

Reflections

**HENRY STREET SETTLEMENT
COMMUNITY CONSULTATION CENTER**

1969-2013

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A Little About Us

The three of us, Lorraine Ahto, Florence Samperi and Lela Charney, are licensed clinical social workers and trained family therapists, and have been colleagues and friends for over forty years.

Upon our retirement, we decided to write about our experiences at the Henry Street Settlement Community Consultation Center, located on the historic Lower Eastside, New York City. When we started to do research about the Consultation Center, we learned that there was very little written or preserved at the University of Minnesota where the Settlement's papers are archived. This prompted us to make a commitment to document our work and leave a historical record of our more than 40 years of service from 1969-2013.

We started out with the idea of writing a book but settled on writing a monograph, leaving the idea of a book for a later time. In a discussion with our consultant, Michael Kraten, he asked us if there were particular experiences that had significant impact on our work. Within minutes, the three of us came up with a range of events that influenced our work and the growth of the Community Consultation Center. Thus, our monograph, "Reflections" was born.

We enjoyed thinking, reflecting, writing and sharing our story. We hope you enjoy reading it as much as we did writing it.

Introduction

Henry Street Settlement's mental health clinic opened in 1946 under the leadership of Helen Hall, the Settlement's second executive director. Years later, in a conversation with Hall in 1976 on her visit to the clinic, (now known as the Community Consultation Center), Ahto learned that Hall was overwhelmed by a mother's desperation to find mental health services in the Lower Eastside for her troubled child. Hall's experience with this mother eventually led to the development of Henry Street's mental hygiene clinic for the treatment of children.

Our history with the Community Consultation Center (CCC) begins in 1969. It is a story of innovation and creativity in the face of daunting obstacles. It also features the adaptation of a therapeutic model of care from Milan, Italy, the successful renegotiation with the City government for a 100% reimbursement contract to prevent CCC's closure, the development of ground-breaking programs to serve the most in need, and the effort to support the recovery of the world's greatest city after the terrorist attack on September 11, 2001. It is also about the Ahto and Samperi leadership team and Charney's skillful program development and implementation which navigated the Consultation Center through a changing human services environment.

The story concludes with a return to the origins of the Henry Street Settlement (HSS) as the provider of community-based primary care services. It is a conclusion with a cliff-hanger, as the transformation of the American healthcare system threatens the delivery of continued, accessible, low-cost,

neighborhood medical services, impacting consumers and providers.

We begin in 1969 as Lorraine Ahto, future CCC Director, applies for a job as a senior social worker.

Beginnings

The story begins in 1969 when Ahto was hired as a senior social worker (Charney hired in 1974 and Samperi hired in 1981). Drawn to HSS, Ahto was eager to be associated with this historically significant organization whose founder Lillian Wald was a pioneer in the Settlement Movement.

Ahto recalled that her employment interviews took place in the Associate Executive's office, a large comfortable room with bright sunlight and air conditioning. Compared to the large sunlit room where Ahto was interviewed, the site where she began her first day on the job was a total shock. She knew that the mental health clinic was located in the basement of LaGuardia Houses, a public housing complex managed by the New York City Housing Authority (NYCHA). Its location reflected the mission of the Settlement: to bring the services to the people. The area was now surrounded by public housing buildings, which replaced the overcrowded tenements, with HSS operating programs in many of the buildings' basements. Utilizing the basements didn't infringe on the available affordable housing for the community.

As Ahto walked into CCC, she couldn't believe what she saw. Could this be the mental health clinic? It looked dreary, neglected and totally unwelcoming. In several offices, desks were piled on top of one

another. The heat was so unbearable that it was difficult to think. Who works here? she asked herself. Do they not care? What do people think when they walk in requesting help? Do they ever come back? How do people get better?

Ahto soon learned that the clinic was in the process of reorganization, but to her it appeared chaotic and disorganized. Under the leadership of Henry Street's third Executive Director, Bertram Beck, the clinic was renamed the Community Consultation Center from its previous incarnation as the mental hygiene clinic. The name change reflected the expansion of services to include social services and advocacy. This resulted in the clinic's restructuring into two units, a unit of existing clinical professionals and a new unit composed of community residents trained in case management and advocacy.

Staff told Ahto that the atmosphere at the clinic and the Settlement was tense, marked by social and political upheaval among the staff and the community. Ahto soon learned that some CCC staff did not embrace the changes and that staff from other HSS programs perceived mental health services as irrelevant to the local community. The prevailing view at HSS seemed to be that mental health services were not essential. Collaborative attempts by CCC staff with other HSS departments were not sustained and referrals to CCC from HSS programs were few.

What was playing out at HSS mirrored what was occurring throughout the United States in the 1960s through the mid-1970s: social unrest, racial strife and economic disparities. It was the time of the Civil Rights Movement, opposition to the Vietnam War,

and increasing homelessness, resulting from deinstitutionalization and the lack of affordable housing. These issues affected the work at Henry Street. Indeed, it was an environment with stressors on many levels.

Bertram Beck believed in the centrality of community participation to address these issues. He established an HSS Neighborhood Board and a Community Advisory Committee for each department. The Neighborhood Board, comprised of approximately 30 community residents, acted in an advisory capacity to the HSS Board of Directors and held three permanent seats on the HSS Board. Neighborhood Board members were assigned to each department, as an Advisory Committee, based on their interests to collaborate and assure relevant program development.

CCC developed a strong and effective working relationship with the Advisory Committee which positively influenced program development. The committee became a strong advocate and a dominant voice in the community supporting mental health services and successfully collaborated on many projects over four decades. The Advisory Committee, later known as the Community Advisory Board (CAB) endures and continues to remain vital to CCC.

Ahto never forgot her first impression when she walked into CCC. She strongly believed that an agency environment should always support staff morale and be welcoming and respectful to the community and to those they served.

With her promotion to Director in 1976, she made a commitment to budget money for annual repairs,

renovations and upgrades to the facility. Challenged by reoccurring budget cuts, it took 6 years before this commitment could be realized. Renovations and upgrades began in 1982 and spanned over three decades. Before Ahto, HSS tour guides always detoured their groups and visitors around CCC. Eventually, as a result of Ahto's attention to the clinic's environment, every group and visitor to HSS stopped at CCC and shopped at its trendy patient operated clothing boutique, "The Unlimited."

From the beginning of the Ahto and Samperi leadership team in 1981, they believed that staff was their most important resource to assure positive patient treatment outcomes. Recognizing that discord among staff often impacted productive and cooperative work, they committed themselves to change this culture and identified several ways to nurture staff and improve morale.

Ahto and Samperi created an onsite nursery for staff's infants. The idea came from a staff person to accommodate the childcare needs of three pregnant clinicians. Ahto and Samperi supported the concept and, after initial reluctance of HSS administration, received approval to proceed. CCC provided space; a staff social worker/creative arts specialist designed a children's mural; many patients and staff eagerly participated in painting and completing the project; and the mothers paid a retired CCC case manager to care for their infants.



Section of nursery mural designed by staff social worker and artist Henry Leung

The nursery was positive for everyone, becoming a source of comfort for clients and a respite for staff. “CC” and Max, cats abandoned in the building and rescued by CCC staff, became welcomed members of the nursery and the CCC family! The nursery continued with different CCC staff and their children for over a decade.

Ahto and Samperi also created a warm supportive environment and regularly demonstrated and expressed their appreciation of staff members. Since providing meals was an integral part of the Continuing Day Treatment Program (CDTP), breakfast and lunch were provided to staff as well. Participation was optional but most chose to eat together. Prepared meals reflected the different ethnicities and cultures of clients and staff (Spanish, Chinese, soul food). Ahto and Samperi always ate breakfast and lunch with staff to socialize and to be available to hear staff’s concerns firsthand.

Supporting staff members' development as clinicians was essential to the Ahto & Samperi team. Samperi provided in vivo supervision, observing interviews through a one-way mirror, and often joined clinical interviews at the request of the clinician. She organized clinical teams who collaborated in helpful and noncompetitive ways. Ahto and Samperi encouraged continuing education to enhance professional growth and skills and had an open-door policy regarding clinical and administrative issues.

They respected all levels of staff, regardless of job position. They believed it was not helpful to suppress disagreements and encouraged open dialogue for problem resolution. Attending to staff needs strengthened the clinic's capacity to provide effective care which assured more positive treatment outcomes.

The Ahto/Samperi team was also a strong proponent of program integration and included other HSS programs in the planning and development of new projects. Some were successful; others were not. Perhaps a perceived challenge of losing control of one's program impeded effective collaboration with other HSS departments. In retrospect, addressing and resolving these issues from the outset could have resulted in more positive collaborative efforts.

Ahto and Samperi's attention to CCC clients, staff, and physical infrastructure made the Center an inviting and hospitable place. It prepared the staff to address the formidable challenge of deinstitutionalization.

Responding to Deinstitutionalization

The Community Mental Health Act of 1963 mandated the establishment of community mental health centers throughout the country to accommodate patients released from state hospitals. As a result of the Act, long term psychiatric patients, once “warehoused” in state-run psychiatric facilities, were now being discharged into the community. New psychotropic medications were part of this revolution in mental health care.

While 80% of the patients were discharged, only 20% of state funding from these facilities was redirected into the community for aftercare services.

Consequently, the state aftercare sites lacked adequate space to handle the increasing number of discharged patients assigned to their clinics. In 1972, the previous CCC director offered clinic space for psychiatrists from the New York State Office of Mental Health (OMH) to provide medication management for their discharged Lower East Side patients.

What occurred during these patients' monthly visits at CCC disturbed Ahto. Patients were given block appointments, but the one assigned psychiatrist could not effectively manage the number of patients scheduled. Consequently, patients would “shuffle” up and down the clinic halls, chain smoking, waiting hours to be seen by a psychiatrist for only few minutes. The State was unprepared to handle the numbers of patients discharged into the community.

Ahto, then a senior worker, couldn't see this without taking action. She went to the CCC director and declared: “If we are going to continue working with

the State, we will need to do something meaningful and humane for the patients.”

The Van Ameringen Foundation approved a CCC grant application to hire a social worker to develop therapeutic groups. Lela Charney, a clinical social worker experienced in day treatment programming, was hired to organize and implement this endeavor.

It quickly became apparent in observing these groups that formerly institutionalized patients lacked the basic skills for living independently. Most were undereducated individuals with little or no work history. The majority didn't know how to shop for food and clothing, cook a meal, or maintain a home. Invisible to the public while institutionalized, they were now very visible to all.

To support each patient's return to the neighborhood, CCC developed an Apartment Program directed by Charney. The program was unique in that federal approval was secured from the Department of Housing and Urban Development to remove a seven room apartment in NYCHA housing from the rent rolls, an apartment located in a different building from the clinic. The program was designed to replicate all the activities of daily living required to live independently in an apartment in the community. This program proved to be very effective in developing and improving patients' life skills and much needed confidence.

The CCC team also enlisted the participation of its Community Advisory Committee to help support the patients' successful transition and reentry into the community. The committee took on this project with

much enthusiasm, looking after patients in the neighborhood, reporting concerns to staff, and at times, even walking patients to the clinic for assistance. Working together as a team, the community and staff effectively assured the patients' reintegration.

After two years of substantial referrals, the program was moved to the main clinic site to serve the increasing number of patients and to ensure their safety. The Apartment Program eventually became the Continuing Day Treatment Program (CDTP) certified by the New York State Office of Mental Health and the first to serve the Lower East Side Community. Under Charney's directorship, the CDTP offered support, social and pre-vocational groups and it integrated art, pottery, video and music groups from Henry Street's Abrons Arts Center.



Staff preparing to serve Thanksgiving dinner to the Continuing Day Treatment program members, their families and friends.

With the CDTP in place, CCC expanded its services to include young individuals living in the community who experienced recurrent psychiatric admissions to local hospitals. With this new population, the CCC team developed services based on “wants and needs” articulated by the patients. Although many patients were acutely symptomatic, they attributed their problems to a lack of education and work skills.

Therefore, new strategies were developed to meet patients’ educational and vocational aspirations. Computers were introduced in the CDTP as a component of clinical care primarily to improve frustration tolerance, help alleviate symptoms of psychosis, and improve cognition while simultaneously enhancing clients’ educational and vocational skills. This positive outcome eventually led to the creation of CCC’s vocational services for job training and job placement certified by the New York State Office of Vocational Rehabilitation (OVR) and to the development of an OVR certified computer training program for up to 20 students per training cycle.

CCC also was one of five recipients across New York State to receive an OMH vocational demonstration grant. CCC opened The Unlimited, an onsite clothing boutique, where patients could earn a small stipend and learn work skills in an actual retail setting. The patient interns, under the supervision of a salaried manager, were trained in sales, inventory control, time management and interpersonal communication with customers.

The interns who successfully completed the training were referred to the CCC vocational rehabilitation

counselor for job placement. Others had major social deficits that impeded their ability to secure employment. However, working in The Unlimited and interacting with neighborhood clientele improved their social skills, verbal communication, and self-esteem. This eventually opened other supported opportunities for some.

CCC did not limit itself to providing services on-site. It also extended its care to the hospital setting.

Pre-Discharge Visits to Hospitalized Psychiatric Patients

In the early 1990s, large managed healthcare companies were emerging, threatening the viability of small outpatient mental health clinics such as CCC. For clinics to survive in this competitive environment, it was imperative to provide unique services that managed care companies would want to purchase.

Aftercare psychiatric services for monolingual Chinese were extremely limited at the time with only one mental health clinic in the Lower Eastside serving this population. Since CCC was located near Chinatown, CCC administration made a strategic decision to expand its Continuing Day Treatment Program (CDTP) to meet the mental health needs of this patient group. Chinese staff were hired, and culturally appropriate groups and services were developed and integrated into the program.

To introduce monolingual Chinese patients to the CDTP, CCC began an innovative clinical practice with an inpatient psychiatric unit at Bellevue Medical Center dedicated to treating monolingual Chinese

patients. Bellevue staff was very receptive to this collaboration since, upon discharge, many of their patients never followed up with after care services and often were re-hospitalized.

As a first step in this process, Samperi and a senior Chinese clinical social worker, met with this hospital unit clinical staff including head psychiatrist, nurses and social workers to work out an agreement and to clarify expectations regarding discharge planning. Of utmost significance was CCC's agreement to accept all patients except those patients who remained high risk.

As agreed, a Chinese clinician from CCC was assigned to be a liaison with the Bellevue inpatient staff. This clinician went weekly to the hospital unit to interview new admissions; to continue contact with patients previously seen but not yet discharged; and to meet with unit staff to discuss referrals of patients ready for discharge and aftercare services.

For those patients considered "discharge ready," a hospital attendant escorted the patient to CCC for a psychiatric evaluation to confirm his/her readiness to resume community living. Also, on the same day, social work staff conducted an intake interview with the patient and family and provided a tour of the facility. Generally, Samperi, with the assistance of a Chinese clinical social worker acting as translator, conducted all the intake interviews. These interviews held at CCC helped connect the patient and family to the clinic and the day program prior to the patient's discharge.

Bellevue's goal in working out this discharge process was to prevent the "revolving door" of premature hospital discharges and readmissions. CCC's goal was to increase Chinese patients' positive transition from the hospital to participation in CCC's community aftercare services. At the time, thirty to fifty percent of all discharged psychiatric patients citywide never followed up with aftercare services.

This collaboration proved to be very effective. Virtually all patients, seen both at the hospital and at CCC prior to their hospital discharge, successfully transitioned to community aftercare and engaged in the CDTP. Many of their families also became involved in the treatment process.

The NYCDOHMH, impressed with our success in engaging patients into aftercare services, funded several "linkage" programs in an attempt to duplicate CCC's transition process. However, many of these programs were unsuccessful because the transition from inpatient to outpatient care was handled primarily as a technical linking process utilizing paraprofessionals.

In contrast, CCC had developed an effective clinically driven process provided by professionally trained staff with success achieved by how dynamically that transition was carried out. By the time patients transitioned to CCC's aftercare program, their anxiety was allayed. They were reassured about the care they would receive and with whom they would be working; and, on their tour of the facility, they had seen other patients whom they had met during their inpatient stay.

When this pre discharge transition process was initiated, insurance regulations prohibited outpatient programs from billing for services provided to patients while still hospitalized, considering it double billing for the same patient. Consequently, this service was not provided by the majority of outpatient clinics as it was considered financially unfeasible.

However, CCC recognized its therapeutic value. It became the most effective clinical process in successfully transitioning all patients, regardless of ethnicity, from inpatient to outpatient care. It dramatically reduced recidivism, with CCC having one of the lowest recidivism rates in New York City. And what was perceived as lost income in the initial phase was regained through the consistency of patients' attendance in aftercare services. It was integrated into CCC's service delivery as a Best Practice.

In recognition for this service, in 1994 the New York City Department of Health and Mental Health honored CCC with its "Creative Connections" award. Additionally, in 2000, CCC received the Department's first William Charet Memorial award for its early and long-standing commitment to the deinstitutionalized and its excellence and leadership in the field of mental health.

It is noteworthy that insurance companies, more than twenty years later, have recognized the efficacy of the CCC transition model. Mental health providers are currently reimbursed for pre discharge visits and, as a result, there is greater utilization of the model by mental health providers.

Adopting a holistic model from Milan, Italy, CCC utilized a unique approach for treating individuals with high acuity mental health conditions.

The Milan Model

In the late 1970s, CCC initiated an informal study of its terminated cases to better understand why patients dropped out of treatment. In conducting follow-up phone calls, many patients indicated that they resolved their presenting problem, felt they were helped and made their own decision to discontinue treatment.

Interestingly, an unexpected outcome of this study revealed that CCC treated different children from the same family over time. This pattern was repeated with many families. When one child's treatment was terminated, another child from the same family would be brought into treatment by the parent(s). This new information led us to conclude that it was necessary to understand the meaning of each symptomatic child in the context of the family and parental dynamics. Consequently, CCC shifted from seeing the parent as an adjunct to the child's treatment to a family systems approach focusing on the family dynamics as central to the treatment process.

In 1981, when Samperi joined CCC, she requested and received permission to attend, at her expense, the Milan Systems Summer Training Program in Milan, Italy. This program was conducted by two of the four co-originators of the Milan Model, Drs. Luigi Boscolo and Gianfranco Cecchin, at their training center, Centro Milanese di Terapia della Famiglia. Samperi had previously attended a conference in which Drs. Boscolo and Cecchin presented their ground-breaking

work and was impressed with their optimistic approach. After Samperi returned from the training in Italy, she enthusiastically introduced Milan thinking to the clinic.

The Milan Approach rejected the idea of a linear causality (cause and effect) in human systems. No one thing or one person was seen as the cause/blame for a problem. Pathology only made sense when you viewed the individual/family from a systemic perspective. In fact, Boscolo and Cecchin “depathologized” and reframed what others saw as pathology. Their approach enhanced growth through curiosity and optimism; they considered the behavior of each member in the family and gave each narrative a more positive meaning. With a new narrative and no one to blame, family members began to see things differently and became “unstuck” from their usually fixed positions. Family members became more optimistic about the future and symptomatic behavior diminished.

The attraction of the Milan Model was its emphasis on therapeutic optimism for positive change. Samperi mastered Milan and the art of asking the “future question” which recognized a patient’s capacity for change and potential well-being. Samperi would ask a person labeled persistently mentally ill, “When you are better, what will you be doing?” Patients and their families were struck by this unexpected question. When questioned about their future, patients would often reply no one had ever asked them that before. The positivity of the question shifted the outlook for patient and family from hopelessness to hope, to believing that change was possible and that the patient

had a future. Therapeutic optimism and hope were always conveyed from staff to patient and to families.

Samperi's staff training program incorporated these new and innovative concepts into CCC's treatment protocols, revolutionizing the delivery of care and treatment outcomes for clients. Samperi, a master therapist and Director of Training at the time, was in a unique position to implement the Milan Model. Most revolutionary was providing supervision and training simultaneously in vivo with the staff and client present. Working in teams, staff used one-way mirrors for both observing and conducting interviews. During each interview, the team would break to discuss the treatment process and agree on a treatment strategy and an appropriate intervention. This process enhanced the Milan principle of "thinking together" and broadened the depth of understanding and problem solving on behalf of the patient and family.

In 1983, Boscolo and Cecchin spent a week at CCC to consult and observe how CCC implemented their model in a publicly funded clinic.



Group discussion with Drs. Boscolo and Cecchin during their 1983 visit to CCC.

They were so impressed with the implementation of their approach that they invited Ahto and Samperi to be their New York representatives. Although CCC did not become a training center for the Milan Approach, Ahto and Samperi remained in communication with the Milan Center and Samperi delivered a paper at the Center for its 25th reunion. A total of six clinical staff attended the training in Milan Italy at their own expense; Samperi in 1981, Ahto in 1982, Charney and three other senior clinicians (Loewengart, Blady, and Kinsella) in 1986 and in 1997, Ahto, Samperi, and a senior clinician (Kinsella) attended its 25th reunion of all trainees.

Over time, CCC Milan teams were modified to ensure that productivity levels required by the NYC Department of Mental Health contract were met. Samperi, in lieu of the team, would often observe the interviews or, when needed, join the clinical staff person directly in the interview. The clinicians welcomed her presence and her clinical acumen,

particularly when they needed help. The client always knew when someone was observing the interview, always welcomed the observation and, if the client requested, could meet and talk with the observer. In fact, clients consistently demonstrated an appreciation of how staff worked together on their behalf.

The Milan Model became the underpinning of all clinical work. Over time, Milan concepts were integrated into the administration and management of CCC. Milan Systemic thinking informed Ahto and Samperi's management style. They worked together and often included staff whenever there were fiscal and/or management issues. To resolve problems, Ahto and Samperi made an effort to understand how activity in one part of the system affected another part. For example: if conflict arose among clients in the day program, a clinical staff and/or an administrative group would be convened to determine sources of disagreements. Was it the result of client and family dynamics, unresolved issues among staff or with administration that was affecting clients' well-being? Often the discussion itself was therapeutic for the group and usually resulted in an amicable resolution, improved morale and greater stability in the therapeutic milieu. This process was always helpful in avoiding recurring hospital readmissions and/or unresolved conflicts.

Ahto and Samperi always maintained the Milan principles of collaboration, teamwork, thinking together, and therapeutic optimism while calibrating to the changes in mental health regulations. Clinically, Samperi remained the common thread for Milan through her accessibility to staff and patients.

The clinic focused on generating positive clinical outcomes for patients with multiple and interrelated needs. The severity of patient needs required an intense level of patient services, prompting a search for a suitable and stable funding structure.

One Hundred Percent Funding

In July 1982 Ahto learned that CCC was to be closed and all staff positions terminated in two months. Only HSS administration knew this information, withholding it from Ahto and others.

The projected closing came to Ahto's attention inadvertently. Ahto had submitted a purchase order (PO) to the accounting department to purchase video equipment for taping treatment sessions for clinical and educational purposes utilizing the Milan Model. The controller contacted Ahto. "With CCC closing in two months, do you really want to incur this expense?" he asked. Learning that Ahto had not been informed of the closing, the controller was shocked and dismayed, especially since retrenchment pay was already calculated for the entire staff. Ahto, in shock herself, reflected a moment and then advised the controller to process the PO. "Are you sure?" he asked, surprised. Without hesitation, Ahto responded emphatically, "Of course. The executive office never officially notified me about their plan so I will continue business as usual."

Since the late '60s and '70s, the clinic was funded 50% by HSS and the other 50% through a contract with the New York City Department of Health and Mental Health (NYCDOHMH). At HSS' annual budgeting time, the clinic was always considered

expendable if the Settlement faced a budget shortfall. Furthermore, a cut from the HSS mental health budget also resulted in a commensurate reduction from the City. Closure due to fiscal problems had been considered twice previously, once by the City and another time by HSS. Both proposed closures were successfully thwarted through community advocacy and political intervention.

This projected closing was different and quite unusual as no alternatives were discussed with Ahto. Believing that this threat required swift and decisive action, Ahto called the NYCDOHMH for help. This was not unusual since Ahto was responsible for CCC contract negotiations. It was fortunate that the Department knew of CCC's successful work with the persistently mentally ill. An Assistant Commissioner and a program analyst from the Department had previously visited the clinic to view its family work utilizing the Milan approach and they were quite impressed.

Learning of the HSS' decision, this Assistant Commissioner agreed to meet expeditiously with representatives from the Settlement. Ahto then informed the executive director of her knowledge of the pending closure, her contact with the Department for possible funding, and their willingness to meet. HSS executive director readily agreed to a meeting with representatives from the Department.

At this meeting hosted by two City Assistant Commissioners representing both program and finance, HSS disclosed that they could no longer fund their 50% share of the contract. Ahto stressed the importance of continuing CCC's innovative work with deinstitutionalized patients and their families. The

Department respected and valued this program and was concerned about losing these services. However, the Department was interested in funding only the continuing day treatment program 100% as there were no comparable programs on the Lower East Side. Ahto pointed out that the outpatient clinic and day treatment components could not be separated since CCC provided an integrated model of care; the family work by the clinic treatment unit was equally essential in treating this patient population.

Since the negotiation process seemed favorable for HSS, Ahto also raised the issue of staff salaries; salaries were too low, she argued, since the clinic hired the most professional staff to work with this population. The commissioners countered that CCC salaries were commensurate with the other Settlement mental health clinics. Ahto stressed that the salaries should be in parity with the larger prestigious mental health clinics since CCC delivered professional services to a challenging population that most providers were reluctant to serve.

The Department's decision was made immediately. One hundred percent funding was approved for the entire clinic including salary increases. Ahto successfully argued the case for CCC's integrated model of care to survive and helped pave the way for other Settlement mental health clinics to become one hundred percent publicly funded.

This was a pivotal moment in the history of the Community Consultation Center under the Ahto and Samperi co-leadership. This 100% funding gave them the confidence and autonomy to pursue their entrepreneurial spirit and creativity in program design

and development over the next three decades! CCC was no longer a financial burden to the organization but now an asset both financially and programmatically.

Although 100% funding of the clinic ended over time and CCC assumed financial risk, new sources of revenue through grants from the federal Department of Health and Human Services, the NYS Office of Mental Health, the NYC Department of Health and Mental Health, foundation grants, and health insurance contracts financially sustained programs. Additionally, new award-winning program initiatives continued to be designed and implemented to assure CCC's financial stability and its contribution to Henry Street's rich historical legacy.

CCC's position in the HSS organization clearly changed over time from a nonessential service to one that was valued and respected for its innovative work in mental health with both national and international recognition.

With 100% funding in place, CCC was in a strong position to address one of the worst epidemics of the twentieth century.

The HIV/AIDS Epidemic

Toward the late 1970s and the early 1980s, the country began to deal with a catastrophic health problem that became known as the AIDS epidemic. It had a tremendous impact on New York City and, from the outset, appeared to almost exclusively affect the gay community where thousands became ill and died. In the early years of the epidemic, the HIV virus was believed to be sexually transmitted. The etiology of

the illness, however, was unknown and no cure or treatment was in sight.

It was later found that HIV was contracted through contaminated needles shared by people addicted to drugs; through unprotected sex with infected individuals; through the transmission of infected blood; through maternal transmission in utero; and through breast feeding by infected mothers. Many of those infected were parents with small children who unwittingly put their children at risk to be orphaned at a young age. In time, it became clearer that HIV/AIDS was not solely a “gay disease” as originally believed; and the HIV/AIDS work at CCC led to our recognition that intervention had to include both those **infected** and **affected**.

CCC became one of the first mental health clinics to provide HIV/AIDS related mental health services. Due to CCC’s early commitment to this work, the NYC Department of Health and Mental Health designated CCC as the AIDS mental health provider for the Lower East Side and awarded the clinic a 100% funded AIDS contract. Charney was pivotal and instrumental in spearheading this endeavor and was appointed Program Director of HIV/AIDS services.

Several issues occurred during a short period of time which created the impetus for CCC’s involvement. CCC began providing family treatment services to HIV infected mothers in preparation for placement plans for their children in the event of their death. For example, a woman with her three young children was emphatic that she did **not** want her mother to have custody of her children even though her mother often took care of her grandchildren and agreed to assume

custody of them after her daughter's death. This was an unusual request by a mother who had also indicated this wish in her will. She clearly harbored an unresolved angry relationship with her mother. Charney's clinical treatment with this client and her family for over a year and half focused on resolving the intense conflict in the mother-daughter relationship. Once resolved, the mother changed her will: after her death the children would remain with their maternal grandmother.

Many HIV infected mothers and their children were under the care of multiple agencies with each agency focusing only on the parent or child/children in its care. There was limited coordination among the agencies resulting in fragmented services for the families. For example, in one situation, a terminally ill hospitalized mother of seven in the end stages of AIDS requested to see her children. The NYC Agency for Children Services (ACS) had placed her seven children in different foster homes after she became too ill to care for them. Although each agency worked only with the child/children in its care, the older children stayed in contact with each other and with their younger siblings.

An agency familiar with CCC's family work requested help in reuniting all the children for a visit with their mother. Charney arranged a meeting with the children's workers from the different foster care agencies. This took weeks of planning and negotiating as it was not a customary service of these agencies. The session with the workers was an incredible event. One worker opposed having the mother see her children because the mother was a drug addict; another felt that a six-year-old child in her care was

too young to know that his mother had AIDS and was hospitalized. However, the worker did agree to let Charney speak to the child in her presence about the mother's hospitalization. When they talked with the youngster about mom being ill, the child responded, "I know she is sick. She has AIDS." The foster care worker, somewhat shocked, asked how he knew. He responded, "My brother told us."

Eventually all the workers agreed that the children could visit their mother in the hospital. On the day of the visit, as the children and their workers were about to enter the hospital elevator, a staff person anxiously took Charney aside. The mother had just passed away! The children were taken into a room and told the devastating news. The children decided that they still wanted to see their mother as a family without the workers. Their wishes were respected, and they spent private time alone with their mother.

It became evident that with multiple agencies involved, integrated care was essential. CCC took on this care management role in several situations to maintain the integrity of the family and to prevent fragmentation of services.

In the spring of 1988, a local school guidance counselor, aware of the clinic's work, contacted Charney. The guidance counselor expressed concern and sought help in understanding why students who previously did well academically were now failing and coming to school unkempt. Charney and a senior clinician went to the school, met with the guidance counselor, and then met with the children.

Surprisingly, the children had one major life event in common: they had all experienced the recent death of a parent. It seemed unusual for so many young children in one school to lose a parent. Most did not know the cause of death. CCC assumed, although this was not confirmed until a later time, that some deaths may have been AIDS related. Due to the stigma of AIDS at that time, deaths from AIDS were never disclosed or discussed, particularly with the children.

Charney organized a clinical team and initiated the first in-school bereavement and support groups. These groups expanded and multiplied as children brought cousins and friends who had also experienced losses. The groups were successful and continued for several years until, under the guidelines of a new contract, they could no longer be facilitated in a school setting. When the groups ended, with school administration approval, the children and families planted a tree on the school property and held a dedication ceremony to honor their lost parents. School personnel constructed an arbor near the tree as a memorial to the children's lost parents; a memorial plaque, written in both English and Spanish, was placed next to the arbor.



Construction of a memorial arbor and tree planting at a local public school in memory of students' lost parents.

Although these bereavement groups ended, CCC's collaboration with schools became an integral part of the clinic's community services and an important resource in identifying children and their families in need.

Another pivotal event occurred when a grandmother called seeking help in caring for her grandchildren. Her daughter had died and she was overwhelmed; she never anticipated that she would be parenting a child in her senior years. From interactions with many HIV/AIDS infected mothers, children, and extended family members, CCC staff concluded that clinical treatment needed to be addressed on multiple generational

levels. Familial issues needed to be explored and resolved so that AIDS orphans could survive within their extended families and avoid foster home placement.

Based on this expanded intergenerational understanding, Florence Samperi developed an AIDS related three generational model of care that became the basis of a three-year federal government grant, a Special Project of National Significance (SPNS), awarded to CCC in 1992. A SPNS grant analyst commented in a telephone call to Ahto that, "We thought we knew all about AIDS until we read this grant proposal and knew then that we had to fund it." CCC Co-Director Florence Samperi and Lela Charney, Program Director of AIDS services, worked together with a dedicated team of clinicians to implement this groundbreaking intergenerational work.

The SPNS grant, based on Samperi's paper, "AIDS and Survivorship," brought the plight of AIDS orphans to the attention of the federal government, thereby expanding HIV federal funding to also include those **affected** by HIV/AIDS. After the completion of the SPNS grant, CCC was awarded a Ryan White contract with the NYC Department of Mental Health to continue its work serving individuals and families living with HIV/AIDS.

What was especially alarming working with families living with HIV/AIDS was the potential loss of housing. A pattern emerged that as parents had recurring hospital admissions, the children had to be placed with extended family when possible or in foster care. Often this family disruption resulted in

homelessness and cyclical admissions to temporary shelters. This problem prompted Ahto, Samperi, and Charney to conceptualize a housing initiative that could keep the family together during the parent(s) acute medical crises. This idea involved developing housing that could temporarily expand an apartment from a two to a 3 bedroom to accommodate extended family to support the ailing parent and avoid foster home placement of the children.

A collaboration was initiated by HSS/CCC with the New York City Housing Authority (NYCHA) and the NYC Human Resource Administration (HRA) to develop supported housing for homeless families living with HIV/AIDS. CCC developed the program conceptualization and worked with the architects on the projected housing design. With property deeded to NYCHA by Henry Street (which was deeded to HSS by the non profit Pueblo Nuevo specifically for this housing), the Housing Authority financed new construction for supported housing for thirteen homeless families. Guided by Federal Housing and Urban Development (HUD) regulations, the housing was approved for families living with immunological disorders of a degenerative nature including HIV/AIDS.

This was the first and only supported housing constructed by NYCHA and was a unique experiment bringing three organizations together to address a major health crisis. After fourteen years of extensive bureaucratic challenges, coupled with substantial changes in the final housing design, this supported family housing was finally completed and opened in 2003.

CCC received many awards for its innovative HIV/AIDS work. Its work was featured in a 1984 New York Times article by Bruce Lambert; was honored by the NYS Department of Social Services in 1992 with its “No Time to Lose” award, recognized by the United Neighborhood Houses (UNH) in 1993; and featured in a book and video “Mommy Who Will Take Care of Me?” funded by the UPS Annie E. Casey Foundation.

The crisis management skills that CCC acquired during the HIV/AIDS epidemic proved invaluable in responding to the most catastrophic civilian disaster in American history.

The National Tragedy of 9/11

Everyone in New York City can tell you exactly where they were the morning of September 11, 2001. That day two commercial airplanes filled with passengers crashed into the World Trade Center Towers.

The 110 stories of the South Tower imploded 56 minutes after impact at 9:59 AM; the 110 stories of the North Tower collapsed at 10:28 AM. Only a mile away and in direct view of the Towers, CCC staff witnessed this catastrophe.

That morning, as was the ritual at CCC, some staff were having breakfast before the workday started. The clinical staff had just left to start their Tuesday morning meeting while administrative staff remained to talk. Suddenly there was a loud jarring boom. A moment later, a staff member ran in screaming, “The World Trade Center is on fire. A plane just crashed into one of the towers.”

Immediately staff and patients ran out of the building to see what was happening. The top floors of one of the towers were on fire. Stunned, people gasped in horror, as they saw the second plane hit the South Tower. Everyone was overwhelmed. Thousands of people were in those towers. This was no accident. It was a terrorist attack.

Hordes of people were escaping from the burning towers and many were running in the direction of the CCC offices. They were covered from head to toe in ash, some without shoes, and most appeared terrified and disoriented, running but uncertain where they were going.

CCC staff and patients quickly mobilized. They carried out tables, chairs and water for a “comfort station” while CCC medical staff positioned themselves on the sidewalk to assess those in need of medical assistance. Eager to reach their families, they were directed into the clinic for telephone access. Fortunately, CCC still had phone service for several more hours. Refrigerators and pantry shelves were emptied, and food was offered in the dining area for a short respite. A staff person was strategically stationed on a street corner to direct people uptown, away from the chaos, because many were running in the wrong direction. Here was a community-based clinic responding to the needs of the community. At that moment, CCC became a crisis center.

The devastation and its consequences were widespread, particularly in Lower Manhattan. Although government officials denied it, the air quality was toxic; an overwhelming odor of death lasted for weeks. Because there was no phone service,

temporary phone booths were set up on street corners. Many subway stations in Lower Manhattan were closed for months. Vehicular traffic was banned from the area and only drivers of carpools and local commercial traffic could gain access with ID cards.

CCC had no contact with the Manhattan office of the NYC Department of Health and Mental Health for several weeks as the Department's offices, blocks from Ground Zero, were directly affected. While CCC continued providing ongoing services, Ahto and Samperi quickly made staff adjustments to dedicate personnel and clinic hours to post 9/11 emergency services.

Within a short time, CCC organized an outreach unit in Nino's Restaurant, located at Ground Zero. The restaurant provided free meals to first responders. The CCC team met at the restaurant to offer support and resource information to those wanting to talk. The team assisted others with mental health screenings and referrals as needed.

Several weeks after the attack, all CCC clinical staff completed Red Cross training specifically designed for this crisis. After the training, some staff were deployed to sites near Ground Zero to support individuals and groups traumatized by the events. CCC also opened a satellite office (rent free) at Ground Zero to provide counseling and social services to local area residents. Charney also facilitated support groups for departmental staff as HSS was located in the impacted area and many staff lived in the neighborhood.

In 2002, CCC received a generous grant from a local public school to work with their elementary students who witnessed the collapse of the Twin Towers from their classroom windows. Ahto and Samperi initiated a joint project with two other HSS departments, Youth Development and the Abrons Art Center, to bring theater and clinical services directly into the classrooms to help students express their thoughts and feelings related to 9/11.

Post 911, the needs of community residents shifted dramatically. People, who had previously been self-sufficient, sought help because of their sudden loss of employment and income, necessitating access to funds and supports such as legal assistance, health insurance, housing, and crisis counseling.

HSS was awarded 9/11 funds that were dispersed throughout the Settlement. Samperi, recognizing the need for improved access to these services, conceptualized the Neighborhood Resource Center (NRC), a walk-in service that consolidated and made 9/11 services more accessible to the community. With a generous grant from the Robin Hood Foundation, CCC opened the NRC in 2004. With the addition of NRC, CCC could more effectively respond to individual and community needs with comprehensive and integrated medical, psychiatric and social services. NRC also served as an entry point into other HSS programs.

NRC was housed in an HSS landmark building which unfortunately posed barriers to consumers with physical challenges. HSS administration therefore agreed that NRC would eventually be relocated to the decommissioned firehouse adjacent to HSS' original

landmarked buildings. Once relocated, the plan included that NRC would apply to become an approved OMH satellite of CCC, thereby expanding the delivery of mental health services.

As the Lower East Side began to heal in the aftermath of the 9/11 attacks, CCC returned its focus from crisis response to community health by continuing its implementation of its approved Diagnostic & Treatment Center.

Health UnLimited (HUL)

“Good Morning, CCC, how can I help you?” “Yes, this is ‘ABC’ Health Clinic calling. Can you please send someone to get one of your patients from our waiting room? He is disturbing everyone!”

This was not an uncommon call from local healthcare providers. Throughout the years, it became increasingly clear that medical providers were not trained to manage the symptomatic behaviors of people with severe and persistent mental illness. Consequently, there was little or no coordination between medical and psychiatric providers resulting in many of these patients receiving inadequate healthcare.

In reality, these were the patients who required more coordinated and integrated care. They generally neglected their health, usually never kept their medical appointments but required more consistent routine health monitoring to identify medical issues and side effects related to prescribed psychotropic medications.

In working with this population over the years, Ahto and Samperi were convinced that integrated medical and psychiatric care from one provider at one site would be more effective to improve both health and mental health outcomes.

Persuading HSS administration to establish a medical practice to co-locate medical and psychiatric services, was a major challenge. After three years of research and many consultations and discussions with HSS administration, the idea was finally presented by the HSS executive director to a Board Committee which finally approved the concept.

After the Committee's approval, it took two more years to complete the licensing process with the New York State Department of Health (DOH) to operate an outpatient healthcare facility (designated as an Article 28 Diagnostic and Treatment Center). This arduous process included obtaining approvals from various committees of state and city health departments, securing agreements with the NYC Housing Authority (NYCHA) and neighboring health providers, and obtaining architectural and construction site plans approved by DOH and NYCHA. Our perseverance took a total of five years from the original idea to the submission of our application to the NYSDOH.

After our submission, the CCC team was shocked and dismayed to learn that the NYSDOH had decided unexpectedly to place a moratorium on granting Article 28 licenses. Fortunately, CCC's application, unlike other applications, was requesting approval to provide healthcare primarily to the major mentally ill. The NYSDOH needed these services; the moratorium was temporarily lifted to approve specific

applications. CCC's application for onsite healthcare was approved!

Health Unlimited (HUL) officially opened in 2001. CCC was one of the first community based mental health clinics in the Lower East Side to integrate physical and mental health services. For CCC psychiatric patients, this was especially positive. Patients kept their appointments consistently; medical issues and psychotropic medication side effects were managed more effectively; and there was improved coordination of care. HUL and CCC medical staff worked well together and shared staff when coverage was needed. There seemed to be good will among all staff and patients.

HUL was chosen as a Beta test site and became one of the first medical clinics to become fully digitized. It was so early in the development of computerized medical records that HUL and CCC unfortunately could not use the same database which prevented achieving the full integration of care that was visualized.

HUL also provided limited health care on site at HSS' Third Street Shelter for homeless women with mental health issues and planned to have a permanent medical satellite there. By providing medical care to the homeless population, it was anticipated that HUL would submit an application to become a Federally Qualified Health Center (FQHC), a federally funded comprehensive medical service.

The opening of HUL was envisioned as the initial step in a progressive plan towards the development

of an FQHC at Henry Street. In this vision, HSS could eventually offer healthcare to the majority of its consumers. This would have benefited homeless families and homeless mentally ill housed in HSS shelters and in its supported housing. Also, as a FQHC, HSS would have been eligible for federal funds and grants to which HSS normally did not have access. This plan never came to fruition. Regrettably, the vision for a comprehensive health service was not shared throughout the Settlement and thus limited the growth and financial viability of healthcare at HSS.

Nevertheless, the development of HUL as a primary healthcare resource brought CCC full circle, back to providing general health services as originally envisioned by Lillian Wald.

Conclusions and Implications

We began writing this monograph for the Settlement archives to highlight and document significant events that influenced the growth and development of four decades of work at CCC. Our story is an important part of HSS history.

As we wrote this monograph, it became clear to us that some of our experiences were shaped by the past and cannot be duplicated while others are still valid.

One hundred percent funded contracts may no longer exist and, in fact, they ended during our tenure. As other organizations without the financial backing from City and State government, CCC continued to be confronted and preoccupied with financial risk. This risk continually challenged our creativity in

programmatic development, redesign and/or organizational change.

Instead of “going after the money” as many organizations did, the driving force that assured CCC’s continued existence and financial viability was maintaining relevancy in addressing patient needs and community concerns. CCC’s work with the deinstitutionalized, people living with HIV/AIDS and its response to 911 are examples of this approach.

What is not limited to the past and remains timeless is the Ahto/Samperi leadership philosophy. Staff was considered our most valued resource. All staff, regardless of position, were respected and nurtured. Our motto was “you are only as good as your staff”. Creating an environment, where staff could grow professionally and personally and enjoyed working together as a team, resulted in improved patient clinical care and positive treatment outcomes.

We adopted key principles to inform and guide our work:

- Provide a patient-centered environment from the initial phone request to termination of care.
- Handle all phone requests for help immediately.
- Interview all “walk-ins” on the same day.
- Never maintain a waiting list by always “making room for one more.”
- Always maintain hope and therapeutic optimism with patients for their future. Samperi’s future question with patients, “When you are better what will you be

doing?” gave patients hope for healing and a more positive outlook for their future.

- Encourage team collaboration and “thinking together” with clinical and administrative staff, both planned and spontaneous, for continuous learning and creative program development. Administration and clinical staff must be a cohesive team in order to be creative.
- Comply with funding sources’ rules and regulations but always make time for creativity. This remained a guiding principle as articulated by Dr. Boscolo to staff in his visit to CCC in 1983.
- Listen carefully to patient issues, wants/needs and community concerns which are the driving force for continuous creativity in program development.
- Persevere in your belief in the creation of your work.

In summary, the ultimate lesson that we learned from our leadership of the Community Consultation Center is that an organization that engenders mutual respect, and enables, encourages, and supports the creativity of its staff, has the potential for a positive trajectory for sustainable growth and development.

And the story continues!

Timeline Highlights

1969

Ahto is hired as senior clinical social worker for the Henry Street Settlement Community Consultation Center.

1974

CCC receives a grant from the Van Ameringen Foundation to develop support groups for deinstitutionalized patients discharged from state psychiatric facilities. Charney is hired to develop and direct this effort.

1975

Ahto is promoted to Director of Community Consultation Center (CCC).

1976

The Apartment Program opens at LaGuardia Houses, 250 Clinton Street designed to assist deinstitutionalized patients reintegrate into the community.

Family treatment services are introduced at CCC.

1978

CCC establishes its New York State certified Continuing Day Treatment Program, one of the first programs in Lower Manhattan to treat the deinstitutionalized patient population.

1981

Samperi is hired as Director of Clinical Services and Director of Training for CCC. Samperi attends

training in Milan, Italy on the Milan Systems Approach conducted by conducted by 2 of the originators, Drs. Luigi Boscolo and Gianfranco Cecchin.

CCC develops an on-site nursery for staff's infants/children, an innovative experiment for a mental health clinic.

1982

CCC achieves one hundred percent funding from NYCDOHMH avoiding HSS closure of the clinic. This paves the way for other settlement mental health clinics to receive one hundred percent funding.

CCC expands its model of care to include the Milan Model, a family systemic approach to care.

CCC begins its involvement in HIV/AIDS work and is one of the first mental health clinics to be trained by Gay Men's Health Crisis (GMHC) regarding the medical aspects of AIDS.

1983

Drs. Luigi Boscolo and Gianfranco Cecchin, two of the Milan Model founders, spend a week at CCC to observe the clinic's application of their model in a publicly funded clinic.

1984

CCC begins to look at mental health issues of families **affected** by the HIV/AIDS crisis, broadening the traditional focus from solely that of the infected patient.

A New York Times article by journalist, Bruce Lambert, describes CCC's work with HIV affected families and its innovative initiatives with families to prevent AIDS orphans.

1985

Samperi, Associate Director, presents "The Adaptation of the Milan Approach in a Publicly Funded Clinic" at the American Association for Marital and Family Therapy conference in San Francisco, California.

CCC receives a State Office of Mental Health (OMH) grant for its Young Adult Project and collaborates with Gouverneur Hospital.

1986

CCC is awarded one of the five competitive vocational demonstration grants offered statewide by the New York State Office of Mental Health and establishes The Unlimited, a patient operated clothing boutique.

Samperi presents her paper, "Milan Approach with Chronically ill Young Adults" at the American Association for Marital and Family Therapy (AAMFT) conference held in Orlando, Florida.

1987

CCC is designated by NYC Department of Health and Mental Health as the HIV/AIDS mental health provider for the Lower East Side and is awarded a 100% funded contract.

1988

CCC begins the first school-based bereavement and support groups for non-infected children of parents who died of AIDS.

CCC brings the plight of AIDS orphans to national attention. Samperi develops a Three Generational Clinical Model which eventually influences AIDS public policy and expands federal funding to also serve those **affected** by HIV/AIDS.

Samperi authors “AIDS and Survivorship” related to CCC’s AIDS work and the Three Generational Model.

1989

CCC conceptualizes and assists in the design of supported housing for families living with an immunological disorder of a degenerative nature including AIDS in collaboration with New York City Housing Authority and NYC Division of AIDS Services.

1991

Samperi is invited and attends the First International Conference on the Biopsychosocial Aspects of AIDS in Amsterdam, Netherlands to present her paper “AIDS and Survivorship: A Three Generational Approach.”

1992

CCC initiates a unique treatment model for the major mentally ill to improve their transition from inpatient to outpatient aftercare services. New patients and their families are interviewed both at the hospital and at CCC clinic site prior to their discharge. This service

resulted in reducing the recidivism rate to one of the lowest in the City.

CCC receives the “No Time To Lose” award from the New York State Department of Social Services for its services for children and parents living with HIV/AIDS.

CCC receives a federal grant, Special Project of National Significance (SPNS), from the Department of Health and Human Services (HRSA) to implement Florence Samperi’s Three Generational Model and to research its replicability on a national level.

1993

United Neighborhood Houses honors the CCC AIDS Team with the Exemplary Employees Award for its innovative work in AIDS.

CCC AIDS work is featured in a book and video “Mommy Who Will Take Care of Me” funded by the UPS Annie E. Casey Foundation.

1994

CCC receives the NYC Department of Health and Mental Health award for “Creative Connections and Systemic Care” recognizing CCC’s pivotal role in developing the Pre discharge Transitional model from inpatient to outpatient care.

1995

CCC is awarded an HIV/AIDS Ryan White contract by the New York City Department of Health and Mental Health after the conclusion of the SPNS grant.

1996

CCC officially establishes the Asian Bi-Cultural unit in the CDTP and implements an East/West Approach in partnership with a Chinese inpatient unit at Bellevue Hospital.

CCC conceptualizes a New York State Article 28 Diagnostic and Treatment Center to co-locate medical and mental health services at CCC for the major mentally ill.

1997

Samperi presents “The Milan Approach in the Context of Managed Care” at the 25th Anniversary Conference of the Centro Milanese Di Terrapia Della Famiglia in Lake Orta, Italy.

1998

An occupational therapy unit is integrated into the CDTP program.

The New York State Office of Vocational and Educational Services for Individuals with Disabilities (VESID) approves CCC’s application as an approved VESID provider and opens a certified computer training program for up to 20 trainees per cycle.

NYS Office of Mental Health awards contract to CCC to provide fifteen scattered site supported housing units for the major mentally ill.

CCC begins development of a customized database to digitize case records, reception desk functions, staff productivity data, and billing.

2000

CCC receives the first Bill Charet Memorial award from the New York City Department of Health and Mental Health for its excellence and leadership in the field of mental health.

Ahto spearheads the corporate development of Settlement Outreach Services (SOS). Four settlement mental health clinics, Henry Street, Educational Alliance, University Settlement and Hudson Guild, join as a single corporate entity to deal with the growth and anticipated competition of managed care organizations. SOS is legally incorporated by the State of New York.

2001

Ahto receives the New York State Office of Mental Health's Lifetime Achievement Award.

Health Unlimited (HUL) is Incorporated.

CCC responds to 9/11 on the day of the disaster and during the aftermath. Provides grief counseling to first responders at Nino's Restaurant at Ground Zero.

Samperi co-authors published paper with Irene Cheung titled "An East West Approach in Servicing Chinese Immigrants in a Mental Health Setting."

2002

CCC receives a NYC Department of Mental Health Project Liberty award to expand mental health services to those impacted by 9/11.

CCC opens 9/11 satellite office at Ground Zero.

CCC receives generous grant from local school PS 137 to serve children traumatized by 9/11.

Health Unlimited, Henry Street's NYSDOH licensed Article 28 primary health care clinic opens, providing CCC with the opportunity to co-locate and integrate health and mental health care.

2003

Permanent supported housing for families living with an immunological disorder of a degenerative nature including HIV/AIDS opens in collaboration with HSS/CCC, New York City Housing Authority (NYCHA) and New York City Human Resources Administration, Division of AIDS Services (HRA/DAS).

2004

The Parent Center opens with funding from the Louis and Anne Abrons Foundation. It is located in a landmarked building owned by HSS.

The Neighborhood Resource Center (NRC) opens with a grant from the Robin Hood Foundation. It provides 9/11 free case management services and can serve as an entry point into all HSS programs. NRC is co-located with the Parent Center.

2005

Ahto becomes Deputy Program Officer for Health and Wellness through an agency-wide Strategic Plan Initiative under Executive Director Verona Jeter with the restructuring of programs into service modules. Ahto is also designated Program Officer for Program Development and Integration.

Vita Iacovone, Director of NRC, authors published essay, "9/11: The Great Equalizer," describing mental health responses and practical knowledge gained after 911.

2006

Ahto chairs an HSS interdepartmental strategic planning initiative to standardize intake procedures throughout HSS. The tool, 'Impediments to Success' (ITS) is designed by the committee to create uniformity among all HSS program intake workers.

2007

HSS/CCC opens 290 East Third Street, a new construction consisting of 43 studio units of permanent housing for the homeless mentally ill. An additional 9 apartments are set aside as affordable housing for single adults from the local community. The building is managed and clinically serviced by CCC.

2008

Samperi authors "An Integrated Biopsychosocial Approach to Care" utilized for staff clinical training.

2009

Funding for The Unlimited is transferred from the New York State Office of Mental Health (SOMH) to the Assisted Competitive Employment (ACE) program under the aegis of NYC DOHMH.

2012

A School Based Program, transferred from the Education Alliance, is initiated to provide mental health services at three local public schools. CCC is

approved as an OMH certified school-based satellite for the three schools.

2013

OMH funded program, Personalized Recovery Outpatient Services (PROS) replaces the Continuing Day Treatment Program as CDTP funding ends. The PROS application process is finalized and implemented during subsequent CCC administration.

Ahto and Samperi retire from HSS.

2014

Kristin Hertel, LCSW, is appointed to the position of Deputy Program Officer of Health and Wellness.

2015

Charney retires from HSS.

Special Recognition

During our tenure at HSS, our lives were touched by many people who influenced our thinking and our work. With gratitude and appreciation, we wish to acknowledge some of them and their significance to us.

The Abrons Family: We are forever grateful to the late Abrons brothers, Herbert and Richard and Herb's daughter, Anne Abrons, who played significant roles in supporting us and the Community Consultation Center. Herb was profoundly committed to our work at CCC and often made spontaneous visits to chat and to see how we were doing. He was a strong advocate, always willing to rally and march with the community to prevent closure of the clinic. Richard supported our family approach and came to the clinic to view live treatment sessions with the consent of the families. With Anne, we had wonderful and interesting discussions about mental health issues and family life. Anne was responsible for the initial conceptualization of the Parent Center. The Center thrives today because of Anne's enduring commitment and the family's generous support from the Louis and Anne Abrons Foundation.

The late Lorraine Albritton made a profound impression on us personally and in our work. A long-time resident of the LES, she was a community activist and strong advocate for CCC and community mental health. She was a member of the HSS Board of Directors and chairperson of the CCC Advisory committee, both positions held for over 25 years. She was a cherished friend and most supportive through some of CCC's rough financial times.

Nathalie Weeks, LCSW and the late William “Bill” Charet, Assistant Commissioners with the NYCDOHMH, approved the 100% funded contract that rescued CCC from closure. Nathalie was in charge of all mental health program services and new initiatives for Manhattan; Bill was the person with whom we conducted annual contract negotiations and discussed everything financially related. Both, very special people, caring and approachable, were always willing to listen and find solutions. They expressed high regard for our work through their continued renewal of our City contracts and always considered CCC in awarding new contracts. We were honored to receive the first William Charet Memorial award from the Department.

The late Luigi Boscolo, MD, and the late Gianfranco Cecchin, MD, profoundly influenced our work. It surprised many in the field that they would travel from Italy and spend a week at a clinic located in New York’s Lower East Side in the basement of a housing project! They were so impressed with how we implemented their model in a publicly funded clinic that they asked if we would be one of their US liaisons. CCC’s clinical work is documented in Boscolo and Bertrando’s book “The Times of Time.” Boscolo and Cecchin’s therapeutic approach and sustained optimism in living made a far-reaching impact in all aspects of our work at CCC and in our own lives.

Michael Kraten, PhD, CCC healthcare consultant, was first hired on a limited basis for us to better understand managed care and its potential impact on CCC. That consultancy lasted almost 20 years. We first met Michael at a meeting where he was the guest

speaker on managed care. His presentation was impressive; his knowledge was extensive and so well integrated. He never seemed to take notes but remembered everything. Working together, we developed many special projects including Health Unlimited and the corporation, Settlement Outreach Services (SOS). Over the years, he became a very special friend and was always there when we needed him. Michael played a pivotal role in the development of this monograph and expertly guided us throughout the process.

Roberta Samet, LCSW, a senior program analyst with the NYCDOHMH, came to the office one day at the Department's request. We had just written the Department that our service levels for the month had dropped because we were changing our clinical approach to include the Milan Model. This was our first encounter with Roberta and she gave it to us straight: she came to observe our work and report back to the Department since they had not heard of the Milan Model. Her report back to the Department put us on the map. Thank you, Roberta! We remained in contact and years later came together in our mutual interest in working on the HIV/AIDS epidemic. She became our consultant in developing supported housing that included families living with HIV/AIDS.

Saba Hocek, BS, our computer consultant, was initially hired for a month. That consultancy lasted many years. Energetic, productive and a superb programmer, she developed a customized database for mental health for CCC which, at the time, was one of the few in existence. Through her extensive work, CCC was the first program to be computerized at HSS.

Jean LaGalia, program Manager of The Unlimited, was hired directly from the retail merchandizing field with no prior experience in a mental health setting. She was exactly the person we wanted: someone who could create a real work environment within a vocational training program for individuals with major mental health challenges. She did not disappoint us. She patiently and respectfully worked with her client interns and set expectations for their job performance. Thanks to Jean, many excelled. She designed The Unlimited that looked like a “high end” boutique with affordable prices. The community loved shopping there and their close and positive interaction with the interns truly dismissed the stigma of mental illness.

Melanie Austin, OTD, now a tenured professor at New York Institute of Technology, educated us to the value of occupational therapy. As an occupational therapy (OT) student at CCC, she brought high energy and creativity to the Continuing Day Treatment Program (CDTP). We attribute to Melanie the incorporation of OT services in the CDTP and her conceptualization and development of all group protocols that continue to be used in the current PROS program. Early on, she developed and supervised OT student units in the CDTP and later became the first program director of the Parent Center. Melanie, always eager to share her knowledge, introduced health and wellness training in many departments throughout HSS.

Alison Alpert, DMin, LCSW, served in many capacities at CCC. After she terminated her employment, she was hired as a consultant specifically to write a proposal for CCC to become an approved New York State vocational rehabilitation

program. If anyone could overcome the exhaustive challenges and produce a positive outcome, it was Alison. She persevered with her intelligence and dry wit. Thanks to Alison's efforts, CCC did become an approved program. This gave CCC the opportunity to hire staff and develop a most successful vocational rehabilitation program for people with disabilities including an approved computer training program and job placement services.

Irene Cheung, PhD, LCSW, co-designed with Florence Samperi, an innovative "East-West" approach in the CDTP integrating an understanding of Eastern culture and values with Western principles of care. They also spearheaded an innovative approach to discharge planning with monolingual Chinese patients to increase their successful transition from inpatient to outpatient aftercare that substantially reduced recidivism.

Vita Iacovone, LCSW, BCD, trained family therapist, had an essential role in developing 911 services. She organized CCC's satellite office at Ground Zero and was appointed the first director of the Neighborhood Resource Center (NRC). Based on her 911 experiences, Vita wrote an essay, "The Great Equalizer" which was published.

Executive Staff:

Atkins Preston, MSW, Associate Executive Director, hired Ahto as senior social worker giving her the opportunity to be part of the historic Henry Street Settlement. When Ahto first rejected the job offer, it was Kin's phone call to her and Kin's humanity and decency that helped change Ahto's mind.

The late Bertram Beck, MSW, third Executive Director, promoted Ahto, a senior social worker, to Director of CCC over more senior qualified resumes giving her the opportunity she so desired. Bert was such a formidable individual that Ahto always considered his confidence in her and her promotion an honor.

Niathan “Nate” Allen, DSW, fifth Executive Director, willingly agreed to attend the NYCDOHMH meeting to secure 100% funding. We are grateful to Nate for his positive response. It was also Nate who made the suggestion to hire Florence Samperi. He met her at an HSS rally and, in a short time speaking with her, recognized her intelligence and humanity. He encouraged her to join the HSS staff. Thanks to Nate, that suggestion eventually led to the beginning of the successful Ahto and Samperi team that spanned almost four decades.

Daniel Kronenfeld, MSW, seventh Executive Director, who had the gift of supporting the creativity in his staff, gave us the space and opportunity to design and develop new program initiatives. It was Danny’s strong encouragement that led to our application and subsequent award of a SPNS grant for Florence Samperi’s Three Generational Model. A strong advocate and leader in developing housing for the homeless, he played a pivotal role in initiating HSS/CCC supported housing that included families impacted by HIV/AIDS.

Verona Middleton Jeter, MSW, eighth Executive Director, was Chief Administrator of HSS’ Transitional and Supportive Housing for many years before becoming HSS Executive Director (ED). It was

in her ED position that we actually began to work together. Verona was caring, supportive and always expressed a positive regard for our work. We had wonderful conversations together and sought each other out to share project ideas. She was pivotal in our securing a Robin Hood Foundation grant to fund the NRC. Her Strategic Plan was the first ever initiated at HSS which resulted in the establishment of HSS' first Human Resources Department and the consolidation of programs into service modules, boldly leading the HSS organization into the twenty-first century.

David Garza, BA, ninth Executive Director, continues to dynamically lead HSS since his ED appointment in 2010. In the short time we worked together, he respected and supported our work. He encouraged CCC to assume the transfer of onsite mental health services at 3 local public schools from Educational Alliance. This program was very successful and continues to thrive. Upon our retirement, David graciously gave us space at the HSS administrative offices in support of our writing about our work at CCC. David is always welcoming and encourages our continued communication and participation in the life of HSS.

The late Leona Gold and Josephine Lume, BS, CPA, Chief Financial Officers working in different eras at HSS, have been impressive CFOs. The late Leona Gold worked in the 1950s, 1960s and 1970s; Josephine Lume is the current CFO serving since 2002. Both very intelligent women, they always willingly shared their knowledge and offered their assistance. They wanted you to succeed. Leona was strong and focused yet maternal and caring. She worked all the budgets with only an adding machine

and pencil. When she completed a budget, she would give such a huge sigh of relief that Bert Beck would say, "It could steer a ship in the night!" Josephine makes the job look easy even though it is not. She is upbeat, positive and has a laughter that is identifiable and infectious. While these women had completely different personalities, working with both was a learning experience and a joy. When Ahto became Director of CCC, Leona became Ahto's mentor; as mature seasoned professionals, Josephine became an invaluable advisor and our dear friend.

Diane Rubin, MSW, Chief Program Officer, was the first person to hold this new position which was established in 2005. Diane respected our longevity, autonomy and our contribution to HSS and CCC. We admired her indefatigable energy and commitment to the Henry Street organization.

Kristin Hertel, LCSW, Deputy Program Officer for Health and Wellness, a seasoned clinician with over 20 years of clinical, supervisory and administrative experience at CCC, was offered Ahto's position upon her retirement. Unfortunately, the timing was not right for Kristin due to family responsibilities. When the opportunity arose again in the late 2013 when the position was vacated, Ahto and Samperi encouraged her to take the position. Kristin, thanks for stepping up to the plate. Your leadership has provided continuity to our legacy and beyond.

ACKNOWLEDGEMENT

It is not possible to identify each and every staff member who had an impact on the success of CCC without a possible unintentional omission.

We do wish to acknowledge all the CCC dedicated professionals and support staff with whom we worked over the past four and a half decades. The staff's love of learning, teamwork and commitment to public service made it all possible to change and improve the lives of so many people.

Special thanks to Maureen Kraten for her support and encouragement for this project. Much gratitude to Dena Romero for her generous offer and time to review and edit this monograph.