



ReachOut e-Diversity News

An Electronic Publication of the Ohio Developmental Disabilities Council

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January 2008 Edition | Volume 2, Issue 1

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by Lynn Cook

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Supervisor of Service Coordination
Franklin County Board of Mental Retardation and Developmental Disabilities

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Parent

Deceived, Disabled, Dejected, Dehumanized, Dismissed, and Dying: The Widespread Dilemma of MCS Disability

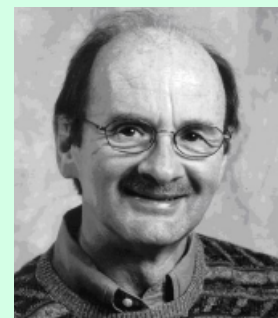
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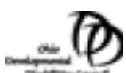
An Ohio Mosaic - The Publicly Funded Mental Health System



by Michael Schroeder
Manager, Community Services
Development and Special Projects
Ohio Department of Mental Health

Save the Date

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Know What to Do When Disaster Strikes...

D e v e l o p a P e r s o n a l D i s a s t e r P l a n

by Lynn Cook

Director of Communication & Marketing
American Red Cross of Greater Columbus

Disasters can happen anytime, anywhere and sometimes without warning. Your American Red Cross and local government agencies will respond when a disaster threatens and after a disaster strikes. However, they can't be everywhere at once. Being ready for a disaster is a part of maintaining your independence. Although you may not know when a disaster will strike, if you are prepared ahead of time, you will be better able to cope with the disaster and recover from it more quickly.

When a disaster occurs, the first priority of disaster relief organizations and government agencies is to provide basic needs - food, water and safe shelter - to everyone who needs them. Your personal needs, such as replacing

medications, replacing adaptive equipment, restoring electricity for power-dependent equipment and restoring your regular ways of support for daily living may not happen right away. It is important for everyone to be prepared to meet his or her own basic needs by storing food and

Knowing about disaster threats and their aftermath and being prepared are critical for staying self-sufficient after a disaster. In this column, we will focus on some issues that people with disabilities may face when a disaster strikes, how you can get to a safe place and how you can meet your needs after the disaster. Self-confidence based on knowledge, preparation and practice will give you, your family and your community the best chances for recovery from a disaster.



American Red Cross

water for a minimum of three days or more. You should also be ready to meet your specific disability-related needs by storing sufficient oxygen, medications, battery power, etc., for a least seven days after a disaster.

But first, to find the best ways to prepare for a disaster, consider the following questions:

1. What kinds of disasters may occur in your area?
2. How are residents informed of possible disasters?
3. What are the effects of disasters on you and your community?

In Ohio, as all across the country, home fires are the most frequent and costly disaster we face. American Red

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Cross volunteers respond to more than 74,000 disasters across the country every year, and roughly 93 percent of these

happen where you live. For example, regular insurance does not cover floods.

watch television for information and advice.



Warning: A “warning” means that the event is happening now; it is imminent or has been seen on weather radar. This is the time to immediately protect yourself.

Some events happen very quickly, so warnings may not be issued or you may not receive them. Always pay attention to the weather around you. Take action when you think severe weather may be moving into your area, even if no official warning is given on the radio or television.

are fire related. In addition, Ohio is not immune to tornadoes, flooding, chemical spills, severe winter storms, acts of terrorism and other natural and man-made disasters. Contact your county emergency management office or your local fire department to get more information about the kinds of disasters that happen in your area and how often they occur. Check with your insurance agent about whether your insurance policies cover the types of disasters that can

Know the difference between a “watch” and a “warning”

The National Weather Service gives information to the public about some severe weather events such as thunderstorms, winter storms, hurricanes, floods, flash floods and tornadoes. Listen or watch for these terms:

Watch: A “watch” means that severe weather is threatening and may occur in your area. Continue to listen to the radio or

Know what your environment is likely to look like after the disaster

Disasters have many effects. Some are predictable and others are not. You should know what can happen and what your environment may be like after the disaster. It is our goal to help you deal with the hardships of a disaster. And you can. But first we must take a realistic look at what can

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happen during a disaster. Consider the following circumstances:

- In disasters that have high winds and during earthquakes, a great deal of shaking may take place. This can break things and scatter debris. Hanging objects, such as plants, mirrors and pictures, are likely to fall. Books may be flung from bookcases and the bookcases may fall. In your office, file cabinets and computers may fall. Acoustical ceiling tiles and all of the dust behind them may drop. Large and heavy furniture may move and block your pathway.
- Floods, earthquakes and winter storms can cause sidewalks and roadways to crack or become impassable. Roads and sidewalks may be covered by mud, water or debris, so you may not be able to tell where they begin and end. In floods, water may be moving very rapidly, preventing you from leaving the area.
- There could be so much debris on the streets that it would take weeks to clear it away. This could leave you stranded at home and keep caregivers from reaching you.
- Familiar landmarks you use to help guide you may move or be destroyed, both indoors and out.
- If you have a service animal, the animal may be hurt or too frightened to work after a disaster.
- Your home may be destroyed or isolated. Or, it could have enough damage to make it unlivable for a long time.
- Your usual ways of getting groceries, medications and medical supplies may be disrupted.
- You may have a hard time reaching or getting help from police and fire departments, ambulance services, doctors, hospitals, pharmacies, veterinarians, markets and home health providers.
- Utilities like electricity, water, gas and phone service may be disrupted.
- You may not be able to do the following:
 - Cook
 - Cool or heat your home
 - Make or receive phone calls
 - Use telephone relay systems and/or teletype equipment
 - Light your home
 - Receive emergency information from television or radio
 - Use equipment dependent upon power, such as battery chargers, oxygen, suction devices or home dialysis equipment
 - Access cash through an automatic teller machine (ATM)
 - Fill vehicles with gas

Now that you know what may happen, what can you do to reduce the effects of the disaster and to develop a personal disaster plan? Watch for additional information in upcoming ReachOut e-Diversity Newsletters.

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Navigating County Boards of MR/DD



by *Leslie Summers*
Supervisor of Service Coordination
Franklin County Board of Mental
Retardation and Developmental
Disabilities

The last month of the year was both an ending and a beginning. It was also a time to remember children, parents and all the individuals who work toward the goal of supporting every child, no matter the age, to their full potential.

Individuals receiving services and supports from the 88 County Boards of MRDD in Ohio work in tandem forging a partnership that begins for

participants with an Individual Service Plan and ends in one year. During this span, many of the goals identified in the plan are accomplished, some goals will continue throughout life, while other goals identify future needs. Each County Board has annual goals, a stated mission, and an annual action plan.

As 2007 ended, it was helpful to review the year from the perspective of the individual participant and from the perspective of the County Board of MRDD. We are reliant upon one another as we journey together on roads, while full of potential, have detours and closures preventing us from reaching our objective.

Did you meet your goals last year? If yes, was it due in part to the fact that you clearly communicated what you wanted and needed? Did you inform your team when an aspect of the plan was not working for you? Did people on

your team listen to you? Did it take a lot of effort to make change happen? Were you disappointed at times? Did you refuse to give up?

On the other hand, did your goals turn out to be pipe dreams? Did you know what you wanted to suggest for a goal? Were the goals yours or someone else's? Did you tell anyone that you did not like your goals or that your focus changed during the year? Did you give up when no one listened to you?

Who did you feel is responsible when you met your goals or when your goals fizzled away to nothing?

County Boards of MRDD face the same types of successes and failures as individuals with the only difference being that of scope.

Individuals and County Boards need to talk and to listen to one another. Success for one is

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success for the other as is failure. All interested parties should ask questions and receive answers to further the accomplishment of stated goals. If the answer to a question is not acceptable then everyone has a stake in working toward a reasonable resolution. We build on our success-

es and learn from our failures. Through active communication, individuals, families, advocates and County Boards of MRDD are walking hand-in-hand toward the future.

As we looked at the year 2007, it was exciting to know that increased growth and accom-

plishment was available for both individuals and County Boards as a direct result of the Martin versus Strickland settlement that provided 1500 Individual Options Waivers to individuals. The bulk of these waivers will be initiated in 2008. What a way to end one year and begin the New Year.

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Living with Life Circumstances



by Pam Carter, Parent

What thoughts crossed your mind after you learned of your child's disability?

I was carrying twins. One of my twins died during my fifth month of pregnancy. I was given the option to abort because it was life-threatening to carry a dead fetus. Doctors said it could poison my blood. However, I was determined to give the other baby a chance to live. Doctors developed a special plan of care for me. Their goal

was to get me to at least 28-weeks so that the other baby had a chance to survive. I made it to 38 weeks. I had to see my gynecologist once a week, a high-risk specialist twice a month and go to the hospital once a week for blood tests. I was told that they would have to take the other baby if any of the blood test results showed toxins. I knew there was a chance that my other baby might have some medical issues because of these circumstances.

I did not receive an official diagnosis for my daughter until she was eleven-months old. Doctors like to wait until the child is close to one before they diagnose cerebral palsy. However, it was no surprise to me. I knew what my daughter had before the doctor diagnosed her. I had a baby book that showed the milestones as the baby grew older month-by-month, like being able to hold their head up and turn over. My daughter wasn't doing any of

that. I knew that something was wrong. I decided to conduct my own research and purchased a book on medical conditions. The information about cerebral palsy described my daughter.

Did you go through a grieving process after the diagnosis?

By the time I received the official diagnosis, I had already grieved. Now, I was determined to provide my daughter with the best care and resources that were available. I got on every waiting list for services. I got her in Early Intervention and took her to an Easter Seals class. She had eight therapy sessions a week. I contacted the United Cerebral Palsy Association. I wanted to know about cerebral palsy from an adult who had it. I wanted to know what resources I needed to provide my daughter so that she could develop to her full potential. Additionally, I set aside time each week to conduct research on cerebral palsy.

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How did you tell your family about your child's diagnosis?

My mother is deceased. I called my father and my aunt once I read about cerebral palsy in the book. They informed other family members. There was no one in the family with different physical abilities at that time.

What was their reaction?

My father was encouraging, but did not understand the condition. He thought it was something that my daughter "could grow out of." My aunt was encouraging, but thought that it would be too much to care for my baby and to work full-time as a newspaper reporter. My daughter has always been included in all family functions.

What are the challenges and setbacks that a parent of a child with a disability faces?

Just realizing that your child may have more difficulties in life is hurtful to a parent. You have to endure multiple surgeries, consider the level of motor

skill functioning when buying toys, adaptations in clothing, appropriate educational opportunities, alternative play for inclusion for socialization and seeing many medical specialists.

As a parent with a child with a disability, do you consider yourself an expert on your child's care and well being?

I consider myself an expert who needs continuing education credits. I have disputed some medical advice and suggested surgeries because I knew they were not appropriate for my daughter. I've had to fight for inclusion in the typical classroom, adaptive equipment, therapies and modifications to my home.

After the first diagnosis, did you feel a need for second opinion?

I didn't seek a second opinion on the diagnosis. I have sought many opinions on suggested treatments. I have been to the Cleveland Clinic, Children's Hospital of Pittsburgh, and the Shriners' Hospital in Tennessee

and of course Nationwide Children's Hospital. I am currently seeking the advice of an orthopedic surgeon in Georgia.

How much research did you do on your child's disability?

I spend a few hours a week researching the latest treatments and options for people with cerebral palsy and other different abilities. My aim is to keep her functioning level up. I am a big supporter of adapted recreation for physical and social well being.

Did you, or do you, get any assistance from any community programs, government or otherwise?

Yes. We have been in Early Intervention, Easter Seals and private therapies. We also have a waiver and BCMH.

If so, how did you learn about these programs?

I learned about these programs by conducting research and asking questions.

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The members of the Ohio DD Council's Outreach Subcommittee decided to publish this article to raise public awareness about a population that is unserved/underserved.

The opinions, beliefs and information contained in the article are those of the author and do not reflect the official position of the Ohio DD Council's Outreach Subcommittee.

Toni Temple, the author of the following article, shares the experiences of those persons with MCS.

From the NADD Environmental Health Project

Deceived, Disabled, Dejected, Dehumanized, Dismissed, and Dying: The Widespread Dilemma of MCS Disability

Toni Temple

Founder and President
The Ohio Network for the
Chemically Injured

My name is Toni Temple and I am a non-traditional, self-appointed poster child. I'm "non-traditional" because I am not an adorable child with Shirley Temple curls standing on crutches that you might have seen growing up in slick March of Dimes or Polio Prevention ad campaigns. Heck, I'm not even a child - I'm 63 years old. And I'm "self-appointed" because the disease from which I suffer is not recognized or acknowledged by significant portions of the medical and health care

communities. I am a victim of, and poster child for, Multiple Chemical Sensitivity (MCS). A better understood term would be chemical poisoning, but MCS is the name they gave us.

You may have heard about MCS but don't understand what it is, or you may have been falsely led to believe that it is not a legitimate disability. To simplify, MCS can be caused when people are exposed to certain chemicals and toxins on a daily basis for a period of time or they have been exposed to a harmful substance in a major single exposure (e.g., pesticide application to their home or yard, new carpeting, treated wood deck or fence installation,

remodeling chemicals, etc.). These exposures can harm the body by causing permanent sensitization to numerous chemicals and products used in daily life and can also cause other illnesses including cancer, developmental disabilities, and asthma. Reading my article may help you with your own health problems or those of your unborn child. Everyone can be affected by chemical exposures that are inhaled, ingested, or absorbed through their skin (see Toxicological Profiles in Resources section).

Those harmed by chemical exposures have included: Gulf War Veterans, Viet Nam

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Veterans, 911 Rescue Workers, nurses (exposures to latex and disinfectants including gluteraldehyde), farmers (pesticides), factory workers (heavy metals and solvents), the housewife (uses modern chemistry to decorate and clean her home), and ordinary people like you (who may have had jobs that exposed them to harmful toxins, took pharmaceuticals for other health issues, or just happened to be in the wrong place when a toxic event occurred). Toxins can be ingested, e.g., dyes, preservatives, pesticides, and other food additives.

I became permanently disabled with MCS in 1988. I learned how to survive by following my instinct and avoiding triggers (e.g., pesticides, petroleum products, perfumes) that cause me to have severe health reactions. When I joined an MCS support group I learned this health problem was international (Ashford, et al. 1995) and political, and that discrimination was the rule, not the exception. MCS was not "validated" by physicians who were uneducated about it

(Schenk et al., 1996). That set the stage for families, employers, friends, and others to degrade and disbelieve those being harmed by toxins. I learned how to study toxicology and scientific articles out of necessity and took pertinent ones to my physician for review. One of these, the U.S. Department of Health and Human Services Toxicological Profile on Zinc, literally saved my life.

My MCS disability was caused by an exposure to zinc chloride being emitted from oxidized galvanized metal in my home furnace ductwork. I learned from the Zinc Toxicological Profile that zinc can replace iron in your body and cause dangerous iron deficiency anemia. The zinc apparently also mimicked iron in the CBC blood tests I had been given. I was not diagnosed with anemia until after I gave my physician the Zinc Profile and he decided to take a ferritin iron level blood test. It showed I was in imminent danger, and iron transfusions were immediately ordered for me.

MCS is only one of many illnesses caused by toxic exposures. Most diseases caused by these exposures take time to develop. However, MCS symptoms occur almost instantaneously upon exposure to a triggering agent (Miller, 1994). The immediate effects are similar to being placed under anesthesia and include: confusion, disorientation, drugged feeling, headache, short-term memory loss, slow mental response, imbalance, difficulty speaking coherently, and other disabling symptoms. Many times those with MCS also develop other illnesses in addition to their MCS. Is it any wonder those with MCS want to be and need to be understood and accommodated? Quite ironically, when accommodations are provided, those with MCS can feel relatively well.

Known toxins that disable and trigger reactions include pesticides (Reigart & Roberts, 1999) — a category that includes disinfectants, herbicides, fungicides, and rodenticides; petroleum, solvent, and gas exposures; heavy metals;

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and molds. Although it takes only one of these to disable, once MCS presents, minute exposures to any of these can trigger severe reactions (MCS Definition, Multiple Chemical Sensitivity: A 1999 Consensus, 1999).

In addition to the short-term effects from chemical poisoning, there are also long-term effects, particularly when people cannot get away from every day exposures (e.g., exposures at the workplace, schools, or in their homes). Long-term effects include neurological problems and peripheral nerve damage (peripheral neuropathy), anemias (more than one type), diabetes, arthritis, chemical cellulites, vascular disorders, including life threatening blood clotting, nutritional deficiencies, asthma, and sometimes even cancer.

From 5 to 15% of the U.S. population is affected by chemical sensitization in varying degrees (Miller & Ashford, 2004; Caress & Steinemann, 2003; Neutra, Kreutzer, & Lashuay, 1999; Vorhees, 1999; Meggs, Dunn, Bloch, Goodman & Davidoff,

1996). When you also consider that chemicals cause other diseases including cancer, birth defects, asthma, and Parkinson's, the percentages skyrocket. As a society, we have become careless and irresponsible about the production and use of chemicals. We have been lured into believing that there are "safe levels" of toxics and that additives and pesticides in our foods will not harm us.

"Experts" on health news shows and commercials have led us to believe that we are at fault for our health problems. They tell us we have bad genes, eat too much, and need to exercise more. They neglect to inform us that the addictive substances, dyes, preservatives, artificial sugars, MSG, and other food additives store in our fat cells. We remain hungry and our health suffers because our bodies recognize and utilize only nutrients. The artificial ingredients in our food store in our fat cells instead, continuously poisoning us while we utilize our fat for energy.

It is shocking and inexcusable that most doctors have not

been and are not being trained to recognize chemical poisoning in medical schools, including those for occupational medicine. Death from taking prescription drugs, as directed, occurs more and more frequently, and more have been permanently harmed. Toxicologists are appropriately trained and capable of recognizing how various toxins affect our health. However, they are not permitted to treat patients (unless they also have medical school training). As a result, many MCS patients are misdiagnosed and inappropriately labeled with psychological disorders while anemia, nerve damage, and other life threatening harm takes place. Having PhD toxicologists teach in medical schools would be a great start!

I firmly believe in the adage "Seek and ye shall find." There is a cause for every health problem and disability. As a society we can fix some of the problems. But first we have to be responsible and appropriately educate ourselves, and then learn how to communicate with each other to find the solutions.

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Resources

IEQ, Indoor Environmental Quality <http://ieq.nibs.org>

The Ohio Network for the Chemically Injured, www.ohionetwork.org

Toxicological Profiles are available at www.cdc.gov. Enter name of element or chemical and "toxicological profile" in search box on cdc website (e.g., Toxicological Profile Zinc). The toxicological profile for zinc is available at www.atsdr.cdc.gov/toxprofiles/tp60.html.

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For further information, please contact Toni Temple at ohionetwork@netzero.net or by mail at P.O. Box 29290, Parma, Ohio 44129

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Reach Out e-Diversity News is produced by The Outcomes Management Group, Ltd.

This product is funded all or in part by the Ohio Developmental Disabilities Council.



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Disability Issues in the Election



by *Paul Jarvis*
ODDC Staff

The public policy work of the Ohio Developmental Disabilities Council is dedicated towards giving self-advocates and their family members a seat at the table, a voice in the debate and an opportunity to make choices about how government serves them.

Many advocates understand their ability to have an impact on public policy can be shaped by what happens on Election Day. Some advocates may already know who they support and others may still be looking for answers.

The DD Council does not engage in political activity nor can it give recommendations about candidates for political office. Rather, Council strives to educate advocates where to obtain information on their own and come to their own conclusions about what candidate will best serve them.

Voters who have a disability come from all walks of life and have differing values and priorities. But do voters with disabilities represent a significant voting bloc?

A 1998 study by Rutgers University and the New Jersey Council on Developmental Disabilities revealed that people with disabilities were less likely to vote than their peers without disabilities. The study also indicated that people with disabilities were less likely to participate in civic activities when the activity was based on a disability issue when compared to civic activities that are based on non-disability issues.

This would suggest that voters with disabilities are not single-

issue voters. It may also explain why campaigns have never made a concerted effort to reach out to voters with disabilities as a single voting bloc.

Presidential and other candidates may not be targeting their public policy agendas specifically at voters with disabilities, but they are developing statements and other platform planks that include disability issues in their overall approach to governing.

The American Association of People with Disabilities (AAPD) has attempted to consolidate all of the Presidential candidates' positions on disability-related issues. Many, but not all, of the candidates have responded to requests from AAPD to provide policy statements about disability issues. To see which candidates have responded and what their public policy positions are, visit www.aapd-dc.org/News/election/peac2008.php.

Of course, a candidate's lack of response to AAPD doesn't mean a lack of a platform on these issues. Almost every

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candidate operates a campaign website that includes information about the policymaker's priorities. If it can't be found on their website, start talking to the candidate's people in your area.

Remember, Primary Election Day in Ohio is Tuesday, March 4, 2008. Every polling place is

required by state and federal law to be accessible to people with disabilities. The Ohio Legal Rights Service provides a tremendous amount of information about the rights of voters with disabilities. This information can be found online at

http://olrs.ohio.gov/ASP/olrs_Voting.asp.

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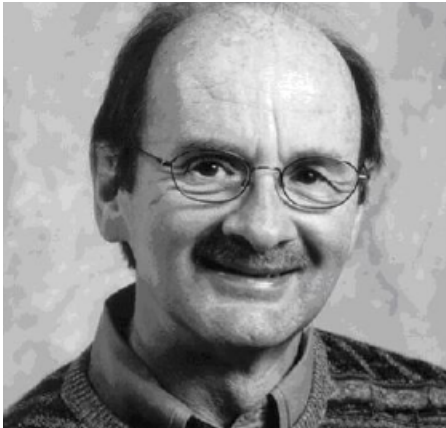
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An Ohio Mosaic – The Publicly Funded Mental Health System



by *Michael Schroeder*
Manager, Community Services
Development and Special Projects
Ohio Department of Mental Health

Ohio's publicly funded mental health system consists of several elements in a public/private partnership. Serving about 250,000 adults, children, and adolescents annually, it consists of the Ohio Department of Mental Health (ODMH), a cabinet-level state agency, 50 Community Mental Health/Alcohol, Drug Abuse, Mental Health Boards (CMH/ADAMH), about 450 community agencies, family and consumer organiza-

tions and advocates, and, most importantly, the people we serve.

Ohio Department of Mental Health

ODMH is charged by statute with being a "significant provider of mental health services." It operates five behavioral healthcare organizations (BHOs) on nine campuses:

Northcoast Behavioral Healthcare has sites in Toledo, Cleveland, and Northfield

Heartland Behavioral Healthcare is in Massillon

Appalachian Behavioral Healthcare has sites in Cambridge and Athens

Twin Valley Behavioral Healthcare has sites in Columbus and Dayton

Summit Behavioral Healthcare is in Cincinnati

Each of the BHOs operates both inpatient and community support network services, providing both hospital-based and community services in response to the perceived needs of the CMH/ADAMH Boards in the communities they serve. Each is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

One thing that many people do not understand is that, because of a provision in federal law, free-standing psychiatric facilities with more than 16 beds are termed "institutions for mental disease" (IMDs). In general, people in IMDs are not eligible for Medicaid, so the Boards must pay for those services out-of-pocket.

In addition, the ODMH provides for statewide planning for serv-

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ices, technical assistance, funding, monitoring, and evaluation. The Department licenses residential treatment settings, psychiatric hospitals, and psychiatric units in general hospitals, as well as certifying the community mental health agencies. It promotes excellence in culturally competent clinical practice, through the promotion of evidence-based practice, continuous quality improvement, and the use of consumer outcomes. It is believed that every Ohioan with severe mental illness should have the opportunity for recovery, and is committed to resiliency for severely emotionally disturbed children and adolescents, and their families. It works with other state and federal agencies to provide for the needs of people with mental illnesses.

CMH/ADAMH Boards

Ohio's 88 counties are covered by 50 Boards which do planning, evaluation and funding to meet the needs of the people in their service districts with mental illness. They do not

provide direct clinical services but are charged with providing for a coordinated system of care at the local level, and, in fact, serve as the local mental health authority. Most Boards have been successful in passing local tax levies, greatly contributing to the funding needed to support services.

Community Mental Health Agencies

Ohio has a rich diversity of over 450 community mental health agencies. They range from large, comprehensive Community Mental Health Centers to small, "niche" agencies which may offer only a few services to select populations. While most agencies offer outpatient services, some provide residential treatment.

There are growing numbers of consumer-operated services. Some offer peer support, recreation and self-help, and others provide a broader array of services. While most are stand-alone, some are attached to larger agencies.

Community mental health agencies, under contact with the Boards in their communities, provide the direct clinical and support services needed by individuals with mental illnesses in their communities. In general, it is through them that one would apply for service(s). Each community may have a different way of assessing need and assigning people to agencies.

Advocacy Organizations

Both consumers of mental health services and their families and friends have formed advocacy organizations to work with local Boards and agencies, ODMH, and legislators to make known the needs of people with mental illness in Ohio. Often, those organizations have offices or some presence in the BHOs and in some Boards and agencies. People looking for a group in their area should contact the local Board or agency, and they will be able to direct them to what is available in their community.

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Consumers

Mental illness does not discriminate by age, social class, by income, by race, creed or national origin. People with severe and persistent mental illness often find themselves in poverty, regardless of education or background. While some have very successful careers, most have difficulty, and full employment, unfortu-

nately, is not the norm. While that is beginning to change, and more people with mental illness are working, the numbers are not large enough. Work is often a key element in recovery.

Recovery

No article about mental illness should be printed unless it addresses the issue of recovery.

What we now know is that people can and do recover from the effects of mental illnesses, and that hope is essential to that recovery. Recovery is to the mental health system what self-determination is to the MRDD system. It is based on the dignity of choice and the hope that one can live a happy and productive life in spite of the illness.

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Save The Date

Inspiring Equality: A Disability and Cultural Tribute to Dr. Martin Luther King, Jr.

Friday, February 22, 2008

2:30 p.m. – 5:30 p.m.

The Ohio State University – Main Campus

The Young Adult Transition Corps, an AmeriCorps program of The Ohio State University's Nisonger Center on Excellence in Disabilities is hosting a workshop in honor of Dr. Martin Luther King, Jr. and Black History Month. For more information, check out this website: <http://yatcoho.org/events/mlkevent.html>

Call for Student Posters – Proposals are due March 21, 2008

The Eighth Annual Multiple Perspectives On Access, Inclusion & Disability, an interdisciplinary conference exploring disability as an individual experience and social reality that cuts across typical boundaries of discipline, theoretical & applied, public & private, town & gown. Hosted by The Ohio State University's ADA Coordinator's Office in the Pfahl Executive Education and Conference of the Fisher College of Business, this year's conference on April 21-23, 2008, will feature a Student Poster Reception on April 22nd along with over 30 concurrent sessions & two pre-conference sessions.

This year's theme, "Looking Back and Thinking Ahead," is meant to encourage presenters and participants to consider topics, methods and programs from fresh perspectives.

Graduate and undergraduate posters addressing the themes of Access, Inclusion, and Disability are sought for the Eighth Annual Multiple Perspectives Conference.

For more information, contact: ADA-OHIO (The Americans with Disabilities Act), 700 Morse Road, Suite 101, Columbus, OH 43214, 800-ADA-OHIO (800-232-6446), 614-844-5537 (fax), adaohio@aol.com, <http://www.ada-ohio.org/>

Mark Your Calendars for the 2008 Accessible Technology On-line Seminars February 11, 2008 2:00pm -3:00 pm Eastern Standard Time

Topic: "State Laws Addressing Accessibility"

The DBTAC-Great Lakes ADA Center is sponsoring a new on-line seminar series on accessible technology in 2008. The goal of the series is to increase awareness on technology accessibility for people with disabilities.

Several states have passed and implemented laws specific to website and other technology accessibility. This seminar will highlight the recently passed Illinois Information Technology Accessibility Act and present information about other states that have implemented such laws.

The seminar is free, but pre-registration is required. Please e-mail jpete@uic.edu to register for the session or for more information.

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