency to individuals with psychiatric disabilities, to promote consumer informed choice and participation, to increase access to services, and to increase employment outcomes for these individuals.

This MOU outlines functional criteria that should be present when making a referral to NYSED :: ACCES :: VR : current diagnosis or referral information that indicates the presence of mental illness, desire to change vocational status, positive view of employment, willingness to cooperate in the vocational rehabilitation process, successful symptom management as related to employment goals, ability to meet basic need for food, shelter, and health care and availability to participate in vocational services. A critical element is a local mechanism in place to help expedite referrals to ACCES-VR or to MH treatment clinics. ACCES-VR District Offices and local MH treatment programs are strongly encouraged to identify staff liaisons to help expedite the referral process between agencies and clarify efficient local referral procedures.

2. What is the most effective way for a mental health program to refer to ACCES-VR? Best practices have shown that referrals to ACCES-VR occur expediently when there is a regular communication process in place between ACCES-VR and MH Program liaisons. If the designated liaisons determine that a referral is appropriate, the functional criteria described in the MOU should be forwarded to ACCES-VR along with other pertinent referral information so that consideration for eligibility for ACCES-VR services can be determined by ACCES-VR. It should be noted that the functional criteria described in the MOU is also very similar to the "IPRT Readiness Tool" criteria that many MH providers utilize in NYS to assess an individual's rehabilitation levels in several domains including vocational. There must also be consumer involvement, concurrence, and informed choice in the decision to make the referral to ACCES-VR.
3. How is it determined whether someone can benefit from ACCES-VR services? Eligibility for ACCES-VR services must be determined by ACCES-VR in relationship to the individual's ability to benefit from services and to achieve an employment outcome. The ACCES-VR counselor begins the eligibility process with the presumption that all persons can benefit from the vocational rehabilitation process. ACCES-VR will utilize a trial work experience and/or an extended evaluation when there is a question whether the person can benefit from vocational rehabilitation services.
4. Can anyone with a psychiatric disability apply for ACCES-VR services? Yes. Any individual who has a psychiatric disability and wants to seek employment can apply for ACCES-VR services. However, completing a ACCES-VR application does not automatically mean a person meets ACCES-VR's eligibility criteria. An individual can seek ACCES-VR services directly or be referred by others with the applicant's consent to the referral.
5. What happens next when a person with a psychiatric disability is found not eligible for ACCES-VR services? The ACCES-VR/OMH MOU recommends formal contact between mental health providers and ACCES-VR. Best practices show that ACCES-VR Counselors and MH Program Liaisons should identify other needed services to improve vocational readiness. The applicant as well as the referring agency is also to receive a letter from ACCES-VR stating that the individual referred is not eligible at this time. Best practices also assure that the consumer and referral agency understands what's necessary in order for an applicant to be reconsidered for ACCES-VR services.

6. What documentation does ACCES-VR prefer in order to open a case on someone with a psychiatric disability and to establish eligibility?
Many ACCES-VR district offices have pre-prepared referral packets for individuals with psychiatric disabilities to help clarify information that is preferred in order to establish eligibility and development of the Individual Plan for Employment. It would expedite the process if when making a referral to include information on functional limitations, individual strengths and any previous training/education or employment history. Persons on SSI or SSDI should provide ACCES-VR with a copy of their award letter or "Ticket" to provide evidence of having a disability that constitutes a significant impediment to employment.
7. What does ACCES-VR mean by presumptive eligibility?
The law states that all SSI/SSDI recipients who want to work have presumptive eligibility for ACCES-VR and should bring proof of receiving benefits. Individuals who verify that they are receiving SSI or SSDI and intend to work are assumed eligible for ACCES-VR services. Only when a trial work experience or extended evaluation shows that there is clear and convincing evidence of a disability too severe to benefit from ACCES-VR services, are individuals determined to be ineligible for ACCES-VR services.
8. Must an individual with mental illness be receiving treatment in order to be eligible for ACCES-VR services?
No. If it is found not necessary for the person to benefit from ACCES-VR services. However, the person must be ready to commit to a process that leads to an employment outcome. During the vocational planning process, if mental health treatment services are considered to be an essential component of a successful rehabilitation plan, a discussion should occur between the ACCES-VR VRC and consumer as to the benefits of such treatment services. The individual should be encouraged to seek appropriate services based on the ACCES-VR Counselor's judgment as to the necessity of treatment to preserve a viable vocational plan. ACCES-VR can assist in locating such services.
9. What should the ACCES-VR Counselor do when referral information is not available from referral sources such as schools, for students who are labeled ED (Emotionally Disturbed)?
ACCES-VR cannot demand information that doesn't exist or is not normally available from the referral source. The ACCES-VR Counselor should authorize an appropriate psychological, neuro-psychological or psychiatric evaluation, if needed. It should be noted in the case of referrals from schools, that if educational records confirm that a student has a mental illness (ED or emotional disorder) that results in functional limitations and impediments to employment, this may be adequate documentation to confirm that the person has a psychiatric disability.
10. Is it necessary to attend a ACCES-VR Group Orientation in order to apply for ACCES-VR services?
No. ACCES-VR District Offices may use group orientation to expedite and facilitate referrals of prospective consumers. However, group orientation should not be seen as a requirement for an individual to apply for services that would not benefit from a group orientation. All reasonable efforts should be made to assist the applicant in benefiting from the ACCES-VR referral and orientation process, including having

someone accompany the applicant. If a first time applicant desires a one-on-one initial meeting with a counselor or intake worker, rather than attending a group orientation, it should be noted that this may be slower than the first available group orientation date.

11. What needs to be done at the local level to help expedite referrals to ACCES-VR MH for individuals with psychiatric disabilities?
ACCES-VR District Offices and local MH Programs are strongly encouraged to identify staff liaisons to help expedite the referral process between agencies and clarify efficient local referral procedures. Whenever possible, written special referral procedures should be available to help expedite local procedures.
12. Why is it important for ACCES-VR to try to expedite referrals for individuals with psychiatric disabilities?
It is particularly important to process referrals quickly because of the profound ramifications of additional stress and frustration that a lengthy referral process may have on this population.
13. Whose signature is required on written referral documentation?
A signature is preferred but not required by ACCES-VR for medical or specialty reports. A consumer or guardian's signature is required on a ACCES-VR application.
14. What is the best way for ACCES-VR and OMH providers to mutually serve individuals with mental health diagnoses achieve employment success?
Continuous collaboration needs to be promoted between ACCES-VR and OMH providers so that a partnership is formed that will combine our services throughout the vocational rehabilitation process. Vocational rehabilitation services should be commenced at the earliest stages of mental health treatment as possible. As long as consumers can benefit from services, there is no reason to postpone those services until treatment is completed. Mental health providers need to be educated by ACCES-VR as to the importance of continuing mental health supports while consumers are receiving ACCES-VR services. It should be stressed that it is equally important for mental health providers to continue those supports when consumers become employed, if those supports are needed. Utilization of Extended Evaluation and the Trial Work Experience should also be considered for consumers with mental health diagnoses who appear to have questionable potential to benefit from services. Additionally, because recovery does not occur in a linear fashion and many psychiatric illnesses are cyclical in nature; use of ACCES-VR Case Status 24 (Interrupted Services), may be indicated to get through some exacerbation periods. By using status 24 rather than case closure at this juncture, ACCES-VR can continue to collaborate with the mental health provider about their consumer's treatment progress. ACCES-VR may then be in a better position to provide a more timely resumption of services when the consumer is again able to benefit from the vocational rehabilitation process through ACCES-VR. (Utilization of ACCES-VR Case Status 24 is based entirely on individual ACCES-VR Counselor judgment)
15. Can college attendance (vocational training) be considered as a suitable employment goal?
Any type of training, including college attendance, is not considered by ACCES-VR

as an employment goal in and of itself. Any vocational training program will be considered only when it is necessary to achieve an identified employment outcome