

Handouts and Reference Materials from Mark Ragins, MD

I have enclosed in this packet several short documents that highlight various aspects of recovery based transformation...

- 1) Up Close and Personal
- 2) Hiring and Supporting Consumer Staff

If you would like more detail, I have written several longer documents that contain almost all of the details and stories in my presentations. You can find these on the MHA Village website at www.mhavillage.org at dr. "mark's writings."

- 1) A Road to Recovery
- 2) A Guide to Mental Health Transformation on a Personal Level
- 3) Proposition 63 Begins: The Mental Health Services Act Implementation Toolbox
- 4) Building MHSA Programs

As you will see, the website contains my writings over a number of years. I try to add new articles as I write them. For more information on the MHA Village, peruse the website! You can also check out www.mhala.org.

I can be reached at MHA Village (562) 437-6717 x275, mragins@mhala.org, or through MHALA's Training & Workforce Development Department (contact: Kate MacKenney, 562-285-1330 x244, kmackenney@mhala.org). MHALA has other Training & Workforce Development Products & Services under the new brand "Build Your Own Box."

thinking outside the box is so 1969. to be truly innovative and make new ideas work you need to build your own box.

what we do. we enhance your existing programs, help you build new ones, and develop your staff into a strong, recovery-oriented workforce.

we help you build your own box.



buildyourownbox@mhala.org
www.buildyourownbox.org 562.453.6274

UP CLOSE AND PERSONAL: A Plea for Emotional Closeness with Patients

By Mark Ragins

I went to medical school intending to become a psychiatrist. I was excited when finally in my third year, I got to my first clinical rotation in psychiatry at Malcolm Bliss State Hospital in St. Louis. I was looking forward to spending time with “real” mentally ill patients. I rapidly figured out if I just sat in the day room lots of patients would come up to talk with me. Soon, however, one of the nurses came out to chastise me, “Don’t sit there talking to the patients like that. You’re only here for six weeks. They’ll just get attached to you and then they’ll be hurt when you leave.”

There was more to it than that. No one was talking to the patients. The nurses all hid behind a glass wall in the nursing station, studying charts and talking to each other, only coming out to do their “patient checks”. The psychiatrists, mostly foreigners, were on another floor entirely, in the library studying for their exams. And the psychologist only appeared once when we admitted a fragile, traumatized young woman he thought might be appropriate for psychotherapy. The patients, hungering for attention, or at least acknowledgement, tended to clamor at the locked windows and doors. Eventually most gave up and withdrew quietly to their rooms waiting for smoking breaks. I had seen this avoidance of emotional contact, and even basic conversation, on many other medical services, but this was psychiatry. Weren’t we supposed to help people by talking with them?

Even at the Menninger’s Institute, a famous psychoanalytic hospital, conversation had to be carefully limited. I spent some time talking to a young man about his beliefs that satellites were putting thoughts into and out of his head. My supervising psychiatrist also chastised me, “Stop talking to him about the satellites. Don’t you know that you’re feeding into his delusions?” I didn’t know enough then to wonder how we were going to build a trusting relationship with him without talking about the things in his life that were the most powerful, disturbing, compelling experiences that he’d ever had. Ironically, the psychiatrists’ interpretation of his patient’s delusions was that he was feeling unable to communicate and had the unconscious fantasy that his thoughts could be shared directly without needing speech. Maybe normal conversation would’ve helped him.

As medical school went on, I found two islands where connecting emotionally to patients wasn’t discouraged: A substance abuse treatment program and a hospice. When I told the recovering addicts, who were running the rehab unit, my story about wanting to talk to the patients in the day room, they were thrilled, “Finally a med student who’ll be able to help people.” The family practice doctors who ran the hospice actually encouraged me to share the patient’s worlds, to write letters for them, watch T.V. with them, wash their feet, to reminisce. They wanted me to learn to care for patients instead of cure them. I also learned a valuable lesson: the most difficult and frustrating patients that overwhelmed standard medical and psychiatric care could be helped by connecting emotionally with them.

I hated getting up early checking stitches, fluid balances and labs on surgery rotations, so I made a deal with the surgery residents. I would talk to any patient who had a problem they didn't want to deal with (consents for surgery, pain management, grief and anger mostly) and I wouldn't have to get up early to do the checks. The ward ran wonderfully. I made almost all the problems go away just by talking

When I ask psychiatric patients who have done well, what I did that was helpful to them they rarely answer. "It was that brilliant combination of Depakote, Risperidone, and Zoloft." They almost always recount some moment of human connectedness: "It was when you hugged me and I could tell you knew how much it pained me to have my child taken away." "It was when you believed in me, when I couldn't believe in myself." "It was when you lent me \$5.00 even though you're not supposed to." "It was when you drove me home from the hospital in your car even though I was smelly." "It was when I knew you really cared and wouldn't give up on me." Almost all of those healing moments are "against the rules" of my profession: Don't share yourself, don't break boundaries, and don't get emotionally involved.

I was taught two major reasons for these rules: First, getting emotionally involved clouds our rational judgment. Second, getting emotionally involved makes it harder to act decisively. Although these both sound reasonable, they both produce strikingly disturbing outcomes.

Rational judgment is the foundation upon which the medical profession are based. We break down problems, collect and analyze data, scientifically study syndromes and interventions, and base our diagnosis and treatment on scientific research. The problem with this methodology is it only works for relatively simple problems that can be broken down and studied systematically. If things get too complicated we're stuck unless we try a more holistic approach. Unless we're theoretical physicists or symbolic mathematicians or musical composers we're likely to have to use our emotions and intuition as our holistic tool.

For example, when today's complex computers malfunction and we call in an expert to help, he does not progress through a rational analysis of the problem. He sits down and tries to "get a feel" for what wrong. He literally creates a holistic relationship with the computer to fix it. That's why he can't tell us how to fix it next time. Why does he do this? Because computers are too complex to diagnosis and treat rationally. So are humans and doctors used to know that. That was the basis for the "art of medicine." Not coincidentally those doctors used to relate to their patients as whole people.

I once read a book by the director of the medical diagnostic clinic at Stanford. He estimated that for about 40% of patents he could find some physical condition that seemed to be connected to their complaint (like finding a streptococcal infection in a patient with a sore throat). For 20% he found a physical condition that might be connected to their complaint (like finding high blood pressure in a patient with a headache). For 40% he couldn't find any physical condition connected to their complaint. His plea was that doctors should stop doing more and more tests vainly looking for a treatable condition and

instead look at the person's entire life. Or, in my words, we should give up rationally breaking down the problem and connect emotionally to get a holistic understanding.

It has been claimed that the most common diagnosis in Medical Emergency Rooms is "battered woman" but it's hardly ever made. I'd argue that's because "battered women" is a holistic diagnosis that is very hard to identify entirely rationally without "getting a feeling" that something bigger is wrong.

In psychiatry, the drive to rationally diagnose, to become scientific professionals, has led to the creation of the amazingly fragmented, overly simplified, rarely explanatory Diagnostic and Statistical Manual. I have a psychiatrist friend who says, "You'd better diagnosis someone rapidly before you really get to know them and realize they don't fit into any pigeon hole". DSM's approach to complexity is not causal understanding or holistic connection, but rather to stack numerous oversimplified diagnoses on top of each other on multiple axis. The end result of making sure emotional involvement does not cloud our rational judgment is a fragmented, overly simplistic, formulaic diagnostic system devoid of almost all true wisdom; labels without meaning.

It is difficult to act decisively while we're emotionally involved. I struggled as a medical student to start IV's in people's arms because I was concerned about hurting them. Sticking long needles into the backs of crying children was almost impossible for me. Staying emotionally detached makes it possible to act without considering the emotional impact on our patients. But how much "inconsiderate intervention" do we really want from our doctors? Maybe a little in an emergency, but usually none for chronic illnesses. As a psychiatrist I was taught to "inconsiderately intervene" by hospitalizing people against their will, tying them down, and forcing them to take medications. Is that what we really want from our psychiatrists?

I would claim that our salvation from psychiatry based on fragmented "rational diagnosis" and "inconsiderate interventions" depends on us connecting emotionally with each other.

Many people with serious mental illnesses feel that they are more disabled by stigmas than by symptoms. When we give this view any credibility at all, we start by blaming the media and social stigma, rather than looking at our own prejudices. We invariably prescribe education as the treatment for stigma. I don't agree. If education was the solution, then doctors should be very low in stigmatizing behavior and attitudes. All of us know this just isn't true. It seems to me that stigma is most effectively combated with emotional connections. The old cliché goes "I hate black people ...well except that one I know ... and she's an exception too, she's nice...and not him either"... and so on until the prejudice dissolves away.

Our field routinely, and generally unintentionally, does enormous amounts of segregating, prejudicial, stigmatizing things to our patients. We make them use separate bathrooms and eat separately. We keep watch over them in our waiting room with armed guards to keep us safe rather than protecting everyone together. We don't hire them or

even socialize with them. We urge them not to have sex, get married, or have children. We set up segregated housing for them. We separate them from other medical patients and other social service recipients. I could go on and on.

I would claim that our salvation from disabling stigma depends on us connecting emotionally with each other.

So what's really going on here? If emotional connectedness is what our patients want, what's most likely to help difficult, frustrating patients; if it could reduce fragmented diagnoses and inconsiderate interventions, and dissolve disabling stigma, why aren't we doing it? I don't think it's because of the usual suspects - professionalism, psychoanalytic counter transference concerns, ethical concerns about how we'll misbehave if we lower boundaries, or even fears of liability and getting sued. I think there are three powerful emotional reasons for distancing ourselves: (1) We don't want to feel our patients' disturbing feelings because we are afraid we'll be "burnt out". (2) We don't want to lower our defenses because we don't trust our patients. (3) We're physically frightened of our patients because we've experienced serious violence with them.

Many of our patients experience truly terrible emotions. That's usually why they come to see us. One man once told me, "Being paranoid is like being in a Nazi concentration camp knowing you could be tortured or killed at any moment for no reason, except that no one ever comes to liberate the camps and no one believes you that they exist." Another woman told me, "Having your child taken away is like having your heart ripped out of your chest, leaving an enormous black hole that no matter how much you cry just goes on aching."

Part of us knows or vaguely remembers that we have to share these feelings with them if they're really going to heal. We can't just toss them a diagnosis and a pill. But can we really handle it? Won't we burn out? "Your job must be very hard on you," our friends tell us. "I don't know how you do it." If we were being honest, we would admit that mostly we don't "do it". We block out feelings. We keep patients at a distance. If we were being honest, we'd have to explain why we're in mental health at all, if we're not doing it with feeling. If we were being honest, we'd wonder if we were actually helping anyone this way.

I agree with Patch Adams on burnout. I think burnout is not from feeling too much, but from trying not to feel. We build burnout when we block out our heart-felt responses and deaden ourselves a little to avoid the pain. Feeling too much doesn't burn us out, it frightens us, and makes us feel small and vulnerable. We instinctively respond to fear by lashing out in anger or by hiding away by ourselves. It's those reactions that harm patients far more commonly than true neurotic counter transference.

If we work by ourselves in small rooms one-on-one, walled in by confidentiality rules, with nowhere for the feelings to go, we're at our most vulnerable and won't be able to handle much. If we're part of a team, if many people are emotionally involved, if our program is full of life and support for us, we can experience more feelings with less fear.

And our ethics will be less likely to get lost along the way. A supportive community is the best setting for safely lowering boundaries and healing emotionally. We can do more together than we can do alone. Although it feels unnatural, we know that in truly emotionally frightening situations (9/11 for example) it's best to reach out to each other, not to be left alone.

We do have to be aware of when we're feeling our own feelings and when we've become characters in our patients' emotional dramas. We can only begin to take responsibility for our feelings and to give back to people their feelings to take responsibility for, if we actually feel. If we don't have a lot of psychodynamic background or training it's often helpful to ask everyone else: "Is everyone feeling angry at John or is it just me?" "Is Susan making you guys feel like wanting to be a strong, protective man too?" If psychodynamically trained "therapists" are members of an open team instead of working in isolated offices, there's a good chance, as feelings are openly shared, of everyone learning how to be more emotionally healing.

Almost every clinician has been emotionally hurt by their patients. Usually it's small hurts like being lied to, or unfairly lashed out at in anger, or manipulated, or showered with ingratitude. Sometimes it's big things like being falsely accused of sexually molesting a patient, or being sued unfairly, or being reported to our supervisor and getting fired, or being blamed in their suicide note. The small hurts make us more defensive and can gradually distance us from them. The larger hurts can be truly traumatizing. We may disconnect entirely or put up massive defenses. Sometimes we're not even aware of it.

Once I was talking about this issue with a middle aged social worker, who said she couldn't relate to patients like friends because she couldn't trust them. I helped her remember why: When she was an intern she was diagnosed with cervical cancer and had to leave work for a month for treatment. When she returned her patients weren't at all concerned for how she was or what illness had forced her to leave. They were angry with her, "How could you leave me when I am going through so much?" She'd forgotten how hurt she felt by them, but from then on she's "known" not to expect any caring from her patients.

So, what's wrong with that? Our patients aren't "there to make" us feel cared about. The problem is that we'd like our patients to grow enough to get emotional connections from friends instead from therapists and they'll have a great deal of trouble keeping friends if they don't learn to care about the people who care about them. That social worker was inadvertently teaching her patients not to care about her, which may well have the impact of keeping them friendless and relying on therapists forever. The more real we are with our patients the more likely we're teaching them to be able to be friends with real people and not need us forever. Certainly there are goals to therapy beyond paid friendship, but far too often not having friends keeps patients needing us far too long.

Sometimes patients physically assault staff. This can frequently leave us seriously traumatized. One day one of my very aggressive female patients was hospitalized out of control. When the very sweet nurse wouldn't take her out on a cigarette break fast enough,

she shoved her down and kicked her in the head opening a large bleeding gash that required eight stitches. The nurse was literally and psychologically stunned. She took off a couple months but never really recovered. She went from being a warm, empathetic soothing nurse to cowering and trembling, too frightened to reach out any longer. A wonderful healer was lost to us. No matter what apologies or amends I got the sincerely regretful patient to reach out with, the nurse couldn't respond.

Even when it's someone else who has been hurt we can all be affected. I had a close friend, a young woman social worker who worked as the clinic's sole homeless outreach worker. For several months she had been trying to work with a man who had severe schizophrenia, was very delusional, refused all medications or assistance, and lived in garages that were left open. The neighbors were frightened and disturbed. When the police arrested him the judge ordered him into counseling, not medications or housing. My friend had been bringing him lunches on the street and went to court to support him. Several weeks later he came into her office, where she was alone. He thought she was the Devil so he pulled out a knife and stabbed her 27 times. The screams stopped when she died before anyone arrived to help her. This was extremely tragic, not just for me, but for many others. There was a candlelight vigil, a crowded funeral, and the clinic held meetings to help process our feelings. Several staff took leaves and many even quit. I met with a group of troubled coworker friends for dinner over and over. Knowing statistics that mentally ill people are no more dangerous than anyone else was of no assistance.

Ultimately, I had to make a decision. Either I was going to feel betrayed by my patients and distance myself from them, or I was going to feel betrayed by the mental health system and distance myself from it. Either "Why put myself out to help these people when they killed my friend. Forget it, they're not worth it," or "Why did we send out a little woman all by herself to do "counseling" with a dangerous psychotic man without any real treatment available. That's not a system. It's a human sacrifice." Ultimately I chose to stay very close to my patients and to leave county mental health and work for the Mental Health Association devoting myself to radically changing the system that betrayed us.

I'm proud to be the first full-time psychiatrist hired by the Mental Health Association of Los Angeles. One of the things I like about MHA is the logo of the MHA bell on our business cards and stationary. The story of the MHA bell goes something like this: In World War II there was a set of conscientious objectors, mostly Quakers, who were assigned to work in mental asylums instead of fight in the war. The combination of decrepit, inhumane institutions and these highly principled workers proved a volatile one. They engaged in substantial advocacy efforts. Perhaps the most symbolically powerful of these efforts was to collect up the iron chains and cuffs that had been used to literally chain patients to their beds and the walls. They had them brought by train from all over the country and melted down into an enormous bell. On it is inscribed a message something like "from the chains of our enslavement let freedom ring from our eventual triumph over mental illness". When I've retold this story I've always visualized the moment of triumphantly striking the bell. However, for that moment to be possible there must have been many other moments in the months that preceded it, where some staff literally unchained some patient. That staff must've hesitated in fear, wondering if he was going to

be attacked. He must've reached out as though untying a wild animal hoping, and trusting a little, that he wouldn't be hurt. And on the other side, there must've been a patient, filled with anger, sorely tempted to lash out against his captor who had led him by a leash to the toilet the day before, who decided not to attack. The patient had to hope, and trust a little, that the staff was really going to help him this time, when he accepted the staff out stretched hand.

That moment, on both sides, is the moment in which healing and recovery are possible. That is the moment when fear and mistrust is put aside enough to reach out honestly and caringly to each other. That is the moment that makes emotional connectedness possible. That is the moment that makes triumphant bell ringing possible.

If we are to be honest, each of us, staff and patient alike, face that moment every day. We can't respond, "The rules force us to keep them chained," or "It's too risky," or "I've been hurt too many times before." We must courageously reach out to each other every day.

Hiring and Supporting Consumer Staff

By Mark Ragins, MD

I once wrote that I thought that the single most transforming thing the mental health system could do would be to hire large numbers of consumer staff. Now, because of the Mental Health Services Act counties all over the state are doing just that. I wrote that because I believe that hiring consumer staff will have an enormous anti-stigma effect challenging the prevailing image of people with mental illnesses as incompetent, irresponsible, and dangerous.

Consumers who are willing to disclose their experiences with mental illnesses hired in any position will have opportunities to reduce stigma in a variety of ways. Broadly speaking stigma reduction can be directed towards 1) the people we serve and their families (for example by being a successful role model), 2) mental health staff and administration (for example by changing staff's perceptions of the abilities of people with mental illnesses by working alongside them as their colleagues or by "vetting" policies and practice guidelines from a consumer perspective), and 3) our community (for example by promoting social networks that welcome people with mental illnesses through self disclosure or promoting more positive media coverage of mental illness by publicly disclosing personal experiences with mental illness).

However, we must be careful as we move forwards. Potential pitfalls seem to be everywhere. It seems to me that the foremost risk is that if our consumer staff work poorly the stereotypes will be reinforced rather than challenged. If we include consumers in our clinics in only limited protected roles and the professional staff have to heavily support them and give them lots of accommodations we risk reinforcing staff's negative expectations. If we create independent consumer run programs that are poorly run, aren't held accountable, have violent incidents, and turn to the local clinic for help in crises we risk reinforcing our communities' fears.

When the Village first began we hired a few of our "best" members to work answering the phones and making lunches for homeless people. They worked three hours a week in stipend jobs making \$65 per month so their SSI checks wouldn't be affected. They mostly did their jobs poorly and we were "understanding." When Paul Barry came to us from Corporate Cookie, a busy cookie store on Wilshire Blvd. run by people with mental illnesses, he said that we weren't going to have any more little stipend jobs. All jobs would be five days a week, two to four hours a day, and furthermore, all work would have to be done at community standards. I said that was the stupidest idea I'd ever heard. Didn't he understand that these people had serious mental illnesses? They're disabled. They couldn't even do the stipend jobs well.

Since the psychiatrist doesn't run the employment program at the Village we did it Paul's way. Sure enough, he ended up firing most of them. But before I could get up to his office to say, "I told you so!" the strangest thing happened. Most of them wanted to try to get their jobs back and I was too busy working with them figuring out what had gone wrong and helping them change it. We changed medications, created new support plans,

even worked on stopping drugs and alcohol, so they could succeed. And Paul fired most of them again.

By the sixth or seventh time, however, they were starting to really get it. The vast majority of people who did stipend jobs poorly could develop enough to do daily jobs at community standards. Paul called it “work hardening.” I called it frustrating. Ultimately, he was right. Our kindly low expectations weren’t helping them grow and work effectively.

If everybody has to learn that lesson the hard way like I did, we may be in trouble.

We’re not hiring people with mental illness not out of pity for their disabilities, or out of compassion for their struggles, but out of respect for the added strengths and skill sets their experiences have given them. We’re hiring them because they can work effectively, often in ways we can’t, and because if they’re successful it’ll break down stigma and transform all of us.

We’ve already run into difficulties in almost every county with human resource departments mostly because of civil service rules prohibiting affirmative action. Even building in a preference for hiring people with mental illnesses into job descriptions has been elusive. Most counties have reacted by either creating special Peer Advocate or Peer Supporter jobs or by contracting out consumer employment entirely. Both of these approaches widen the distance between consumer staff and “normal” staff decreasing the likelihood of lowering boundaries and stigma and risk creating segregated “separate but equal” arrangements. Unless some arrangement is made for consumers to be integrated as full colleagues we’re unlikely to really succeed.

It’s scary for staff to really accept people with mental illnesses as colleagues. And to be fair, it’s scary for some consumers to give up their “protected” consumer jobs to be integrated. We’re hardly on solid ground for heavy advocacy to human resource administrators who often have other more pressing interests than fighting stigma. To advocate from a position of strength, we need to begin with what employment roles consumer staff will add to our services.

The relevant qualification is not a documented diagnosis or open case in treatment, but rather the ability to use past experiences and self disclosure to help people. We need to be specific about how we expect them to use those experiences (and equally importantly, deal with fears about how they shouldn’t be using those experiences). What are the roles consumers can perform that other people can’t?

1) Consumer representative – Consumers should be included in all levels of decision making, planning, and program design embracing the spirit of “nothing about us without us.” Representatives must be careful to present not just their personal positions, or even just those positions sanctioned by the “consumer movement” and their established organizations. They are responsible for presenting the range of positions of the effected consumers carefully including those unable to articulately speak for themselves.

2) Peer advocate – Peer advocates work to help improve the system on behalf of individual consumers. This must be a collaborative arrangement where the peer advocate's agenda clearly represents the choices of the consumer they are representing, rather than the advocate's agenda, since they are the ones who will experience the consequences of the advocacy effort, both good and bad, most directly.

3) Peer supporter – Peer supporters rely on listening to people's stories and sharing their own stories to support individual consumers. Care must be taken to emphasize shared personhood rather than shared patienthood even when sharing experiences directly related to illnesses and their symptoms. An important function of peer supporters is to reduce the possible stigma and personal damage of the diagnostic labeling process by sharing and thereby normalizing people's experiences. The goal of peer support is not to give advice through the shared stories, but to strengthen the person being supported by creating a feeling of being understood, educating them, broadening their awareness, opening up new opportunities, and increasing their sense of hope, personal power and self-responsibility. Peer supporters will likely benefit from the sharing process as well, but must make sure that meeting the other person's needs take precedence over meeting their own needs.

4) Peer bridger - Peer bridgers may act as a bridge into mental health services outreaching and engaging with people who are not collaborating voluntarily with mental health services. Peer bridgers may also act as a bridge to community connections for people by helping people begin to move beyond strictly professional support, by using themselves as positive role models of people using community supports, and by opening up new opportunities in our community for people with mental illnesses by sharing their stories within the community.

5) Peer counselor and peer case manager – These people provide the same range of case management and community support services as their non-mentally ill colleagues while emphasizing the strengths of their shared experiences, for example promoting engagement, risk taking, empowerment, self-responsibility, acceptance, independence, and graduation. It is expected that these staff's effectiveness would benefit from a decreased perception of power differential and less professional distance.

6) Peer self-help facilitator – Consumers may be facilitators of self-help groups and programs either volunteer or paid. Then they are required to maintain staff responsibilities and ethics. (For example, they may no longer date or have financial dealings with other group members.) Some people's responsibilities will change within the same group when they are hired or leave employment in that program. It is possible to be a participant in one group or program and a staff in another one.

The bottom line is that none of these roles can be accomplished unless consumers are hired. That's solid ground to approach administration with. It's devoid of pity, compassion, or affirmative action.

Each of these roles do not necessarily define job titles or the person’s professional identity. They all may be integrated into our “normal” job descriptions. Each requires specific skill sets beyond experience with mental illness that can be included as “additional qualifications.”

Our next challenge is to properly prepare and support consumer staff so they’ll actually succeed. There’s two basic parts of this task: Job training and personal support. There’s also a need to have training and support available throughout the entire process from recruitment to leadership promotion. Here’s a table of what’s needed:

Function	Content
Engagement	Identifying consumers and families in clinics – engaging with clients interested in MH employment Consumer advisory boards Volunteer assignments and mentoring at their clinic Inclusion in Wellness activities / Self-help programs Inclusion in clinic planning, education, and operations
Job Training	Build on existing curriculums Add needed skills <ul style="list-style-type: none"> • Case management • Recovery relationships • Clinic / program operations • Billing • Self help groups Specific content for each role Specific content for each clinic / program
Transitional Support/Role Training	Consumer issues <ul style="list-style-type: none"> • Disclosure • Peer roles • Consumer movement and advocacy (OCA) • Personal role changes • Benefits effects • Moving clinical care Includes Support Group

Hiring	<p>Job descriptions</p> <p>Job qualifications</p> <p>Approving job candidates</p> <p>Local interviewing and hiring</p>
Orientation	<p>Systematized orientation for all staff</p> <p>Assign onsite clinic supervisor and peer mentor</p> <p>Shadowing variety of staff to be exposed to all clinic functions</p>
On Job Supervision	<p>Job expectations and performance evaluations</p> <p>Extra onsite training if needed</p> <p>Mentoring for supervisors (supervisor group to share problem solving)</p>
On Job Support	<p>Consumer Issues focus</p> <ul style="list-style-type: none"> • Boundary issues • Confidence • Fear of losing benefits • Acceptance <p>Peer Mentors onsite</p> <p>Ongoing Support Group</p> <p>Accommodations</p> <ul style="list-style-type: none"> • Utilizing a job coach • Providing additional individualized training. • Designating a co-worker as peer support. • Benefits counseling • Flexible Scheduling • Job sharing • Allowing workers to shift hours for appointments • Leave during a hospitalization <p>Train team staff to be able to include and support consumer staff</p> <ul style="list-style-type: none"> • Confidentiality • Role confusion • Inclusion • Supervision

<p>Transition to integrated employment (non-consumer restricted jobs)</p>	<p>Additional training and HR policies to transition to paraprofessional jobs</p> <ul style="list-style-type: none"> • Administrative Assistant • Job Coach • Housing developer • Community support worker • Program Manager • Case Manager • Case Manager Assistant <p>Supervision to full staff responsibility</p> <p>Support for professional training to transition to professional jobs</p> <p>Career ladders</p> <p>Leadership training and mentoring</p>
---	--

I don't think we'll have much disagreement over the items in this list. (Although there may be substantial arguments over who has the expertise and authority to provide these trainings and supports. In particular, which of them "must" be provided by consumers can be a thorny issue.) I expect the problem will be having the will to actually create all those items. It's easy to look at a table like that and say, "All that would be nice, but we don't have the resources, and it would take too much time to set up, and we don't have anything like that for our 'normal' staff, and we need to get started now...so let's just hire a few consumer staff now and see how it goes."

The further we go along with hiring and supporting consumers, as with most of this transformation effort, the more detailed and complex everything gets, but also the more plausible it seems.

One final counterpoint before I close: What about family members? Both the President's Commission Report and the MHSA routinely lump "consumers and their families" together and yet their fates seem to be playing out very differently. Families have been effectively involved in the planning process, but rarely included in direct service delivery or mental health employment. We see large numbers of consumers almost everywhere wanting jobs in mental health to "give back," but very few family members. There's probably a wide array of reasons for this, but at least for now families aren't being employed and it isn't high on anyone's advocacy agenda to do anything about it. Should it be?