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SPRING 2015

FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE

VOL. 2 NO. 3

Caring for Our Veterans and First Responders

The Veterans Mental Health Primary Care Training Initiative: Training a Healthcare Workforce to Meet the Mental Health Needs of Returning Veterans

By Richard Gallo
and Rachel Fernbach, Esq.

The New York State Psychiatric Association (NYSPA) is taking a lead role in working to meet the mental health needs of veterans returning from combat duty through its Veterans Mental Health Primary Care Training Initiative (VMH-PCTI). The VMH-PCTI, which provides educational programs on mental health issues affecting returning veterans, is supported by a \$165,000 grant provided by the New York State Legislature and administered by the New York State Office of Mental Health. The grant is intended to provide training for primary care providers, including physicians, physician assistants and nurse practitioners. The training focuses on vet-



eran-specific mental health disorders, including combat-related post-traumatic stress disorder (PTSD), depression, anxiety, substance use disorders and traumatic brain injury.

The primary goal of the grant is to advance the development of a primary healthcare workforce that is well-educated and well-equipped to recognize the unique mental health needs of veterans. Educating

this segment of the healthcare workforce is essential as many veterans visit primary care providers when they return home from active duty, often seeing the same physician who treated them before deployment. Primary care providers who complete the training will gain clinical knowledge and skills as well as learn best practices for identifying, treating or referring psychiatric issues that may become apparent during routine primary care visits.

Training programs are planned as “grand rounds” presentations at teaching hospitals, webinars and separate events at other central locations around the state. The training curriculum includes general guidelines for the treatment of PTSD and traumatic brain injury, including psychotherapeutic and pharmacological

see Training Initiative on page 30

Behavioral Health News to Honor Alan Siskind, Andrew Solomon and Phillip Saperia at Its First Annual Leadership Awards Reception on May 20th

☆☆ You Are Cordially Invited! See Pages 20 and 21 for Complete Registration Details ☆☆

Staff Writer
Behavioral Health News

Behavioral Health News will host its first Annual Leadership Awards Reception on May 20th at NYU Kimmel Center’s Rosenthal Pavilion. Jorge R. Petit, MD, Board Chairman of Mental Health News Education, Inc. (MHNE), publisher of *Behavioral Health News*, made the announcement saying, “We are extremely excited to be holding our first Leadership Awards Reception and equally excited to be honoring three outstanding leaders of the behavioral health community, Alan B. Siskind, PhD, LCSW, Andrew Solomon, PhD, and Phillip A. Saperia, MAT. We hope all of our colleagues and supporters will come out to pay tribute to our three honorees and to help support behavioral health education.”

Dr. Siskind has had an extensive and distinguished career in social work and

mental health as a clinical practitioner, administrator, teacher and author. He had been the Executive Vice President and CEO of the Jewish Board of Family and Children’s Services until September 2007. JBFC is one of the nation’s premier voluntary mental health and family service agency, which serves over 65,000 clients annually in 185 programs in the five boroughs and in Westchester. Dr. Siskind is currently in independent practice with individuals, couples and families. Alan was the Founding Board Chairman of MHNE and will be receiving MHNE’s “Founders Award” at the May 20th event.

Dr. Andrew Solomon is a writer and lecturer on politics, culture and psychology, and a Professor of Clinical Psychology at Columbia University. His newest book, *Far From the Tree: Parents, Children, and the Search for Identity* won the National Book Critics Circle award for nonfiction; the Wellcome Prize; the Green Carnation prize; the J. Anthony Lukas

award; the Anisfield-Wolf Award; the Books for a Better Life Award; the Dayton Literary Peace Prize; and more than 30 other national honors. Dr. Solomon’s previous book, *The Noonday Demon: An Atlas of Depression*, won the 2001 National Book Award for Nonfiction, was a finalist for the 2002 Pulitzer Prize, and has been published in twenty-four languages. His prior books are *The Irony Tower: Soviet Artists in a Time of Glasnost* and the novel *A Stone Boat*. He writes regularly for the New York Times and The New Yorker and appears frequently on NPR. Andrew will be receiving MHNE’s “Humanitarian Award” at the May 20th event.

Phillip A. Saperia, MAT, began as Executive Director of the Coalition of Behavioral Health Agencies in 1994. In that position, he has overseen The Coalition’s program of education, advocacy and technical assistance to the diverse community-based behavioral health providers of New York City. Today, he serves on New York State’s Medicaid Redesign Workgroup on

Behavioral Health as well as the Subcommittee on Children and Families. He is deeply involved in the impending transformation of the health and behavioral health sector that he serves, including policy, advocacy and organizational reengineering. Starting as a teacher, he has been in the fields of community and government relations for over 30 years. Phillip will be receiving MHNE’s “Advocacy Award” at the May 20th event.

Ira Minot, LMSW, Founder and Executive Director of MHNE stated, “I am very proud of our Board who are undertaking this first ever event for our organization. Our Leadership Awards Reception this May will celebrate our 15th year of providing vital behavioral health education to the community. I am very honored that we will have this opportunity to pay tribute to three outstanding leaders of our community, and hope everyone will come out in support of their lifetimes of achievement.”

see Awards Reception on page 6

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Behavioral Health News
2015 Theme and Deadline Calendar

Summer 2015 Issue:
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New York State Tailors Treatment Services For Veterans with Alcohol and Substance Use Disorders

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

New York State and the country at large face formidable challenges in meeting the behavioral health needs of veterans returning from active duty in Iraq, Afghanistan, and other countries. The New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS) and its treatment provider partners are taking a leadership role in meeting these challenges by overseeing and supporting state-of-the-art residential services for female and male veterans, specializing in veteran-tailored treatment, and making veteran-aware referrals available through NYS OASAS' confidential toll-free HOPEline.

Understanding Veterans Behavioral Health Needs

Since the beginnings of Operation Enduring Freedom in 2001, Operation Iraqi Freedom in 2003, and Operation New Dawn in 2010, more than 2 million U.S. military active duty service men and women and reservists have been deployed overseas. More than half of them have been redeployed multiple times according to the United States Department of Defense. The New York State Division of Military and Naval Affairs estimates that 80,000 of these troops have already returned or are in the process of returning home to New York. In this time of ongoing overseas conflict, NYS OASAS recognizes that the demands of military service and trauma from combat exposure can make the return to civilian life a difficult one.

With each deployment and redeployment, service members can encounter increasing strains on their physical and mental health, which can result in increased rates of physical and behavioral health problems, most notably post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). The stress of deployment, combat exposure, and exposure to other types of trauma can also lead to increased use of alcohol and/or prescription or illicit drugs by many veterans. These stresses also contribute to increasing rates of veteran suicides and homelessness.

Like our returning veterans, their family members struggle with the ramifications of extended and/or repeated deployments which can result in serious emotional and psychological tolls on the family unit.

NYS OASAS commends the service of the state's 1.1 million veterans from all generations who have sacrificed both at home and overseas to serve their country. The agency continues to work to provide best practices in behavioral health services, including specialized veterans services for returning soldiers and their families.

Alcohol and Substance Use Disorder Treatment Services for NYS Veterans

Residential & Outpatient Service Models:
To address the issues often encountered



OASAS Commissioner
Arlene González-Sánchez, MS, LMSW

by returning veterans or the veterans who returned some time ago, and to provide a welcoming, supportive environment, in 2008, NYS OASAS began the process of establishing three 25-bed residential programs exclusively for housing and helping veterans with alcohol addiction and/or substance use disorders. NYS OASAS has provided \$26 million in funding that contributed to the building of three new, state-of-the-art residential facilities:

- Freedom Village Veterans Treatment Center, operated by Horizon Health, Inc. in Sanborn, N.Y., in Niagara County;
- the Women Veterans Program, operated by Samaritan Village in Ellenville, N.Y., in Ulster County;
- and the recently-opened Colonel C. David Merkel, M.D., Veterans Residence, operated by St. Joseph's Addiction Treatment and Recovery Center, Inc., in Saranac Lake, N.Y., in Essex County.

The Women Veterans Program in Ellenville is one of only a few programs nationwide that is devoted solely to serving the needs of female veterans.

The Samaritan, Horizon Health and St. Joseph's programs are "best practice" models that have been replicated by other NYS OASAS-certified-providers across the state. Several NYS OASAS-certified providers have established veteran-specific treatment programs which provide patient-centered care in supportive, trauma-informed environments, much like the care offered at these programs. These programs pride themselves in recognizing the values, core beliefs and unique culture of military service.

Today, including these three programs, there are 386 veterans treatment beds, operated by eight certified providers, throughout the state. In addition, three providers are also supporting veterans-only outpatient programs. These residential and outpatient programs for veterans support a clinical culture grounded in con-

cepts of trauma-informed care. They also take military pride and values into account when offering a patient-centered approach to care.

Many treatment providers across the state offer outpatient services geared toward veterans with substance use disorders. The Realization Center in Manhattan, for example, began a comprehensive outpatient treatment program for male and female veterans with alcohol or substance use disorders in November 2014.

Veteran Specific Treatment: Because of the spirit of teamwork and camaraderie upon which the culture and traditions of the military are based, veterans often perform best when approaching challenges or tasks together even within a treatment setting. Veterans feel most comfortable, understood, and safe when they are with their "battle buddies" or "brothers in arms." Many veterans say that no one quite understands the term "got your back" better than a fellow soldier, sailor, marine or airman who's been through combat. Perhaps that is why NYS OASAS data indicates that veterans complete treatment at a higher rate than their civilian counterparts. For many of them, treatment is seen as a mission and completion of one's mission is a familiar objective for military members. When possible, provider program staff members are veterans themselves, which helps build empathy and rapport.

In addition to alcohol and substance use disorder treatment, many NYS OASAS-certified providers offer additional specialized services including individualized case management, 12-step theme lectures and onsite meetings, onsite medical services, HIV prevention lectures and HIV testing, family reunification counseling, individual and group therapy, individualized treatment planning, therapy facilitated by substance abuse specialists, vocational services, recreational therapy, and anger management training.

These programs typically use the "Sanctuary Therapeutic Model," a comprehensive approach to developing a trauma-sensitive culture in which psychological and social trauma can be addressed and resolved, and the "Seeking Safety" model, a present-focused, coping skills therapy designed to help people feel safe from PTSD and other traumatic events that may have influenced their alcohol addiction or substance use disorder. These evidence-based practices have been shown to be effective in treating veterans.

In addition to these treatment modes, NYS OASAS established a screening, brief intervention, and referral to treatment (SBIRT) program in the vicinity of Fort Drum, the largest military facility in New York State located near Watertown, NY. SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. This SBIRT program was begun in 2012 to serve the behavioral health needs of active member of the military, veterans and their families.

Best Practice Trainings for Clinical Staff that Provide Treatment for Veterans: Trauma, including the types of trauma

typically suffered by those serving in the military, is often deeply rooted for those who are diagnosed with an alcohol addiction or substance use disorder. Trauma can function as both a cause and continuing trigger for addictive behavior. To make sure that clinical staff in NYS OASAS-certified programs better understand and can more effectively serve traumatized patients, NYS OASAS developed a two-day training titled, "Trauma-Informed Care: An Awareness Perspective." This 12-hour program, delivered to providers throughout the state beginning in 2012, seeks to provide participants with an understanding of the significant role traumatic life experiences can play in addiction. Clinicians attending this training learn to ask their patients, "what happened?" as opposed to "what's wrong?" This helps individuals focus on what events may have shaped their behavioral norms and views, how they are coping with the trauma/s they were exposed to, and how these events may be contributing to their addictive behaviors.

NYS OASAS' goal is that repeated deliveries of this training will embed a heightened level of knowledge and understanding system-wide about the influence of trauma, and pave the way for more advanced training in trauma-informed care. In 2014, NYS OASAS conducted 15 trainings, which benefitted approximately 525 clinicians across the state. Through this type of system-wide-focused initiative, NYS OASAS looks to enhance quality of care state-wide and improve services for New Yorkers and others whom the agency serves, including veterans.

Accessing Services: 24 Hours-A-Day Through the State's HOPEline

Though it is known that increasing numbers of veterans are returning with serious mental health and substance abuse issues, unfortunately, many service men and women in need do not seek help. According to the United States Army, only 40 percent of veterans who screen positive for serious emotional problems seek help from a mental health professional (*Mental Health Advisory Team IV: Operation Iraqi Freedom, 2007*). In addition, only 30 percent of veterans with PTSD or depression seek help from the Veterans Affairs Health System (*Invisible Wounds of War, 2008*).

The Army recognizes that stigma is a major barrier for veterans in need of mental health care (*Mental Health Advisory Team IV, 2007*). According to SAMHSA, service members frequently cite fear of personal embarrassment, disappointing comrades, losing the opportunity for career advancement, and dishonorable discharge as motivations to hide symptoms of mental illness, and alcohol or substance use or abuse, from family, friends and colleagues (2007).

To help reach veterans with behavioral health and addiction problems, masters-level clinicians who staff the NYS OASAS HOPEline, have been trained to

see Treatment Services on page 36



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What to Expect When Your Service Member Returns Home

By Paige Prentice, MM, CASAC
Vice President of Operations, Horizon
Health Services/Horizon Village

It is incredibly important to discuss how family members can prepare themselves for the physical and emotional changes they may have to make when their spouse, partner, parent or child returns home from combat. Many service members experience intense stress reactions as they readjust to a very different life at home. These stressors can result in symptoms of anxiety, depression, post-traumatic stress and substance abuse.

What should you watch for? There are common physical and mental/emotional reactions that your service member may experience in the first few months of being home such as; trouble sleeping, upset stomach, headaches, flashbacks / frequent unwanted memories, anger, guilt and becoming easily upset or agitated. Some common behaviors to look out for could also be, trouble concentrating, being on guard and lack of self-care. Again, these behaviors and reactions should subside after a few months as reintegration takes place, but if problems last longer, or if your service member is coping with stress by drinking, doing drugs, withdrawing or having sudden emotional outbursts, it's probably time to seek outside help. Ongoing symptoms like these could be the beginning signs of post-traumatic stress disorder (PTSD). Your service member could also be experiencing other common mental health issues such as: depression, suicidal thoughts, violence and substance abuse. If you are seeing any of these behaviors in your loved one, take the first step by educating yourself.

The service member isn't the only one making adjustments. It's important that family members also consider their own adjustments as everyone involved will have changed, both physically and emotionally. Here's how families can prepare.



Paige Prentice, MM, CASAC

Spouse/Partner

If the returning service member is your spouse or significant other, you'll probably experience a "honeymoon phase" for a time after demobilization. Then reality will have to kick in. If you have children, they've grown and changed and developed new habits and behaviors. And whether you have children or are child-free, you and your spouse or partner will have to figure out how to balance responsibilities and expectations again. If your service member has been through traumatic experiences, these experiences will affect your everyday lives for some time.

Children

Children may take some time to warm up to this person who has suddenly reentered their lives. They will react differently depending on age and temperament, but in general:

- Infants (younger than 12 months) may react to changes in their schedule, physical environment, or caretaker by showing apathy or refusing to eat
- Toddlers may be clingy, throw temper tantrums, or not sleep well
- Preschoolers may backslide with potty training or thumb sucking, or experience sleep problems, clinginess, and separation anxiety.
- School age children may be irritable, aggressive, or whiny, or complain of stomachaches or headaches.
- Adolescents may rebel against new family roles and responsibilities after the deployed parent returns home.

Prepare children to be with your returning service member by giving them extra attention, care, and physical closeness when possible, encouraging them to talk about their feelings and maintaining routines as best as you can.

Parents/Siblings

If your returning service member's parents live nearby, they will have to make many of the same readjustments as spouses or partners. They will also have to recognize that everybody has grown and changed, and adjust their boundaries as they get reacquainted with their loved one. If they, or the service member's siblings, have been helping you and your family while your partner was away, those roles will have to be renegotiated also.

One of the best things you can do to prepare yourself and your family for a service member's return is talk to someone who has experienced it and/or get help through counseling. Family and couple sessions are often an integral part of the therapy process. Many family members seek additional help for themselves

or their loved ones who are already in treatment. It's vital to find a valuable and private outlet for veterans to manage their stress and maintain their ability and passion for the lifesaving work they do. Learning and practicing healthy self-care through a coaching style therapy helps to stimulate productivity, a renewed interest in personal growth, and reconnection with family, friends and loved ones.

The VA, the military and other veteran organizations can provide you with helpful information. You can also reach out to Community Mental Health Organizations such as Horizon Health Services and Horizon Village in Western New York, Samaritan Village in New York City and Ulster County, J-CAP in Queens, New York and/or St. Joseph's Rehabilitation in Saranac Lake. Two other tremendous resources are NYS Office of Alcoholism and Substance Abuse Services (NYS OASAS) and Alcohol and Substance Abuse Providers of New York State (ASAPNYS).

On May 15, 2015, the Veteran Services Committee of ASAPNYS is presenting a one-day Veteran Summit (see display ad across from this article). If you wish to learn more about issues impacting our Veterans and their loved ones and the resources available to help them, contact Janet Braga at ASAPNYS to inquire about this event and/or register. Phone Janet at 518 426-3122 or email her at jbraga@asapnys.org.

Paige Prentice, MM, CASAC is Vice President of Operations, Horizon Health Services, Horizon Village, Inc., in Buffalo New York. She is the Co-Chair of ASANYS's Veteran Committee, Committee member of their Women, Children and Family Services, and a member of the ASAPNYS Board.

Awards Reception from page 1

More About Our Honorees

Dr. Alan Siskind is called upon frequently as an expert on family issues, the treatment of adolescents and young adults and mental health and social services in the City of New York. He had more recently been asked to share his expertise on evaluating and dealing with issues of structural racism in human service agencies. He has served on numerous human services advocacy groups and special commissions, most recently the Mayor's Commission on Economic Opportunity. He currently leads a monthly group on dealing with structural racism for leadership in New York's social services sector. Dr. Siskind is currently serving as co-editor on a book on Racism in Human Services which is currently in process with Alma Carten and Mary Pender Greene.

Dr. Siskind is Past Chair of the Human Services Council of New York, The Coalition of Behavioral Health Agencies (formerly The Coalition of Voluntary

Mental Health Agencies), the Mental Health News and the American Association of Children's Residential Centers. He has been on the board of numerous mental health and social service organizations, including the Child Welfare League of America's AAPSC Child Mental Health Division Advisory Board, the Council of Family and Child Caring Agencies, and the Interagency Council. He has been an adjunct Professor at Columbia University School of Social Work and the Smith College School for Social Work. He has been named a Distinguished Practitioner by the National Academies of Practice and is a fellow of the New York Academy of Medicine.

Dr. Siskind has received numerous awards for his leadership and service including the Coalition of Voluntary Mental Health Agency's Founder's Award, the Human Services Council Leadership Award, the Horowitz Award from UJA-Federation of New York, the Latino Social Work Task Force Leadership Award and appointments to the Boston University and the Columbia University School of Social

Work Halls of Fame, the Partners in Justice Award from Avodah, and the Leadership Award from The Shield Institute.

Dr. Siskind received his B.A. from Boston University, his M.S. from Columbia University School of Social Work, his Ph.D. in Social Work from Smith College School for Social Work, and a post-Doctoral certificate in Community Mental Health from Harvard Medical School's Laboratory of Community Psychiatry.

Dr. Andrew Solomon is an activist in LGBT rights, mental health, education and the arts. He is founder of the Solomon Research Fellowships in LGBT Studies at Yale University, and a member of the boards of directors of the National LGBTQ Force. He is a director of the University of Michigan Depression Center and Columbia Psychiatry; a member of the Board of Visitors of Columbia University Medical Center. He serves as Special Advisor on LGBT Mental Health in Yale's Department of Psychiatry. Additionally, Solomon serves on the boards of the Metropolitan Museum of Art, the World Monuments

Fund, PEN American Center and Yaddo. He lives with his husband and son in New York and London and is a dual national.

Phillip A. Saperia, MAT, has been a leading force for change since arriving at The Coalition of Behavioral Health Agencies. He has been immersed in mental health and addictions public policy and community based programs, government support of community behavioral health, the evolution of managed care programs for people living with mental illness and substance use disorders, the intersection of behavioral health and criminal justice and the emerging area of rehabilitation and recovery for people with behavioral health disabilities.

Before coming to The Coalition, Mr. Saperia was a consultant to several not-for-profit agencies on matters related to community siting of special care housing and on the development of local community advisory boards.

During the administration of David Dinkins, he served as Director of the

see Awards Reception on page 36

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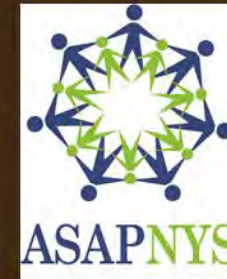
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Welcoming Home our Veterans Summit is presented by the Veterans Issues Committee of the New York Association of Alcoholism & Substance Abuse Providers and designed for substance use disorders services providers and other behavioral health organizations offering services to our Veterans. For more information call (518) 426-3122 ex 103 or visit www.asapnys.org.

From Hopeless and Homeless to Hopeful and HomeBound

By Daphne Dent-Black, LMSW,
Vice President of Transitional Services,
and Christina Mansfield, LCSW,
Senior Vice President, Child and
Family Services, ICL

The term “Homeless Veteran” should be an oxymoron. No Veteran of our armed services should return to a civilian life that doesn’t include a permanent home and the appropriate supports needed to successfully reintegrate back into society, but some do. According to the 2014 Annual Homeless Assessment Report (AHAR) to Congress, prepared by HUD, there were 49,933 homeless Veterans on any single night in the United States. This startling statistic is part of what prompted the Veterans Administration (VA), five years ago, to make a commitment to end Veteran Homelessness in 2015, which includes addressing not only the Veterans’ concrete housing needs, but also their behavioral and physical health needs that will enable them to stay in their own homes.

At ICL, “Homecoming” is a word that has special meaning to veterans returning to family and friends after having been away for long periods of time. A veteran’s return home does not end just because he or she is now back on American soil. Indeed, for many, the long journey “home” only begins at that point. Reestablishing emotional connections and a personal role with family and community after significant time away from home may require ongoing support and assistance. ICL offers services to veterans of all eras to help on the journey home at the ICL Borden Avenue Veterans Residence (BAVR), funded by the New York City Department of Homeless Services (DHS). ICL BAVR is a short-term transitional housing program for homeless veterans located in Long Island City, NY. The BAVR accommodates 243 male and female veterans. Veterans at the BAVR receive case management services that include assistance accessing supportive housing and other appropriate permanent housing placement assistance. BAVR also has on-site medical and psychiatric services. ICL works closely with DHS and the US Department of Veterans Affairs to provide coordinated and comprehensive services to homeless veterans residing at BAVR to smooth and ensure their transition to independence.

For 243 male and female homeless Veterans in living at the BAVR, this temporary transitional residence is where they



Daphne Dent-Black, LMSW

have a safe place to call home while working on permanent housing and where they can simultaneously access other support services to reconnect with family and other relationships. Few of our Vets are newly discharged. Many have struggled on their own for years before arriving at ICL Borden Avenue. The following is a story of one such Veteran, Mr. Michael Rodriguez.

Mr. Rodriguez is typical of the struggles and resilience we see on a continual basis in the vets at BAVR. He entered BAVR in August of 2014. He served in the Navy and was honorably discharged; however his transition back to civilian life was difficult. He had trouble reconnecting to family and finding a role for himself. Although he was back on American soil, he didn’t feel like he was truly home. Due to his income and eligibility challenges for housing options, he felt as if his situation was hopeless. He struggled with domestic and separation challenges from his spouse, medical issues, Post Traumatic Stress Disorder (PTSD), low self-esteem, depression, and a history of suicide attempts and substance abuse issues. His symptoms increased and his personal relationships deteriorated. He was unable to find work. Eventually, Mr. Rodriguez became homeless, which only added to his suffering. Since 1987, he experienced several periods of homelessness with little sense of connection to his family, and was overwhelmed by his symptoms and substance abuse.

PTSD is an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical



Christina Mansfield, LCSW

harm occurred or was threatened. Traumatic events that may trigger PTSD include violent personal assaults, natural or human-caused disasters, accidents, or military combat. People with PTSD have persistent frightening thoughts and memories of their ordeal and feel emotionally numb, especially with people they were once close to. Its effects can affect a veteran’s psycho-social and socioeconomic aspects of life.

Early detection of PTSD, combined with well planned, researched and developed screenings, can assist in providing adequate services to Veterans. According to Jakupcak (2007), “Veterans who screened positive for PTSD reported significantly greater anger and hostility than those in the subthreshold-PTSD and non-PTSD groups. These findings suggest that providers should screen for anger and aggression among Iraq and Afghanistan War veterans who exhibit symptoms of PTSD and incorporate relevant anger treatments into early intervention strategies. Williamson (2009) explains that, “we have yet to see the full extent of troops’ psychological and neurological injuries.” Service members are still deploying on long and repeated combat tours, which increase the risk of blast injuries and combat stress. Rates of marital stress, substance abuse, and suicide are all increasing. Untreated psychological injuries are also a risk factor for homelessness; almost 2,000 Iraq and Afghanistan veterans have already been seen in the Department of Veterans Affairs’ homeless outreach program.

When he arrived at the ICL Borden Avenue Veterans Residence, Mr. Rodriguez had significant trust issues. He consistently voiced the wish for someone to believe in him. Our staff is trained in Trauma Informed Care – a philosophical approach that assumes all our clients are “Wounded Warriors” who have experienced traumatic, painful events or PTSD. Trauma Informed Care is sensitive to an individual’s past experiences and how they may impact current choices and behaviors. Trauma-informed care asks not, “What is wrong with you?” but rather, “What happened to you?” Helping people view their behavior and symptoms as reasonable reactions to bad situations takes the blame away. It starts them on the path to seeing themselves as survivors who found the strength to get through bad times instead of thinking (or being told) that they are to blame for their illness.

Being approached as a person to be respected for what he has survived provided the breakthrough Mr. Rodriguez needed to open up and access help. Mr. Rodriguez felt heard and empathized with, instead of blamed and judged. As he began to feel cared for and valued, Mr. Rodriguez was able to access the services available to him. Mr. Rodriguez was able to see his symptoms as a reaction to what had happened to him, instead of thinking he was a bad person for having these problems. As he felt better about himself, he could envision a future that included a permanent home. After the shame and guilt were removed, Mr. Rodriguez has been able to achieve sobriety and accept treatment for his mental and physical health.

Mr. Rodriguez likes to share his story to give others hope. He remembers when he felt like no one believed in him or cared about him. He wants others to know that they can reach out for help and find caring, supportive staff who will listen to them. Mr. Rodriguez is currently getting treatment for his behavioral and physical health issues and on the path to obtaining permanent housing. It has been a long and difficult road, since he first became homeless in 1987. The stories of Mr. Rodriguez and others like him have and must change the way we address Veterans’ issues. We hope that by providing Rapid Re-Housing and immediate access to social services, the Veterans coming home from Afghanistan will get the help they need to readjust to life at home, at the first sign of difficulty, ending the need for the term “homeless veteran.”



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— Point of View —

Improving American Mental Health Policy

By Michael B. Friedman, LMSW
Behavioral Health Policy Advocate

We mental health advocates all agree that America's mental health system should be better. We do not all agree about how to make it better. That's a problem. Our differences have contributed to a political standoff in Washington where efforts to bring about major changes in the nation's mental health system have been stymied as much by disagreements among mental health advocates as by the inability of Democrats and Republicans to work together on a vast number of important issues. We are a house divided against itself.

As always, our differences are rooted in competing interests, ideologies, and egos. I'll leave egos out of this discussion.

America spends about \$300 billion per year on mental health and substance abuse services. That's a lot of money. It supports powerful vested interests and drives tremendous competition. Hospitals, community providers, private practitioners, drug companies, universities, governments, insurance and managed care companies, and others each have a piece of the action. Each believes that what it provides is essential and that some of what others provide is not only not essential but wasteful. The call to take from them and "reinvest" in us is widespread among mental health advocates.

In addition, some people who care about mental health have a libertarian bent; some have a protective bent. Those who are more or less libertarian want to protect the rights of people said to be "mentally ill"; they are willing to accept some of the inevitable hazards of liberty for the sake of avoiding unjust incarceration and loss of personal privacy. Those who tilt towards protection worry that people with mental illness (and others) are "dying with their rights on." We should, they believe, change the criteria for involuntary inpatient and outpatient commitment and should also change the rules of confidentiality so as to be able to share information more easily among providers and with families. Some also believe that America has gone too far in reducing inpatient utilization. More people, they insist, should be admitted to hospitals, and they should stay there longer.

There are also major disputes about the hegemony of psychiatry and its system of diagnosis. Some people who care about mental health believe that scientific psychiatry, with its heavy reliance on medication (to which America now commits 30% of behavioral health resources), should be the dominant force in the field of mental health. Some people believe



Michael B. Friedman, LMSW

that medication is overused, that the hope for a biomedical breakthrough is sadly unrealistic, and that the dominance of the mental health system by the profession of psychiatry is a mistake. They tend to see most of what is now labeled as mental illness as part of the human condition and to believe that it can better be addressed with humane, or even spiritual, interventions and with efforts to overcome societal problems such as violence and poverty.

I do not believe that we can overcome these deep ideological divisions, nor do I believe that we can find a singular common cause. But I do believe that we can work together to achieve some of what most of us agree about.

I have identified 15 areas of agreement. There are probably more. They include:

1. More and easier access to mental health services
2. Improved quality of services
3. More stable housing for people with serious, disabling mental disorders
4. More outreach to engage people with serious mental illness who reject or fail to go for mental health services
5. More "rehabilitation" services to promote recovery
6. Improved integration so as to overcome fragmentation within the mental health system, between mental health and substance abuse services, and between behavioral and physical health services.
7. More support for families caring for family members with psychiatric disabilities
8. Reduction of the mortality gap—i.e. the difference in life expectancy—between people with serious behavioral health conditions and the general population.
9. Reduction of the rate of suicide
10. Reform of the criminal justice system
11. Enhanced mental health services for specific populations such as children and youth, veterans, minorities, and older adults.
12. Enhanced prevention and early intervention
13. Reduction of stigma
14. Enhanced research
15. Adequate funding to support all of the above.

Fifteen areas of agreement! This is very hopeful, no?

Some advocates will certainly say that the list is overwhelming. They will argue that we need a lever not a laundry list. That is, we need to identify a point of intervention that will set many changes in motion and rapidly produce major change.

Maybe, but what would the lever be?

Our government seems to be betting that health care reform, driven by the Affordable Care Act, will do much to improve the system. Providing more people with health insurance and the inclusion of a requirement that health insurance cover mental and physical health services equally should result in more people having access to treatment for mental and substance use disorders. In addition, health care reform includes a variety of measures to improve integration of behavioral and physical health care and to prevent people in need from "falling through the cracks." The expansion of managed care through complex organizational structures such as health homes and accountable care organizations is, of course, aimed at holding down costs; but it is also intended to engage people in serious need and assure they get the care they need. Improved coverage and improved integration taken together should result in better identification of behavioral health disorders, more treatment, and better physical and mental health outcomes, including longer life expectancy.

Can we achieve a consensus to pursue this health care reform agenda? Partially, yes. I think that we can all agree to work to defend The Affordable Care Act, as it faces a challenge in the Supreme Court and vituperative rhetoric and legislation from a Republican Congress. But I don't think we can all agree on the reorganization of the mental health system being pursued with the creation of accountable care organizations and the like. Many providers are threatened by these experiments, and some of us who are not providers think that the goals are laudable but that the vast complex organizations being created are impractical. Time will tell.

In my experience over 40 years of mental health advocacy it is occasionally possible to rally the mental health community around a single organizing idea, but more often a laundry list, like the one above, has greater unifying power than a silver bullet.

Not that I think it would be possible at this time to rally around *all* of the fifteen areas of agreement that I've identified.

For example, there's real tension between the goal of expanding the mental health system and the goal of improving the quality of the system. Can we do both at the same time and hold a coalition of diverse interests together?

Generally speaking, coalitions do best when there's more for everyone. But addressing the quality of the current system leads to great doubts about doing that. Do we really want to expand the mental health system like blowing up a balloon—more of everything? Does our nation need more use of psychiatric medications, which very clearly are already overused? Do we need more psychotherapy in private offices or in clinics for people who have minor disorders (if any disorders at all)? Or should we give priority to expanding services for people with serious, disabling disorders for whom housing, rehabilitation, outreach and engagement, and improved physical health care are critical? Should we focus on expanding behavioral health services in physical health settings, particularly for people with mild mental disorders, or should we focus on beefing up physical health services in mental health settings for people with serious and disabling mental disorders?

Pretty clearly we ought to be selective about the services we increase. In the process, someone's ox will be gored, and whoever that is will not happily participate in a coalition.

So, I don't believe it's possible to rally around all fifteen of the areas of agreement I've identified. But I do believe that there will be opportunities to achieve some of them, and I think we should take advantage of those opportunities as they arise. We should, that is, go after more incremental improvement of the kind we have had for much of the past 45 years. It will not satisfy our hopes for an extensive transformation of the mental health system, but it is likely to be the best we can achieve, so long as the mental health community remains a house divided against itself.

Michael B. Friedman, LMSW, is the retired founder and director of the Center for Mental Health Policy, Advocacy, and Education of MHA of NYC. He teaches at Columbia University. He can be reached at mj395@columbia.edu.

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— The NYSPA Report —

Community Based Extended Inpatient Care

By Barry B. Perlman, MD
Legislative Chair, New York State
Psychiatric Association (NYSPA)

A cohort of persons with serious and persistent mental illness (SPMI) will continue to require extended inpatient psychiatric treatment beyond 2015, the year during which NYS will enroll virtually all of its Medicaid insured into managed care. Where their care will be provided remains to be determined. I advocate that community based extended care in specialized inpatient psychiatric units with programs developed to meet the particular needs of the SPMI population should be included among the options along with the appropriate use of state psychiatric centers.

Community based extended care deserves inclusion for four reasons: (1) It is best when persons receive care in or close to their own communities thus allowing for easy inclusion of families as part of treatment planning. (2) The clinical strength of the programs on such dedicated units. It is reasonable to believe that those requiring extended stays receive improved services when cared for on dedicated units than when stays are extended on units meant to provide acute care. (3) The federal government, even under Medicaid managed care continues to pay a significant share of the cost which is not the case when persons receive care in state psychiatric centers. (4) By locating such dedicated units within NY's Article 28 hospitals it allows for those often stressed institutions to generate needed revenue by returning units to clinical use which may have been shuttered due to decreasing admissions to inpatient medical and surgical services.

Currently, two such units exist in NYS, both located in Westchester County. For the reasons enumerated above, I have advocated for the creation of such units at strategically placed locations throughout our state since I chaired the NYS Mental Health Services Council. Some questioned about the added value of such units. The key questions then are does treatment on such units permit more of those with SPMI to be discharged to the community rather than requiring transfer to state psychiatric centers and do they improve the community tenure of those discharged from them?

In an effort to answer those questions I reached out to the NYS Office of Mental Health (OMH). OMH staff was generous in their willingness to collaborate. Provided with the names of 12 persons discharged during an agreed on time period from the extended stay unit at Saint Joseph's Medical Center (SJMC), OMH



Barry B. Perlman, MD

captured the cost of care utilized by those persons during the year prior and subsequent to their stay on the unit using OMH's powerful PSYCKES claims based data base.

These data, based on the experience at Saint Joseph's Medical Center, offer strong support to the value added by care on the extended stay unit. Dramatically, the total number of inpatient days for the cohort in the year prior to admission was 1508 whereas it dropped to 623 in the year after discharge. The total expended by the Medicaid system for inpatient care during the year prior to admission to the extended stay unit was \$892,734; it dropped to \$315,473 during the year subsequent to discharge, a meaningful decrease. During the year prior to admission the amount expended on all outpatient services was \$185,895, the amount paid for prescriptions was \$13,622 and the number of prescriptions filled was 358. During the year subsequent to discharge the amount expended on all outpatient services rose to \$311,977 and the amount spent on the 569 prescriptions filled was \$23,643. (Outpatient service use captured included: licensed mental health clinic, continuing day treatment, partial hospital, care management (TCM), community residence, and assertive community treatment (ACT).) Clearly the trends are those which recipients, their families, advocates and policy makers would wish, that are less spent on inpatient care and more on outpatient services, including what appears to be improved adherence to prescribed medications as evidenced by prescriptions filled. (The SJMC unit opened in 2006 at a time when transfers from community hospitals to state psychiatric centers were marked by long delays. The

program was meant to avert such transfers and return the vast majority of those admitted to the community without need for state psychiatric center admissions. With regard to this goal, the unit also has met with success.)

I suggest that these data provide a compelling reason for maintaining those extended stay units licensed by OMH to provide these specialized services and considering establishment of such units more widely across NYS.

OMH, I believe, has data which would allow reasonably accurate prediction of the number of extended stay beds which would be likely to be needed in a managed care environment. As for the financing of such units, two approaches seem workable and there are likely others. One would be to include in the per member per month (PMPM) payments to the Medicaid managed care plans either regular or HARP, an actuarial allowance for such stays in a cohort of covered SPMI lives. The other would be to carve out the cost of stays on such units. Under either scenario, but particularly appropriate under the former, managed care plans might reasonably be expected to manage stays

on such units as long as those plans were expected to play a collaborative, risk bearing role in implementing appropriate discharge plans for the individuals served and actively working to pave the way for access to the next level of care. (It is worth noting that under the current plan, extended stays in state psychiatric centers will not be managed.)

In conclusion, I assert, for the reasons laid out in this article, that the maintenance of and creation of additional units the mission of which would be to care for those persons with SPMI requiring extended inpatient psychiatric care would represent a win for the persons served, for the state, for the hospitals and even for the plans. They should therefore be considered by those currently working on the redesign of the mental health delivery system as part of the NYS Medicaid Redesign effort and the federal Delivery System Reform Incentive Payment (DSRIP) Program implementation.

Dr. Perlman is the Legislative Chair of NYSPA, and the Director of the Department of Psychiatry at Saint Joseph's Medical Center in Yonkers, New York



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MHA Vet2Vet Program: Leading the Way in Peer Support

By Carl T. Clark, MSG, USA (Ret.),
Vet2Vet Program Coordinator,
MHA in Orange County, New York

Mental Health Association in Orange County, Inc. (MHA) is pleased to provide Orange County's only Vet2Vet Peer Networking Program, also known as the PFC Joseph P. Dwyer Peer Support Project. The program is named in honor of Private First Class Joseph P. Dwyer, an Army Medic who served in Iraq, and subsequently passed away from an overdose due to self-medicating his Post Traumatic Stress Disorder (PTSD).

Vet2Vet Peer Networking provides veterans and members of the Armed Forces the opportunity to network with one another in a safe and nonjudgmental environment. Peers share the challenges they are facing and/or have faced and provide solutions and/or support to their peers on topics such as: PTSD, Traumatic Brain Injury (TBI), Military Sexual Trauma (MST), suicide, addiction, VA benefits, employment and education, among other topics. Services exist in the form of peer networking groups which meet in Orange County's three cities, a 24 hour Helpline at 1-800-832-1200, a Veterans Community Task Force, as well as linkage to a wide variety of resources are among some of the services offered.

When the Military Uniform Comes Off

Every year more than 180,000 people enlist in the armed forces. Soon after enlist-



ment young men and woman are shipped off to training and given a uniform to wear. It's not just a uniform, for many it becomes a protective outer shell, one that makes them stand tall and proud. Self-esteem soars after completion of initial training which comes in two phases; Basic Training (BT) and Advanced Individual Training (AIT). Many who had never accomplished much in their whole lives now have universally understood roles in our society; Soldier, Marine, Airman, Sailor, etc. Furthermore, they are called Infantrymen, Intelligence Analysts, Logistics Specialists and more. They have a status that needs no explanation, and is for the most part respected. Now members of their respective teams, these proud young men and women

stand strong alongside one another, mutually supporting, encouraging and protecting. Then one day their service is over, and the uniform comes off. Here is how it is after the uniform comes off and why.

Each person's uniform becomes a different kind of protective outer shell. Who a person was when they joined the military has a huge impact on how that uniform's protective outer shell will come off. For those who had some sense of self, status, and what I call pillars of self-esteem, the process will be just another change in life. The pillars of self-esteem I refer to can be many things, but I like to say; recognized skills, experiences, confidences, and who/what they consider themselves to be outside of the uniform.

While the life-change when one leaves military service can be daunting for anyone, most people will adjust in time and be okay with the uniform. For those who joined the military to run from family dysfunction, personal problems, and lesser skills and experiences than others in society, taking off the armored skin that brought them so far is really tough.

Protective shells limit growth as in the case of sea creatures like the crab. It is the same for some men and women in uniform. Whether new enlistees came to the game with adequate pillars of self-esteem or not, putting on a uniform sometimes inhibits personal growth. A period of growth that can last the length of a standard enlistment or one that can last 20 years or more. It's not the size of the uniform but rather the growth of the individuals self and the individuals expectations. Sometimes when people grow as a team they fail to grow as individuals. When the military sets up a service member's bank accounts, feeds them, provides them with free medical services and more, the activity and thought processes of these essential life skills are not etched in the minds of those served. These are basic life skills that civilians must master at an early age. Once out of the military, a veteran's inclination is to turn to people and systems that served them while they were in uniform. Once individuals leave the military, their trusted provider is no longer there to help. Stepping outside the shell is HARD, but change is hard. Most people know this and military folks know

see Vet2Vet on page 37

Integrating Mental Health Services in a Primary Care Setting for Veterans

By Courtney Glashow, LMSW
Veteran Social Worker
Institute for Family Health

When it comes to the treatment of military veterans, often one provider just isn't enough. This particular population, which faces disproportionately higher rates of mental illness than others, can benefit greatly from integrative and collaborative treatment by a mental health clinician, in addition to a primary care provider. With stigma still attached to receiving mental health services, the ability to identify and engage more veterans into treatment may hinge on the development of integrated settings. By embedding mental health services that are specialized in the needs of veterans within a primary care practice, more connections to treatment can be made. Federally Qualified Health Centers, with missions to serve the underserved, often serve veterans who are disconnected from traditional veteran services. These health centers have workflows that integrate disciplines; helping veterans daily by not only addressing their medical needs, but also making sure that a veteran's psychosocial and mental-health needs are also being

addressed. This includes case management, care management, mental health treatment, and psychiatric care.

The ability for a veteran's primary care provider to successfully collaborate with a mental health clinician is highly important. Mental health clinicians, who are specially trained, are able to diagnose post-traumatic stress disorder, bipolar disorder, and major depressive disorder—all common conditions in veterans—during a medical visit. The primary care provider, when they recognize a need, can provide a "warm hand-off" to the mental health clinician, or have the mental health clinician join in together during the visit. The mental health clinician has the ability to perform a crisis intervention, assess the veteran's safety and risk, perform a psychosocial evaluation, or assist with any case management issues the veteran needs help with. The ability to meet a mental health provider during a primary care visit significantly decreases stigma and improves the likelihood of ongoing services.

It is crucial for these mental health clinicians in a primary care setting, to know how to work with this specific population, because veterans qualify for specific benefits that could affect their treatment. There is a need to ensure men-

tal health providers in integrated settings have the specialized training to inform their care and support the needs of this population.

One case example of the effectiveness of a collaborative approach, involves a veteran who saw his primary care physician to address his chronic hiccups. At the time, the doctor had seen this patient multiple times already to address his hiccups, but nothing seemed to be helping him. The physician then contacted a mental health clinician newly embedded in the practice as a consult to assess the veteran during the visit. It was discovered that the patient's hiccups were actually a symptom of his undiagnosed anxiety disorder, and it was found that the veteran was also experiencing depressive symptoms. By the end of the visit, the veteran was scheduled for weekly therapy sessions with the mental health clinician, a follow-up with his primary care provider, and a psychiatric evaluation with a psychiatrist. Through consistent team treatment, the patient began having less frequent hiccups and his Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder-7 (GAD-7) scores have decreased steadily over time. An on-site case manager was added to the team assisting the patient with housing and other concrete services.

Integrated settings, like community health centers, are ideal for meeting the comprehensive needs of veterans in a setting that many veterans already consider their "clinical home". The primary care provider, who often has a long standing relationship with the patient and/or patient's family, can play a critical role in engaging a veteran into mental health treatment.

Research suggests that the collaborative management by the primary care providers has resulted in a decrease in major depressive symptoms, and has improved patients' satisfaction with their care (1). Patients feel more cared for when they see both professionals are working together to follow up with them regularly. Mental health services in the primary care setting are greatly beneficial to veterans because they can receive a multifaceted intervention that specifically caters to their needs.

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Addressing Trauma and Substance Abuse with Peer-Led Programs

By Peter Ashenden, Director of Consumer and Family Affairs, Optum Behavioral Solutions and Lisa M. Najavits, PhD, Director, Treatment Innovations

People who experience trauma, either as children or later in life as adults, are at a higher risk of developing mental health and substance use problems and chronic physical health conditions. Exposure to childhood trauma includes physical, emotional abuse, and sexual abuse; violence; neglect; family instability and divorce. Trauma later in life includes many similar events as well as car accidents, workplace violence or accidents, terrorism, military first responders, and military service (indeed, the original focus on psychological trauma arose in relation to military trauma during the World Wars). Trauma can lower people's sense of security and safety, and challenge their resiliency. Optum and Treatment Innovations recognize that trauma is often an important component of behavioral and physical health and offer programs that support well-being and resiliency.

Seeking Safety (www.seekingsafety.org) was developed by Lisa Najavits, PhD to help people with trauma and/or substance problems. It is an evidence-based model with over 20 outcome studies and is listed on the Substance Abuse and Mental Health Service Administration's

(SAMHSA) National Registry of Evidence-based Programs and Practices. It is a present-focused, coping skills model designed for flexible use: in group or individual settings, for both male and female clients, in any level of care (e.g., outpatient, inpatient, residential), and can be delivered by any staff regardless of licensure, degree, or training. Recently Najavits and colleagues published the first article on peer-led Seeking Safety (Najavits, et al., 2014), showing positive results when conducted entirely by peers in a Florida program. Seeking Safety is published as a book (Najavits, 2002) that includes all of the client handouts as well as the leader guide.

In ten states Optum has implemented Seeking Safety programs for individuals who experienced trauma and may also have substance use and posttraumatic stress disorder (PTSD). Optum has worked with local community-based, consumer-led peer organizations to develop and implement this program as a service to be provided by peer specialists. Optum has trained over seventy of these specialists. There has been favorable response from those who have been trained and are delivering these services, as well as the recipients.

Seeking Safety is a structured model to help keep each session safe and focused on present-day coping skills. Per the Seeking Safety book, each session follows a session format that includes a check-in;

reading a quotation that is relevant to the topic of the session, relating the material to participants' lives; and a check-out. Each Seeking Safety topic is an inspiring coping skill relevant to both trauma and substance problems (although participants do not have to have problems in both areas). Topics include Safety, Taking Good Care of Yourself, Compassion, Coping with Triggers, Asking for Help, Setting Boundaries in Relationships, and Honesty. There are 25 Seeking Safety topics, but they can be done in any order and as few or many as time allows. The model has been found to be extremely safe across over 20 years of implementation in highly diverse settings with diverse clients, clinicians, and programs. It has been translated into nine languages and is one of the lowest cost models available (training is available per www.seekingsafety.org, but is not required).

The Seeking Safety program was designed to enable those who experienced trauma and have behavioral health conditions to develop skills and strategies to help them live healthier and fulfilling lives. Peer-led Seeking Safety expands the reach of the model by offering ways to help peers help others. The core concepts of Seeking Safety encourage people who suffered trauma to stay safe; respect themselves; use coping techniques (not substances) to deal with emotional pain;

see *Peer-Led Programs* on page 36



In Recognition of Sandy Forquer

Optum is honored to announce the retirement of Sandy Forquer, PhD. She has served as senior vice president for state government programs, been a liaison to national organizations, and is a nationally recognized leader in the behavioral health field. Sandy has been a passionate advocate for the development of quality behavioral health services and has described her work as follows. "Creating consumer-friendly and responsive options for persons with serious mental illness has been a lifelong goal of mine. Designing community systems of care that embrace such options has also served as a major driver of all my efforts in whatever positions I have held. My job satisfaction derives from knowing that I have helped to make a difference in the lives of the people we serve." We are pleased to recognize her years of service and wish her the best in her future endeavors.

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Reframing treatment around recovery and resiliency offers new hope and a bright future for those who live with mental illness. While everyone must follow their own path to recovery, and every local community offers a unique set of supports, a few key principles can help ensure success:

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Integrating Trauma and Addiction Treatment

By Robert Olinitz, MS, CADC,
and William Poray, LCSW, CAC,
Marworth Alcohol and Chemical
Dependency Treatment Center

Individuals struggling with addiction who also work in a first responder capacity face unique challenges in addiction treatment and recovery. Often referred to as uniformed professionals, these individuals are very likely to work in high-stress environments with an increased risk of physical danger, exposure to trauma and resulting post-traumatic stress disorder (PTSD).

At Marworth Alcohol and Chemical Dependency Treatment Center, we take a specialized approach to treating uniformed professionals, many of whom are typically employed as correctional officers, emergency medical technicians, FBI agents, firefighters, police officers, probation officers and state department employees.

In these professions, trauma can happen in a variety of ways. For example, a police officer might be involved in a shooting, and that single event may have a profound traumatic effect. Or a firefighter may routinely see dead bodies after devastating fires, so the trauma builds gradually over many years. If the traumatic experiences manifest into PTSD, symptoms may include flashbacks, sweats and nightmares. By using drugs or alcohol to



Robert Olinitz, MS, CADC

relieve anxiety, depression or flashbacks, the trauma survivor can often mask the presence of PTSD, but it becomes a dangerous path to addiction.

Addiction and trauma are not mutually exclusive, but for this population especially, the co-occurring disorders are common enough to necessitate specialized programming that integrates trauma treatment with substance abuse treatment.



William Poray, LCSW, CAC

Traditional substance abuse counseling emphasizes getting sober and developing skills to cope with cravings, but it does not always focus on learning skills for stabilization and containment of traumatic memories. Alternately, when mental health professionals work with a patient specifically on PTSD, they may underestimate the need for a person in recovery to develop coping skills before opening up

about trauma issues. In either scenario, survivors may be re-traumatized and therefore, their vulnerability to relapse increases significantly. In an integrated program, counseling addresses both issues simultaneously and gives patients a higher likelihood of successful recovery.

A key component of integrating trauma and addiction treatment is training staff to identify behaviors that may indicate trauma history and appropriately approach the topic with the patient. Cues of trauma survivors might include frequently displaying extreme emotions without a specific stressor; involvement with abusive or emotionally unavailable partners; engaging in para-suicidal behaviors like cutting; or chronic relapse history. Once identified, staff can implement treatment techniques that help patients learn more adaptive means of containing traumatic memories, self-soothing and regulating emotion.

A common denominator for patients with trauma backgrounds is the basic human need to find or create safety, as outlined in Abraham Maslow's Hierarchy of Needs. With this in mind, Marworth counselors follow the "Seeking Safety" model of treatment with this population. Developed by Lisa M. Najavits, Ph.D. (professor of psychiatry, Boston University School of Medicine; lecturer, Harvard Medical School; clinical research

see Trauma and Addiction on page 35



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Responding to First Responders: Even Superheroes Need Help Sometimes

By Kathryn M. Salisbury, PhD
and Christian Burgess, LMSW
Mental Health Association of New York City

As we contemplated writing about the job-related behavioral health needs of first responders, we were reminded of the post 9/11 poster showing two swaggering 6 year old boys wearing blankets as capes with the tagline “Even Superheroes Need Help Sometime.” This poster was part of an advertising campaign developed by the NYC Department of Health and Mental Hygiene in collaboration with the Mental Health Association to de-stigmatize seeking help after 9/11, particularly as it related to behavioral health needs.

This message is especially relevant for our first responders including emergency medical technicians, firefighters and police officers who are the first people to arrive at the scene of an accident, disaster, or other crisis/emergency. First responders may also include military personnel (including the National Guard) depending on the nature or location of the emergency, and can also include trained volunteers. Response may come in second or third waves of assistance as well, ranging from HAZMAT teams to K-9 units, Citizen Emergency Response Teams (CERTs)



Kathryn M. Salisbury, PhD

to Medical Reserve Corps volunteers. Response actions can include attempts to stabilize an otherwise ‘out of control’ situation, first aid, rescue, evacuation, etc. The men and women who are among the ranks of first responders are our present superheroes. First responders save countless lives and work to prevent emergencies from escalating as well as mitigate the effects of disasters that have occurred, all while



Christian Burgess, LMSW

putting their own lives at risk in service to their communities.

Because the work of first responders puts them at particular risk for emotional distress, trauma, burnout, fatigue and other behavioral health concerns it is important to have behavioral health resources available at the ready for first responders and to make them available, where, how, and when then want them.

Response-Related Distress

Exposure to unusual events/circumstances: Even after extensive training, new first responders may encounter unexpected circumstances on the job, or simply realize that experiencing something directly for the first time is different than simulated exercises. Seasoned first responders with years of experience may still be called to respond to situations new to them, including acts of terrorism, incidents of mass violence, industrial accidents, etc. No matter the degree of training and preparation, sometimes first responders’ minds and bodies can still be overwhelmed during rescue and recovery work which can lead to distress or even trauma.

Longer than average shifts or deployments: Even on a ‘regular’ day, responders often work long shifts and sometimes for days at a time. But during disaster responses, shifts can go even longer – and without breaks or relief. Responders can also be deployed out-of-state (whether assigned or from volunteering), taking them away from coworkers, family and other familiar surroundings.

For additional distress risk factors, visit the Centers for Disease Control and Prevention’s Disaster Mental Health for Responders: Key Principles, Issues and Questions at

see Superheroes on page 34

War Impacts Us All: Minding the Gap Among Veterans and Civilians

By Scott Thompson, MS, MDiv, LMHC,
Director of the Veterans Mental Health
Coalition, Assistant Director of the
National Traumatic Brain Injury and
Emotional Wellness Alliance, MHA-NYC

Much has been made of the many issues facing veterans in our country and the myriad of services and organizations addressing their needs. In fact, veterans returning from war have all faced similar issues through the centuries. These are the common dynamics of adjusting to civilian life, reengaging with work and education, recovery from injuries, both visible and invisible, and the challenges navigating complex systems of support. At a minimum, it can be a daunting task.

There is a more fundamental need that remains unaddressed in this entire landscape. This is the place of the civilian and our necessary relationship to veterans. One of the most difficult challenges veterans face is the sense that their country doesn’t quite realize that the nation, and not just the soldiers, went to war. The burden of war rests on all our shoulders. The chasm or gap between understanding life in a combat zone and life less directly touched by war creates a profound sense of isolation for veterans. Perhaps the most debilitating is the absence of communities for both veterans and civilians to share the impact of war upon veterans and



Scott Thompson, MS, MDiv, LMHC

civilians alike. These communities can make a powerful impact that transfers the burden of war on all of our shoulders.

In ancient times societies used to ritualize both the sending and return of warriors to their community. Civilians were seen as vital in this process. Yet we’ve lost this capacity and ritual process and in doing so have contributed to the plight of veterans in our country. Both groups are in need of each other and have something vital to offer. Carrying home a host of

brutal and traumatic experiences, veterans often manifest the unresolved wounds of war through a constellation of mental health disorders (PTSD, substance use, depression, etc.). Civilians, in turn, carry hidden wounds from the trauma of long-term separation, fear, anxiety and the loss of veterans who are family members, neighbors, colleagues, and fellow citizens.

Despite these shared wounds, there is a profound and paralyzing absence of sharing and community between veterans and civilians about their experiences related to war. Veterans are separated from the whole of society by their very roles. They step into an extreme way of functioning, altogether foreign from civilian life. Civilians are similarly separated from the whole, uninformed of veterans’ experience, misguided in their lack of knowledge and understanding of how to support veterans.

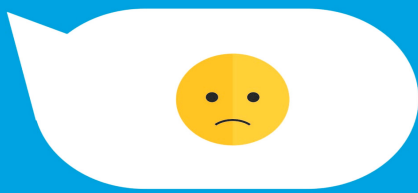
Repeatedly, our societal response to these conditions is reactive; while we work to ensure vets have access to care if and when a mental health disorder appears, we do little to decipher what we might do to prevent the development of such disorders in the first place. While we provide civilians’ with superficial mechanisms to recognize veterans’ for their service, we do little to provide civilians with a meaningful way to connect with those who have served on their behalf.

The Mental Health Association of New York City (MHA-NYC) and its Stories We Carry project has embarked on a na-

tional community building initiative that aims to create communities for veterans to return to. The project brings together both veterans and civilians to discuss the impact of the military and transition issues on both groups, each having something vital for the other. Directly developing and deepening these connections between veterans and civilians promotes a greater context of goodwill and responsibility, important for healing and successful return. Ultimately, this social healing initiative provides a mechanism for communication, health and wholeness that preventatively mitigates the impact of war on both veterans and civilians.

Additionally, veterans have great need for a more informed and militarily culturally competent public. A common myth is that most veterans receive their care at a local VA clinic or hospital. This couldn’t be further from the truth. In fact, more than half of veterans do not access the VA for services. If they receive services, they prefer to receive them in the communities in which they live. Unfortunately, all too often veterans return to local communities that are not prepared to meet their health, mental health, and social service needs. This requires civilian based service providers to be better prepared to respond to the challenges of veterans with health and behavioral health needs. To meet this need, The Veterans Mental Health Coalition of New York City (VMHC),

see The Gap on page 34



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Saying Thanks to Those Who Have Served

**By James R. Dolan, Jr., DSW, LCSW
Director of Community Services,
Nassau County Department of Human
Services, Office of Mental Health,
Chemical Dependency and
Developmental Disabilities Services**

The weather report was that the temperature would be in the mid 80s, but on the golf course it seemed as if it had reached about 90 degrees, with high humidity. It turned out to be the hottest day of the year; which further explained why it was a challenge to walk the 9 holes on this hilly course. I also forgot to bring water.

I did not intend to physically exert myself, because I was only interested in playing a relaxing round of golf. It seemed that walking would be easy, and that idea was supported by the finding that the two men I was playing with, Chris and Bob, both of whom seemed to be a few years older than me, had already decided to walk the course. So, at first, all seemed fine.

Things changed, however, on the 6th hole. We were on the putting green when Chris took a long pause before hitting the ball. I thought he was just composing himself prior to his shot; but after finishing he said that he waited to make his putt because he was feeling light headed.

Chris was the most talkative of the three of us. Early in the game he sought to engage me in conversation and to tell me about his golfing experiences in Las Vegas. Chris noted that the temperature reached 105 degrees on the day he played;



therefore he was not concerned about today's heat, even though it was humid. Chris said that although he did not have to deal with humidity in Las Vegas, he did not believe it would be an issue today, given that he handled the 105 degrees without a problem.

Chris told me that he hopes to retire soon, and that he owns his own business. He also said that he plays golf for free on the NYS course we were on, because he is a disabled veteran. I do not play golf often, but when I do, and when I am paired with someone I did not know beforehand, I usually limit the chatter to golf topics. I am not saying that I am opposed to talking about other issues; it is just is not my first inclination.

I have to admit that when Chris mentioned about being a disabled Veteran, it elicited a fondness toward him.

After the experience on hole 6, Chris walked to the 7th hole and sat on the bench. The heat and humidity had gotten to him. Chris said he was puzzled by this development, citing how he did not have this problem in Las Vegas. He did not seem in distress, but he was having some difficulty; so I offered him an aspirin. I always carry a few aspirins with me, in case they are needed. Chris first declined my offer, but within a few seconds he changed his mind. I gave him the pill, accompanied by some words of encouragement that the aspirin will make him feel better, as it will thin out his blood. I trusted that Chris would have told me if he was not allowed, for medical reasons, to take the medicine.

After a few minutes Chris said that he was done golfing for the day, and that he was going to temporarily remain on the

bench, and rest. He said he would soon walk back to the clubhouse.

Chris was reassuring that he would be fine but I noticed, as I walked ahead with Bob, that Chris had not started his walk toward the clubhouse. As luck would have it, I was able to get the attention of a groundskeeper who was driving by in a golf cart. I told him about Chris and that he was likely still sitting at the 7th tee box, and that he would benefit from a ride back to the clubhouse. The groundkeeper initially responded with a defensive reaction, stating that he just come on duty, and that whatever I was referring to had nothing to do with him. I re-explained myself, without getting annoyed, and the man eventually understood what I was saying. He then drove off in the direction toward Chris.

About 10 minutes elapsed and there Chris was, sitting alongside the ground keeper as he drove him back to the clubhouse. As Chris passed, he waved as a show of thanks. He seemed OK.

I believe the aspirin probably helped him, and since he had not started his walk, the arranged ride was also needed. I do not know for sure if I saved Chris from a grim fate, but it is very possible. I was largely a stranger to him and we probably will not ever cross paths again. Therefore, for the most part, I was an anonymous helper. Chris, on the other hand, helped countless people through his military service, and paid a price for doing so. He did not know the people he helped, but I was one of them; and I am glad that I could return the favor to a small degree.

Accepting Recovery and Coming Home: Integrated Practices for Addiction Treatment with Veterans

**By Michael DeFalco, PsyD, Director of
Military and Integrative Services, and
Aynisa Leonardo, BC-LCAT, Clinical
Coordinator of Military and Integrative
Services, Bridge Back to Life Center**

Since September 11th, 2001, about 2.5 million members of the Army, Navy, Marines, Air Force, Coast Guard and related Reserve and National Guard units have been deployed in the Afghanistan and Iraq wars. Of those, more than a third were deployed more than once; nearly 37,000 Americans had been deployed more than five times, among them 10,000 members of guard or Reserve units. Records also show that 400,000 service members have done three or more deployments (Adams, 2013). Multiple factors related to the conflicts in Iraq and Afghanistan and the Global War on Terror (e.g., multiple deployments, length of deployments, intensity and nature of combat operations) have led to an increase in psychological disturbance among service members following their deployments (Rand Study, 2008). Behavioral health issues such as posttraumatic stress disorder (PTSD), depression, traumatic brain injury (TBI), and substance misuse have been seen at increasing

higher rates not only in active-duty service members, but in our veteran population as well. Obviously, these problems do not end when an individual separates from the military, but the onus of responsibility for who is responsible for their care does. This shift in responsibility does not fall solely on the Veterans Administration (VA), it also falls on civilian providers of healthcare in the community. President Obama's signing of an Executive Order to improve access to mental health services for veterans, service members, and military families on August 31, 2012 highlights how these issues have been recognized at the highest levels of government, and that a change in national strategy is needed to meet the needs of our military that have been identified and continue to be unmet. Part of President Obama's multi-pronged approach asks for partnerships between the VA and community providers to enhance access to mental health care (White House Press Release, August 31, 2012). There is recognition that both within and outside of the VA it can be difficult to identify treatments that work as well as individuals who are competent to provide such treatments.

Examining these challenges for our service members, veterans, and military families on a more local level, the RAND

Corporation conducted A Needs Assessment of New York State Veterans in 2011. Sponsored by the New York State Health Foundation, this study found that, among New York State veterans, a significant proportion of those surveyed (56%) were identified as having a need for mental health services. Despite this need, only about half of those individuals actually sought care in the prior year. Most concerning, for the half who sought services, only half received or completed a "minimally adequate" course of treatment. Regarding preference for where veterans want to go for care, 46% indicated they would prefer to receive mental health services from a civilian provider (as opposed to the VA).

Focusing on the area of substance misuse, it has been well documented that the incidence of alcohol misuse and misuse of prescription pain medications (specifically opiate-based pain medications) has increased dramatically for active-duty service members over the past 10 years, and these difficulties often extend to our veterans as they reintegrate (National Institute on Drug Abuse, 2013). There is a strong relationship between posttraumatic stress symptoms and alcohol misuse (binge drinking and dependence), and there is a real need for us to develop ef-

fective and accessible outpatient programs to assist our veterans (National Center for PTSD, 2013). When considering integrated treatment for substance use disorders for veterans and military family members in an outpatient setting, a program grounded on the following pillars (such as the one we have developed with the ARCH Program at Bridge Back to Life Center, Inc.) is best suited to address the complex needs of the population under consideration.

Pillar One: Integration of trauma theory into the conceptualization of substance use disorders: Prevalence data and clinical experience working with veterans speaks to the high co-morbidity of traumatic exposure (both developmentally and adult-onset) and addiction. Whether an individual's capacity to self-regulate inner experience is derailed during key developmental years by interpersonal neglect or abuse (Cook, et al, 2005; van der Kolk, 2005), or is derailed by exposure to trauma related to military life (e.g., combat trauma) (Shay, 1994), addiction is often the result when the individual turns outside themselves to modulate their emotional swings, recurring thoughts, and physiological arousal/pain. Substance use

see Coming Home on page 28

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Returning Veterans and Readjustment

By George Basher
President and CEO
Loyola Recovery Foundation

While most individuals successfully transition from military to civilian life, a certain number do not – often leading to confrontations with clinicians, law enforcement and the criminal justice system. Understanding these individuals goes a long way towards preventing encounters from escalating into life changing events that lead to prison terms or worse. While a version of this article was directed at the law enforcement community, those of us in the treatment and recovery world can also benefit from a discussion of common Veteran readjustment issues and ways to resolve them.

There are roughly 2.6 million Post-9/11 Veterans in the United States, most of them having served in Iraq, Afghanistan, or both. The nature of these conflicts are different from previous wars, as are the soldiers who fought in them. In both conflicts there were few “safe” areas and the prevalence of Improvised Explosive Devices (IEDs) and ambushes exposed everyone – not just the infantry – to combat conditions. These are also the first protracted conflicts fought with a Volunteer military – unlike the Vietnam conflict when draftees served two years



George Basher

and a single combat tour, these professional soldiers are in for a longer term and many have been deployed to combat theaters multiple times.

We spend a great deal of time, money and effort in turning young high school graduates into highly trained soldiers. Most often we spend less than two days turning that soldier back into a civilian when discharged from the service. Many

of the habits that kept them alive in a combat theater are not acceptable behavior in the civilian world. Nearly every new Veteran requires some amount of time to readjust their habits from the combat environment. That combat environment includes constant stress and uncertainty, exposure to injury and death, separation from friends and family, and stress at home. Nobody comes home from that world unchanged.

In general the combat environment can create a constant state of 360 degree situational awareness – there are no safe areas and they are constantly on alert. There is a mistrust of any civilian authority – trusting only your battle buddies. The soldiers on your left and right are looking out for you – everyone else doesn’t matter. There are also grief, guilt, blame, and shame. Grief from loss of friends, survivor guilt when others around you are injured or killed, blaming superiors for bad outcomes that occur during a mission, or feeling shame over personal actions or lack of actions that got people killed.

The most commonly diagnosed Mental Health condition for this group is depression; the most commonly diagnosed physical conditions are orthopedic injuries – mainly knees and backs from violent physical activity while wearing over 60 pounds of gear. Add in those with TBI and PTS and there exists fertile ground for self-medication – through alcohol, sub-

stance, or prescription drug abuse.

The military has a tradition of “binge” drinking, despite command efforts to reduce the occurrence. Alcohol is cheap, legal, and easy to obtain – even in combat theaters where the open sale is forbidden. Many of these Veterans become addicted to prescription pain medication from injuries – it’s easier for a soldier to be returned to duty with painkillers than taking time to heal properly. With prescription drugs more difficult to find in the civilian world many turn to other substances such as heroin – which is often cheaper and easier to obtain. Finally, many Veterans use drugs and alcohol as a coping mechanism for undiagnosed and untreated stress.

Post-Traumatic Stress is described as a normal response to abnormal events – and some people adjust better than others. Symptoms exhibited include hypervigilance and hyper arousal – an exaggerated startle response or constant surveillance of surroundings. It also presents as aggressive, irritable behavior – overly violent response to minor situations. PTS is frequently accompanied by insomnia – individuals sleeping less than two or three hours a day. Another manifestation is emotional numbness – a lack of engagement with family and friends that is described in the military as the “thousand yard stare.”

see Readjustment on page 30

Creating Home in a Community-Based Art Therapy Program

By Jennifer DeLucia, MS, ATR-BC, LCAT, Wellness Program Manager
Veterans Outreach Center

Recently a veteran referred to our studio as a “second home.” He was referring to an art therapy program I had an opportunity to develop 4 years ago at a community-based organization for veterans in Rochester, NY, Veterans Outreach Center, Inc. During its first year the program more than doubled in size; veterans were hearing about it from friends and came requesting art therapy services specifically. Since its inception, the program has grown to include a fully functioning art studio, three full-time art therapists and a storefront gallery space where veterans can showcase their artwork.

“Home” can be a loaded term for veterans returning from service and reintegrating into civilian life. As treatment providers we need more knowledge to promote and advocate for veterans with community practices that encourage healing and reintegration. Building resilience and promoting successful reintegration is a task that reaches beyond the usual scope of mental health providers (Wheeler & Bragin, 2007). It is a calling for mental health providers to involve family, friends, and the entire civilian community. When art therapy incorporates studio engagement and gallery exhibition, veterans receive unique benefits that can address



Jennifer DeLucia, MS, ATR-BC, LCAT

the multiple levels of need starting with the veteran and reaching out into the context of the community or “home” where the veteran returns.

In July 2013 Veterans Outreach Center received national recognition from the White House with an invitation to present a case study of our program at the Veterans and Military Family Mental Health Conference in Washington, DC. The conference highlighted the work of commu-

nity-based organizations and their vital role in offering complimentary treatments and alternative options to treatment seeking veterans. In our community art therapy has become a sought-after treatment option by veterans working through issues related to readjustment and PTSD. The conference set the stage for President Obama’s national initiative that directed all VA medical centers nationwide host annual mental health summits. The summits brought together community providers and VA representatives to identify ways to improve collaboration and collectively meet veteran needs.

Readjustment

Veterans experience cognitive, spiritual, emotional, and social challenges that may impact supportive relationships and complicate their reintegration into post-conflict or civilian life (Bruner & Woll, 2011). The impact of these challenges may take many forms including difficulties with finding and sustaining gainful employment; reconnecting intimately with spouses, children, and close civilian friends; and attending to daily responsibilities (Caplin & Lewis, 2011). There also are certain risk factors associated with the failure to adjust. I have found such veterans to be at greater risk for the development of mental health conditions like depression or substance abuse. Veterans with a diagnosable mental health condition at the time of separation from ser-

vice often struggle with the tasks of reintegration into routine life, which then leads to greater complications with the readjustment process.

In addition to the mental health and psychosocial issues tied to readjustment, there is a cultural adjustment that veterans may experience when returning home. A military mindset that is developed as service members are socialized into military culture may present challenges in the process of readjustment to civilian life (Coll & Weiss, 2011). Military culture contrasts greatly with civilian culture in many ways. A strong sense of camaraderie comes from being a member of a military unit, holding a shared mission, and knowing that fellow service members are looking out for one’s safety and wellbeing; this strong sense of group cohesion is not easily found in civilian society (Coll & Weiss). At home many veterans lack proximity to their military support network and lose the familiar structure of military culture. Veterans must negotiate the gulf of difference between civilian and military cultures while often lacking the much-needed social support to navigate this process successfully.

Art Therapy

Currently, research on art therapy and veterans has focused on the treatment of posttraumatic stress (e.g. Collie, Backos,

see Art Therapy on page 36



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Innovative Treatment Choices for the Military Family

By Rachel W. Bush, PhD
Assistant Professor of Psychiatry
and Behavioral Science,
New York Medical College

The military family system deserves to be given easy access to the most outstanding clinical treatments that we now have to offer. We are in the process of developing novel psychotherapeutic interventions for the heroes that have taken on the duty of defending our country with honor, commitment and exposure to trauma. Everyone in the system is impacted. Veterans and their families deserve to be able to make informed treatment choices that provide them with the opportunity to have hope filled, and normal lives going forward.

Innovative treatment needs to be inclusive. As clinicians we are not only caring for veterans. When we work from a systems perspective it is abundantly clear that the availability of mental health treatment choices for spouses, children, parents and siblings must always be available.

Resiliency

Veteran resiliency is interwoven with the love, support, encouragement, faith, courage and strength of the social-emotional system. This is a relational model that is driven by our psychological expertise in developmental theory, attach-



Rachel W. Bush, PhD

ment, biology, technology, ongoing empirical research and exceptional, efficacious clinical care.

Optimal multimodal treatment will frequently require and include psychoeducation, individual psychotherapy, psychopharmacologic treatment, group therapy, family therapy, couples therapy, as well as specific clinical services for children and teens. We need to support healthy individual and family functioning.

Deployment

Deployment is a major life stressor that affects the entire family system. The past decade of wars in Iraq and Afghanistan have had more frequent and longer deployments than any other time in history and we have found that Non Deployed Spouses (NDSs) are at increased risk for clinically significant psychiatric distress during and after the spouse is deployed (Bjornestad, et al., 2014). When focusing on the uniformity of evidence based treatments in practice and the psychological consequences of engaging in combat, (Laska, 2013; Sammons, 2008) it is clear that this is the first time in history when psychological morbidity is likely to far outstrip physical injuries associated with combat. The current literature on Post-Traumatic Stress Disorder is extensive. Researchers and clinicians argue that the epidemic of Post-Traumatic Stress and brain injuries has been significant. According to the August Pentagon Report (2012), we are given the news that as two of our longest wars are ending, suicide is now the leading cause of death in the army. The literature on post deployment psychiatric health in Operation Enduring Freedom/Operation Iraqi Freedom have identified high rates of PTSD (21.8%) depression (17.4%). There are estimates that 1900 veterans from Afghanistan and Iraq in the year 2014 have sadly taken their own lives).

Clearly children and families are impacted in profound ways when a parent goes to war (Boberiene, et al., 2014). Children of Service Members are 2.5 times more likely to develop psychiatric problems; there is evidence that 2 million children have been affected by deployment and 30,000 children have had to come to terms with parental death or injury (Lemon, et al., 2009; Gorman et al., 2010; Chandra, 2010).

When focusing on the uniformity of evidence based treatments in practice we find that men are overrepresented within the American Armed Forces, comprising 85% of the population of those returning home. Male veterans are expected to function as husbands, partners, fathers, sons, and workers. In addition they must separate from the military while reconnecting with family and friends and embracing the now unfamiliar civilian lifestyle (Chan, 2014; Cohen et al; 2010; Wells et al; 2010, Delfino, 2012).

Innovative Treatment

Innovative treatment and psychoeducation go hand in hand. First and foremost, we must be sophisticated diagnosticians who understand the complexity of a wide range of symptomatology and psychopathology. Not being thorough and working in the dark is far too risky with this

see Treatment Choices on page 35



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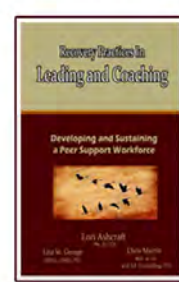
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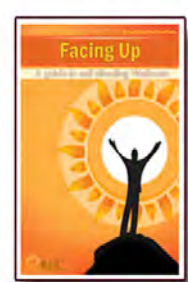
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A Bridge to Employment for Veterans

By Lt. Cdr. Brett Morash, U.S. Navy (Retired), PhD (ABD), MBA, MA, BS, Vice President of Veterans Services, Services for the UnderServed (SUS)

While SUS was recruiting for the pilot 'Tug and Barge' program run through SUNY Maritime College, John Lang was referred for screening as a candidate. Mr. Lang, a former Army Avionic Mechanic honorably discharged after 6 years of service, had fallen on difficult times which forced him to relocate to a homeless shelter. At his screening, he shared that his ideal occupation would be "Tug boat captain, working on the water and with my hands."

With the right credentials and an enthusiastic and positive attitude John was accepted into the program. Thanks to a generous grant from the PIMCO Foundation, John's course was paid for in full. This opportunity became John's bridge to the job of his dreams.

Many people, when introducing themselves for the first time, give their name and then state what they do for a living, supporting the notion that work not only defines who we are but too, how we think society values us. SUS believes that serving the needs of the individual must go beyond providing shelter and food to helping them secure a job that gives meaning to the day and to life.

A large number of the veterans SUS serves have mental health conditions as well as other comorbidities that affect their ability to obtain and retain employment. In many cases, being unable to retain employment because of these conditions has led to a loss of income, and put long-term housing stability in jeopardy.

In the Fall of 2013, to address this challenge SUS' Veterans Division brainstormed operational concepts that would increase employment options for this population, through educational programs readily available in New York City. This took into account the following realities:

- The time commitment of an associates or baccalaureate program necessary to attain the next level of professional potential is often difficult for veterans who are already juggling so much as they reintegrate after service into their families and communities.
- Veterans making the choice to pay for school themselves, in the absence of a Veterans Administration (VA) or state funded opportunity, risk placing them-



Lt. Cdr. Brett Morash

selves in financial straits and therefore are at greater risk of homelessness. (This is particularly true as the VA has defunded the Veterans Retraining Assistance Program (VRAP) as of March 2014.)

- Courses need to be targeted toward employment options that are realistic and available at reputable institutions of higher learning.

Coincidentally, CUNY Hostos Community College's Continuing Education Department was also grappling with these issues, given the pending sundown of VRAP funding. (Hostos' Veterans Services personnel was focused on matriculated students and not on the continuing ed department, leaving those veterans woefully underserved.)

SUS' Veterans Services staff reached out to CUNY Hostos and together determined that a position was needed on the ground at the college that would help to identify needs that could be met through the breadth and depth of services provided at SUS (housing, mental health and wellness). The creation of the Veteran Education and Employment Specialist (VEES) to ensure that these needs were being met, allowed the veterans to focus resources on education and food security, and to give attention to their studies.

As the veterans approach graduation, the VEES ensures that the SUS Veteran Employment Team, made up of a case manager and employment developer fo-

cuses on employment options for the veteran in an associated industry. Provided that the housing stability is adequate, the Employment Team is better informed to help the veteran find placement in their newly chosen profession, with a freshly minted certification from a recognized provider of that training.

Over the past year, SUS has had no less than 50 veterans or their family members served in this manner at Hostos alone. The role of the VEES has since been expanded to include supporting students at CUNY's Borough of Manhattan Community College and LaGuardia Community College.

Over time, SUS looked at other opportunities in continuing education outside of the CUNY system that could lead to direct employment. This past summer SUS was approached by SUNY Maritime College to discuss the tugboat training program that they had on the books. When this course was last run three years prior it had only a 10% graduation rate. In large part the low rate of success was due to students being ill suited to the rigors of a life at sea, drug use, criminal backgrounds, or mental health challenges that could not be managed in a maritime environment.

Using the experience of Hostos, SUS and the SUNY Maritime College reverse engineered the recruitment process to increase the chance of pre-screened candidates completing the course of study and gaining a high level of confidence of

finding employment in the tugboat industry. This approach also mollified the angst felt by many employers that veterans might experience post-traumatic stress (PTSD) to a degree that would make them ill-suited to serving as professional mariners.

John Lang was among this year's class of 12 students, all of whom graduated and are now receiving their final U.S. Coast Guard certifications such as firefighting and documentation, as well as approvals from the Department of Homeland Security Transportation Branch. SUS anticipates an equally high success rate for the veterans finding employment in the tugboat industry.

SUS has been able to leverage this success to acquire foundation funding to help with "micro scholarships" for veterans in continuing education, allowing leadership staff at SUS to sit on a scholarship committee with trusted partners at the schools to help identify students most in need.

SUS believes this model of partnership between educational institutions and the service provider is a replicable one. By leveraging the unique capabilities that each partner brings to the table a comprehensive approach can be made and hopefully an equally successful outcome for those we serve can be achieved. At the end of the day it is all about ensuring that people like John are able to meet outcomes that give them full and enriching lives.



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NYU Honors Alumna Carmen Collado

Staff Writer
Behavioral Health News

New York University Silver School of Social Work recently presented its annual Alumni Awards, honoring six alumni for their contributions to the field of social work and the School. Carmen Collado, MSW '92, received the Distinguished Alumni Award for her tremendous work as a policymaker, program designer, and advocate for the social work profession. The awards were distributed at a luncheon at the NYU Global Center for Academic and Spiritual Life, hosted by Dean Lynn Videka.

In November, Collado joined ICL as chief network and relationship officer. She is responsible for ensuring that relationships between the organization and government officials, clients, collaborators, and donors remain strong and transparent. Collado came to ICL from the Jewish Board of Family Children's Services (JBFCFS), where she had been chief government and community relations officer since 2002. A member of the New York State Board for Social Work, she serves as a social work representative, advising the Board of Regents and State Department of Education on matters of professional regulation.

"My NYU foundation was so strong that my classes, particularly in casework



Carmen Collado, LCSW

and social policy, continue to inform my work over two decades after my graduation," said Collado. She said she has received a "100 percent return" on her educational investment.

Since her time at the School, Collado said she has seen immense positive change during Videka's tenure as dean. She said, "Lynn has transformed the

see NYU Honors on page 35

Susan Ohanesian New at TGCW

Staff Writer
Behavioral Health News

The Guidance Center of Westchester (TGCW) has named Susan M. Ohanesian, ACSW, LCSW-R, CASAC as Deputy Director for Clinical and Substance Use Services. In her role, Ms. Ohanesian is responsible for all aspects the Agency's mental health clinics, school-based mental health programs and substance use treatment programs. Collectively, these programs provide services to more than 1,540 people each year with a combined annual budget exceeding \$3.5 million.

A seasoned professional with an impressive background in social services, behavioral health and healthcare, Ms. Ohanesian most recently served as Senior Vice President and Chief Clinical Officer at Daytop Village in New York City. There she developed implemented, evaluated and maintained programs, services and activities.

Prior to Daytop, Ms. Ohanesian held a variety of increasing leadership positions with Palladia, Inc., one of the largest non-profit, multi-service agencies in New York City. She also held posts with Bowery Residence Committee and Palisades General Hospital.

"Susan's knowledge and expertise will help The Guidance Center of Westchester



Susan M. Ohanesian, ACSW

target strategic opportunities that will enable the agency to grow and thrive by providing integrated services, implementing more business efficiencies and providing high quality services," says Executive Director Amy Gelles.

Ms. Ohanesian earned her Master of Science in Social Work from Columbia University and her Bachelor of Arts from

see TGCW on page 36

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Coming Home from page 22

becomes what in the trauma lexicon is called a "survival strategy" aimed not at pleasure-seeking, but rather at diminishing pain and emotional discomfort (Fisher, 2000). For many who have survived trauma and now struggle with addiction, they vacillate between states of physical/emotional numbness while using and physical/emotional pain when not. Physical/emotional arousal and pain become a trigger for substance misuse, and is part of the individual's addiction and relapse cycles. Adapting treatment models that educate veterans on this relationship and incorporate these concepts into effective treatments is key.

Pillar Two: Incorporating a working understanding of military life and military culture (and how this may inform treatment) into the therapeutic model and organizational culture: Educating clinical and support staff on military cultural considerations is vital in order to both build trust with veterans (a core

issue for many given their experiences in the military and their socialization into a military mindset) and to deliver treatments that take into consideration how military culture may play into the development of certain struggles (including substance misuse) and inform the meaning that these struggles have for veterans. Outside of the obvious, concrete aspects of military culture that need to be thoughtfully woven into the language and treatment environment (e.g., use and understanding of branches of service and differences between each, use of acronyms, visible displays of military culture and patriotism, structure and timeliness of services), one must also consider the context of each veterans military experience and how this may inform their current difficulties with sobriety and possibly readjustment. For example, there is a clear directive from the Department of Defense and each branch of service that alcohol misuse is unbecoming of one who serves and puts them in violation of both the core values of their branch of

service as well as regulations. At the same time, many served in an environment of tacit acceptance of alcohol use or even one where the use of alcohol was part of the social culture and expectation of their unit. Was the discovery of alcohol/substance misuse used punitively to force and individual into treatment or separate them from the military? Has one's socialization to approaching "problems" with quick, definitive action (i.e, a warrior mentality) cultivated substance-seeking as a "quick fix" to manage physical/emotion pain despite short and long-term consequences. Being able to have an informed consideration of these and other salient points related to military culture for each veteran served allows us to direct treatment and support accordingly.

Pillar Three: Offering a clinically-informed amalgam of evidence-based substance recovery programming and specialized wellness and resilience services that address substance misuse and comorbid struggles on multiple functioning levels: Recovery from addiction not

only needs to incorporate trauma theory and the possible role of traumatic exposure in the etiology and maintenance of addiction (see Pillar One), it must also provide a core curriculum of knowledge, structure, and support to assist the veteran to achieve abstinence and initiate a long-term program of recovery. As an example, Bridge Back to Life Center, Inc. has all clinicians trained in the Matrix Model for intensive drug and alcohol treatment (Rawsen, Obert, McCann, & Ling, 2005). This model, with a 20-plus year evidence base, allows for the education and teaching of recovery-specific knowledge and skills that are the foundation for abstinence. Staff are also trained in the Duluth Power and Control intervention to assist those perpetrating aggression as part of their clinical picture. Similar evidence-based models are available for those who we driving under the influence, and Seeking Safety (Najavits, 2002) is available for those with identified trauma are part of

see Coming Home on page 37

When Mental Illness Enters a Family

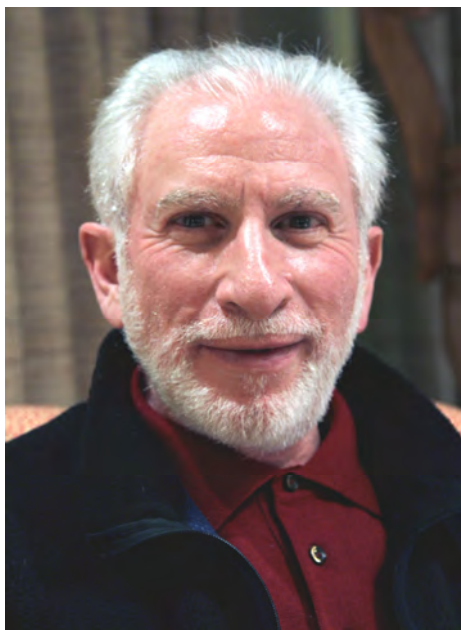
By Lloyd I. Sederer, MD

Families notice when a loved begins to be different from the child, spouse, sibling or parent that they have known. Their loved one isolates him(or her)self from family and friends; shows persistent changes in sleep, eating and hygiene; says or does odd things that suggest their thinking is off, maybe behaving as if there is danger lurking or hearing or seeing things others are not; is moody, irritable or intolerant of the slightest of questions or statements; or uses or abuses alcohol and drugs.

When mental illness enters a family they soon face two types of problems: The first is how to understand and navigate a broken, confusing and too often exasperating mental health system. The second is to understand what they can do to help a love one who – because of guilt, shame, or illness – won't help themselves.

These are questions that can be – and must be answered – if families are to do what they want more than anything, namely to help their loved one get the care that will make a difference in their lives and that of their families.

With more than one in five adults and adolescents effected by a mental illness annually, there are few families who are



Lloyd I. Sederer, MD

spared. And families are often the greatest resource and source of support an ill person can have, whatever persistent illness they suffer – including mental illnesses.

I have four messages for families: (1) Don't go it alone. There are people and places to turn to. (2) Don't get into fights. There are alternatives that work better. (3) Learn the rules of how the mental health

see Mental Illness on page 35

Fighting For Our Nation's Veterans

By Wendy Brennan, MS
Executive Director, The National Alliance
on Mental Illness of New York City

Family members have a unique role to play in the mental health of our nation's veterans. With the current system overwhelmed by mental health service needs and unable to provide adequate access, family members serve at the critical front line of our veteran's mental health needs and are the backbone of veteran recovery.

Readjusting to civilian life for a returning veteran comes with a unique and unexpected set of difficulties that can disrupt relationships with their loved ones. In addition, they live with a heightened risk of Post Traumatic Stress Disorder (PTSD) that could further exacerbate pre-existing mental health issues. Due to the stigma of mental illness and the burden of reintegration, these struggles often go unspoken, leaving both veterans and their family members feeling misunderstood and unheard. For veterans, these feelings deepen an already growing sense of isolation and vulnerability.

In 2009, according to the American Psychological Association, the suicide rate for 18- to 29-year-old male veterans rose to record highs. In fact, veterans have a higher rate of suicide than the national average, reaching a rate of 22 sui-



Wendy Brennan, MS

cides per day. Earlier this year, the House of Representatives passed the Clay Hunt Suicide Prevention for American Veterans (SAV) Act, which requires an annual evaluation of VA suicide prevention programs to determine their effectiveness. The legislation, now awaiting approval from the Senate for the second time in two months, includes a vital increase in

see Fighting on page 35



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Readjustment from page 24

Traumatic Brain Injury is any injury to the head – it can be either open or closed. TBI is a cumulative injury – additional blast (or other) exposures exacerbate the condition and even a slight blow to the head can turn a mild TBI into a severe one. Most TBIs are mild and affect about 15% of returning Veterans. Many of the symptoms mimic those of PTS (they can also co-occur), but the most common symptoms are memory and attention deficits – which can be quite startling for family and friends and quite frustrating for employers and co-workers.

This group is also prone to some very reckless behaviors – a propensity for activities involving motorcycles, hang gliding, and skydiving to replicate the adrenaline rush of combat. In a similar vein, impaired or aggressive driving is the leading cause of death among recently returned Veterans. High speeds, sudden lane changes, and driving off the road are all common combat driving techniques that lead to accidents in the civilian world. Road rage and impaired driving can result from lack of sleep or drug/alcohol abuse caused by PTS, TBI, or other stress related conditions.

Experience with recent Veterans from

a variety of clinical and law enforcement settings indicate that they can be more impulsive and more willing to fight than their predecessors as well as displaying less respect for police or any other type of authority.

A significant group of Veterans are either married or in a permanent relationship. There is a risk of domestic violence if there is significant stress on the family unit as a result of service. Long, frequent deployments can cause significant changes in relationships – if the husband is deployed the wife assumes all the household roles like paying the bills, cutting the grass, etc. Returning home the Veteran finds their role changed and can be unsure how to get back to “normal”. Likewise for National Guard and Reserve soldiers who are deployed they may return home to jobs that don’t pay enough or seem important as those they had in the military – putting stress on everyday living. All of this can be exaggerated if accompanied by PTS or other mental health conditions.

Another potential issue can be firearms. Nearly every Veteran is well trained in their use and they are more likely than the rest of the population to have them. Most have them as a defense and are not likely to pose a threat, but the

mere presence of a weapon can escalate a situation.

There are ways for clinicians to cope with many of these issues – the overarching goal being to keep everybody safe and obtain peaceful resolutions when situations arise. These are strategies for low risk events where we are able to work towards treatment and nonviolent resolution. High risk situations require immediate action by qualified individuals regardless of any other conditions.

The first step is to open a dialog – and determine their Veteran status. Visual cues such as vehicle stickers, clothing, or general appearance can help, but the easiest way is to ask “Were you in the military?” Thanking them for their service is a good way to open a conversation.

The objective in this type of dialog is to keep it calm. Maintain a physical space – don’t crowd into the conversation. Keep a neutral tone and posture – not raising your voice or making any kind of gesture that could be construed as threatening. Ask questions that orient the conversation – “What’s going on?” and use restatements to clarify any ambiguities “I understand that you ...” Be absolutely transparent with any actions taken – communicate clearly what you are going to do and provide a rationale for why you are doing it.

There are communication aids that you should always try to incorporate into the conversation: conveying a non-judgmental attitude, giving undivided attention to the conversation, listening carefully to what is being said, and allowing for periods of silence for reflection.

There are also some communication cautions that you should always avoid in the conversation: overreacting to provocative statements, entering into a power struggle with the individual, making promises you can’t keep, and threatening the individual in any way.

The U. S. Department of Veterans Affairs has a host of specialists and programs to assist non-VA providers in treating Veterans, from VA Medical Centers, Community Based Outpatient Clinics, and Vet Centers. Individual programs for PTS, TBI, Depression, and Alcohol/Substance Abuse are all available. Many larger facilities have walk-in clinics and 24 hour Emergency Departments. Additional resources can be found with State or County Veteran Service Officers and Veteran Service Organizations.

Working together we can provide safe, prompt, and effective treatment for readjustment issues facing returning Veterans – and better serve those who have served their country.

Training Initiative from page 1

interventions. In addition, the program offers a primer on military culture and military mental health issues. Other key elements of the curriculum include advice on questions to ask and questions not to ask and the importance of evaluating possible co-occurring psychiatric diagnoses.

In order to ensure that the training program meets its goals, participants will be asked to complete a pre-training survey and a post-training survey to assess their level of knowledge of military culture and veteran-specific mental health conditions both before and after the program. A final evaluation will be sent to program participants six months following the program to assess actual implementation. This three-part survey process will permit NYSPA to measure and track the grant’s potential impact on the care of returning combat veterans with mental health needs.

The inaugural training session was held at the Albany Medical Center, Albany, New York, on November 14, 2014. The program was hosted by the Department of Psychiatry and included health care professionals from the Departments of Emergency Medicine, Internal Medicine and Family Practice. The lecture was

presented by Matthew Friedman, MD, PhD, a Professor of Psychiatry and Pharmacology at the Geisel School of Medicine at Dartmouth College and a nationally-renowned expert on veterans mental health issues.

The kick-off presentation was attended by several State legislators, including Assemblywoman Patricia Fahy (D-Albany), Assemblyman John McDonald (D-Cohoes), as well as staff from the offices of Assemblyman James Tedisco (R-Glenville) and Senator Kathleen Marchione (R-Halfmoon).

A second training session is scheduled for March 2015 and will be held at Stony Brook University Hospital in Stony Brook, New York. Additional training sessions are being scheduled throughout the state. In addition, there will be a comprehensive web-based version of the training made available in early 2015.

For more information about the Veterans Mental Health Primary Care Training Initiative, please contact the New York State Psychiatric Association at (516) 542-0077 or centraloffice@nyspsych.org.

Mr. Gallo is the NYSPA Government Relations Advocate. Ms. Fernbach is the NYSPA Deputy Director and Assistant General Counsel.

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Patriot Housing and Employment: Helping Veterans in Westchester County

By Howard Charton, Montrose Veterans Program Director, Common Ground, and Donald M. Fitch, MS, Executive Director, The Center for Career Freedom

In 2010 there were 760,329 homeless Veterans on the streets of America. An astounding number. But what’s more significant is that in 2014 that number was 49,933 (according the statistics collected by the Department of Housing and Urban Development). This astonishing number represents a 35% drop in homelessness among Veterans over the course of 4 years and the success of President Obama’s goal to end veteran homelessness by the end of 2015. This drop and continued work has to do with many things which included public funding and support, but also the intermingling of agencies within our communities to build bridges and support those who served. In Westchester County, this has been supported by the Patriot Housing/Employment initiative to house, retrain, and employ (at a livable wage) Veterans who are homeless or at risk of homelessness. This group of agencies (both public and private) has worked to house over 200 veterans and employ over 100 since August of 2013. An essential aspect of this work is to get all the players in one room, to meet on a weekly basis to coordinate housing and services.




**Patriot Housing/Employment Group Leaders
After Meeting Their First 100-Day Challenge of Housing 84 Veterans**

Common Ground Community is one of the largest supportive housing providers with over 3,000 units of permanent and transitional housing throughout New York and Connecticut. In 2008, Common Ground opened its Montrose Veterans Program in Westchester County, New York, serving up to 96 homeless Veterans at any given time, the largest Veteran Specific program in Westchester County. Since opening, Common Ground Community has worked diligently within in this frame work to graduate homeless Veterans to self-sufficiency (discharging over 300 Veterans to permanent housing). Through Patriot Housing/Employers, Common Ground recently started to work

with one such partner, The Center for Career Freedom in White Plains, New York. The Center for Career Freedom trains individuals in computers at different levels leading up to needed certifications (Microsoft and Quick Books). The Centers staff has extensive experience in business, as well as counseling and teaching. This unique blend of skills provides clients with a caring and street-smart approach to reaching their employment goals. The Center has assisted over 4,000 persons with both mental and physical disabilities train for today’s work force. Common Ground began to work with Don Fitch, M.S. the Center’s Executive Director, to match Veterans in need of training

with the proper resources. During a tour of The Center for Career Freedom last fall several Common Ground Residents were able to see firsthand their training capabilities. One of the Veterans, “Charlie”, wanted to know how The Center for Career Freedom differed from a Community College. What would it cost? What day/time were the classes? When did the semester start and end? He was relieved to learn the student-centered learning model meant one-on-one custom classes. Each student works at their own pace, there are no set start or end dates. All training fees for the Vets are funded by ACCES-VR (www.acces.nysed.gov/vr) or One-Stop (www.westchesterputnamonestop.com). Common Ground arranged for a van to transport for some ten men and women to the Center. Following their Certification, the Center will work with the Patriot Housing & Employment Network, ACCES-VR and One-Stop to secure employment. The work of ending homelessness among our nations Veterans continues and only as a community will meet that goal. If you are interested in Patriot Housing/Employment you can find us on the web, Facebook and Twitter (<http://www.programdesign.com>). If you have any questions about either Common Ground or the Center for Career Freedom programs, you can contact the authors at: hcharton@commonground.org; or donfitch.freecenter.org



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EMPLOYMENT CENTER	<ul style="list-style-type: none">• Work adjustment• Increase skills & stamina• Strengthen Résumé	<ul style="list-style-type: none">• Paid employment<ul style="list-style-type: none">- Data Entry- SKYPE Instruction- Graphics• Integrated Workforce• Benefits Counseling
MICROSOFT OFFICE & QUICKBOOKS CERTIFICATION	<ul style="list-style-type: none">• Keyboard proficiency (40wpm)• Portfolio of job skills• Certification in Word, Excel, PowerPoint & QuickBooks Pro	<ul style="list-style-type: none">• Personal Trainer• Individual Schedule• Employer-aligned Curriculum• Multimedia Instruction, on- or off-site (SKYPE)
DROP-IN PROGRAM	<ul style="list-style-type: none">• Stabilization in the community• Socialization	<ul style="list-style-type: none">• Assistance with applications• Recreation• Computer Literacy• Snacks

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Soldiers at Increased Suicide Risk After Leaving Hospital

By The National Institute of Mental Health (NIMH)

United States Army soldiers hospitalized with a psychiatric disorder have a significantly elevated suicide risk in the year following discharge from the hospital, according to research from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). The yearly suicide rate for this group, 263.9 per 100,000 soldiers, was far higher than the rate of 18.5 suicides per 100,000 in the Regular Army for the same study period, the study found.

The researchers looked at data from the 12 months following a hospital discharge for more than 40,000 anonymous, Regular Army soldiers (full-time soldiers excluding Army National Guard and Army Reserve) who served on active duty from 2004 through 2009.

Ronald C. Kessler, Ph.D., of the Harvard Medical School in Boston, and colleagues, report their findings on Nov. 12, in *JAMA Psychiatry*. Army STARRS is a partnership between the Army and the National Institute of Mental Health (NIMH), part of the National Institutes of Health.

The Army's suicide rate began increasing in 2004, exceeded the rate among a similar group of U.S. civilians in 2009, and has remained high through 2014. This study of administrative data shows that 40,820 soldiers (0.8 percent of all Regular Army



Thomas R. Insel, MD

soldiers) were hospitalized with a psychiatric disorder in 2004-2009, the period covered by this research. Suicides occurring in this group during the year after a hospital discharge accounted for 12 percent of all Regular Army suicides during this period.

Researchers also found that it was possible to identify smaller, higher-risk groups within this at-risk population. Analyzing

soldiers' characteristics and experiences, researchers identified the 5 percent of soldiers with the highest predicted risk of suicide after leaving the hospital. This top 5 percent accounted for 52.9 percent of the post-hospital suicides. Soldiers in the top 5 percent also accounted for a greater proportion of accident deaths, suicide attempts, and re-hospitalizations.

The researchers report that, for this group of hospitalized soldiers, some of the strongest predictors of suicide include being male, having enlisted at an older age, having a history of criminal offenses during Army service, having had prior suicidal thoughts or actions, as well as disorders diagnosed during hospitalization and aspects of prior psychiatric treatment. However, researchers found that many factors contributed toward predicting suicide risk in this group, individually and in combination. This fact underscores the complexity of assessing suicide risk and the added value of developing new approaches to better predict very challenging events.

"This is the first publication from Army STARRS that reports on the ability to use Army/Department of Defense data to identify specific subgroups within the Army that have very significantly elevated suicide risk," said NIMH Director Thomas R. Insel, MD. "However, there are sensitivities to using data to identify high-risk subgroups. It's important to remember that although a particular population may be at elevated risk, suicide remains a rare event."

Researchers concluded that the high concentration of suicide risk among this study group, and particularly in the smaller highest-risk groups, might justify targeting expanded post-hospital interventions for such people. Researchers continue to develop and refine computer models to help the Army predict suicide risk among soldiers and prevent self-harm.

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

Reference: Kessler RC, Warner CH, Ivany C, Petukhova MV, Rose S, Bromet EJ, Brown M, Cai T, Colpe LJ, Cox KL, Fullerton CS, Gilman SE, Gruber MJ, Heeringa SG, Lewandowski-Romps L, Li J, Millikan-Bell AM, Naifeh JA, Nock MK, Rosellini AJ, Sampson NA, Schoenbaum M, Stein MB, Wessly S, Zaslavsky AM, Ursano RJ. Predicting U.S. Army suicides after hospitalizations with psychiatric diagnoses in the Army Study to Assess Risk and Resilience in Servicemembers, *JAMA Psychiatry*, November 12, 2014



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Superheroes from page 18

www.emergency.cdc.gov/mentalhealth/responders.asp.

Recognizing the Signs of Disaster Related Distress

Signs that a first responder may be experiencing distress will vary person-to-person, but in general can include any one or more of the following:

- Isolation, withdrawal from family, friends or coworkers
- Difficulty concentrating or performing regular routines; faltering performance at work
- “Hyper-vigilance” at work or home- Increased levels in energy, feeling like one has to keep constantly busy, may volunteer for more work/shifts
- Irritability, mood swings; lashing out at family, friends or coworkers
- “Compassion fatigue” – Doubting the purpose of work, feeling less sensitive to victims’ needs, etc.
- Relying on tobacco, drugs (incl. prescription and over the counter medications), or alcohol as a means to cope with stress
- Other symptoms that may indicate depression, substance abuse or suicidal or homicidal thoughts/behaviors

For more information on warning signs for depression, visit the National Institute of Mental Health Signs & Symptoms of Depression at www.nimh.nih.gov/health/topics/depression/index.shtml.

Tips for Coping with Stress

Like the warning signs of distress, tips for coping for first responders also don’t come in a ‘one size fits all’ package, so it’s important to think about what the unique strengths or personality traits of a person experiencing distress may be and go from there.

Some common ways for first responders to cope include:

- Reaching out to trusted individuals for support, companionship
- Contacting an Employee Assistance Program (EAP) for coping resources and referrals (this can be done confidentially and anonymously)
- Making sure staff/volunteers take scheduled breaks during responses and are provided relief with food, rest, etc.
- Practicing and engaging in spiritual/religious rituals and activities
- Following health and fitness routines, even during breaks in shifts or during deployments; modifying routines for time and location as needed, but always working to get in time for health, fitness and relaxation when possible
- Engaging in healthy coping year-round, to increase one’s resilience and ability to bounce back after particularly stressful or strenuous responses/deployments

For additional tips for Coping with Stress, visit Mental Health America’s Stress: Coping with Everyday Problems at www.mentalhealthamerica.net/conditions/stress-coping-everyday-problems.

Sometimes, even when first responders try to practice healthy coping, or if for any reason a responder feels that she/he is at risk for depression or other mental health concerns that go beyond coping, it’s important for them to talk to their supervisor/commanding officer if they feel comfortable doing so; a trusted healthcare provider; or reach out to a confidential 24/7 crisis/emotional service (see below).

How MHA-NYC Helps First Responders

MHA-NYC has a long history responding to natural and human-caused disasters. For over a decade, the organization and its programs and crisis hotline services have been at the center of the

mental health response to many of this country’s greatest tragedies, including providing services for first responders.

iHelp: Sandy Stress Relief

Sandy iHelp is a 24/7 online cognitive behavioral therapy (CBT) program that provides easy access to help for New York State residents who are suffering emotional distress as a result of Superstorm Sandy: All that is needed is access to the internet. Sandy iHelp CBT is evidence-based and effectively addresses the most common emotional difficulties that surface after a disaster including insomnia, depression, anxiety and substance misuse. Call 1 (866) 793-2765 or visit iHELPCBT.COM online to learn more and enroll.

iHelp: Sandy Stress Relief is particularly well suited to the needs of first responders who may be reluctant to seek help in traditional office based settings. It is confidential, secure and is available 24/7, anywhere the first responder has access to the internet.

Disaster Distress Helpline: The Disaster Distress Helpline is the nation’s only crisis hotline dedicated to providing 24/7 counseling and emotional support. Calls (1-800-985-5990) and texts (text “TalkWithUs” to 66746; Spanish-speakers can text “Hablamos” to 66746) are confidential and answered by trained, caring counselors from a network of crisis centers across the country.

World Trade Center Health Program: The World Trade Center Health Program is a free health/mental health program that screens for access to benefits for responders, workers, and volunteers who helped with rescue, recovery, and cleanup at the World Trade Center and related sites in New York City on/after the 9/11 terrorist attacks, as well as for survivors who were working or residing in the disaster area. Call 1-203-594-9787 to learn more and to request an application.

Visit <http://www.mhaofnyc.org> to learn more about these and other programs.

Additional Mental Health Resources for First Responders

Friends of Firefighters (New York City):

Friends of Firefighters, is dedicated to addressing the physical, mental health, and wellness needs of New York City’s firefighters and their families with long-term support and services through confidential counseling, wellness services, and other assistance required by firefighters and their families (www.friendsoffirefighters.org).

SAMHSA Disaster Technical Assistance Center (DTAC): SAMHSA’s DTAC Disaster Responder information series offers resources on self-care and stress management, a listing of organizations working with disaster responders, links to webinar and podcast trainings, and a summary of available disaster behavioral health interventions (www.archive.samhsa.gov/dtac/dbhis/dbhis_responders_intro.asp).

National Center for Posttraumatic Stress Disorder (PTSD): The National Center for PTSD (a program of the U.S. Department of Veterans Affairs) works to advance the clinical care and social welfare of America’s Veterans and others who have experienced trauma, or who suffer from PTSD, through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders (www.ptsd.va.gov/index.asp).

Recovery and Resilience

Just as first responders can experience distress, trauma and other mental health concerns, so too can they recover and even strengthen their emotional resilience over time with support from loved ones and coworkers, by practicing healthy coping and through accessing effective interventions. There is strength and courage in being the first on-scene and saving lives, and there is strength and courage in recognizing when you need help and then taking steps towards healing. After a disaster, emergency or other traumatic event, no one is ever alone- including responders.

Kathryn M. Salisbury, PhD, is Executive Vice President of Strategy and Business Development, Mental Health Association of New York City and Christian Burgess, LMSW, is the Director of the Disaster Distress Helpline at Mental Health Association of New York City/Link2Health Solutions, Inc.

The Gap from page 18

co-founded by MHA-NYC and NAMI-NYC Metro in 2009, and comprised of over 1,000 individuals and organizations in NYC, provides an ongoing Educational Lecture series that includes panels of veterans to share their experiences directly with providers. The VMHC also advocated and received important funding from the NYC Council on an initiative to offer training to additional providers such as mobile crisis teams, EMS, police cadets, and local health centers. The VMHC continues to be a leading voice in promoting the mental health and well-being of

veterans and their families. With a diverse cross section of key stakeholders, the VMHC disseminates information, resources, and best practices as well as fostering needed practice and policy changes to improve care and supports for veterans with behavioral health needs and their family members.

We know how critical it is for veterans, especially those in crisis, to have adequate relationships and services that address the unique challenges they face. The Veterans Crisis Line connects veterans of all ages and service eras who are in crisis and their families and friends with qualified, caring Department of Veterans

Affairs responders through a confidential toll-free hotline, online chat, or text. By dialing 1-800-273-8255, and pressing “1” when prompted, veterans and their loved ones will receive confidential support 24 hours a day, 7 days a week, 365 days a year. In partnership with the Department of Veterans’ Affairs and the Substance Abuse and Mental Health Services Administration (SAMHSA), MHA-NYC administers this line, which has provided life-saving assistance to more than 1.25 million veterans and members of the armed services since 2007.

The weight of war belongs collectively on all of our shoulders. For too

long we have asked veterans to bear this alone, and at great cost to them. It is this shift in focus to include the civilian and the proper relationship between veterans and civilians. Entering into community with veterans benefits civilians by tapping into a collective impulse and need that we have to carry the weight of war alongside veterans. It further benefits civilians by providing them meaningful ways, beyond the bumper sticker, parades and the greetings at the airport, to show their ongoing support. More importantly, it also reverses the trend of “fixing veterans,” all too common in our efforts.

We Are Now Accepting Articles and Advertising for Our Summer Issue

“Understanding & Addressing the Opioid Epidemic”

Early Submission Deadline: March 30th - Final Deadline Date: April 14th

NYU Honors from page 28

School since she came here, ensuring the legacy of NYU Silver and the high caliber of professionals entering the field. The School has become more inclusive and trains leaders that can serve all communities.”

Major transformations at the School have come by way of research and scholarship growth, rising academic programs, diversity and a more global mindset.

Fighting from page 29

the number of psychiatrists at VA facilities. It was named for the Marine veteran activist who took his own life in 2011 after living with PTSD, an illness that affects more than 20% of service members nationally.

For military families navigating a mental health system where the demand for services outweighs supply, family members often feel as if they must stand in as mental health service providers and experts. This added responsibility can create fear, anger, and confusion for both family

“People come here and get a top education, not just in social work training. Students’ horizons are opened with all the diversity that comes with going to school in New York City,” said Collado. “By supporting NYU Silver students through scholarships, you are providing a better life for students and ensuring we continue to have leaders in the field of social work who will have a positive impact for years to come.”

members and their loved one. To combat these stressors and be effective partners in the recovery of their loved ones, family members need both informational resources and a support network. At NAMI, we are addressing this need through our new NAMI Homefront program, an adaptation of the evidence-based NAMI Family-to-Family program, a general education program for family members of individuals living with mental illness. In the NAMI Homefront course, we focus on PTSD, collaborative problem solving, and how to offer constructive support to a veteran.

Mental Illness on page 29

care system works and how to bend those rules. (4) Appreciate that you are on more of a marathon than a sprint. Which means never, ever, giving up.

In my TEDx talk which you can watch at: (<https://www.youtube.com/watch?v=NRO0-JXuFMY>), I talk about these four messages. I hope you will view the talk.

Dr. Sederer’s book for families who

have a member with a mental illness, *The Family Guide to Mental Health Care* (Foreword by Glenn Close), is now available in paperback.

Dr. Sederer is a psychiatrist and public health physician. The views expressed here are entirely his own. He takes no support from any pharmaceutical or device company. You can follow Dr. Sederer at www.askdrilloyd.com, and at www.twitter.com/askdrilloyd.

Since 2008, we’ve worked with our local VA to support military families. Our NYC NAMI Homefront program started as one of 6 pilot programs in the country; the others are Illinois, Maryland, North Carolina, Ohio, and South Carolina. We pay special attention to meeting families where they are at in terms of understanding the landscape of veterans’ mental health services and navigating the resources available to them. In particular, we are dedicated to creating a supportive social community where family members feel that they have a voice not only in their loved one’s

recovery but in their own self-care. While never a substitute for mental health services, NAMI Homefront does serve as an important component in the recovery process for military families.

As a nation, it’s imperative that we create an environment where veterans feel comfortable speaking up about their mental health without fear of judgment. Family members are a critical component in their recovery process. However, we must remember that in order for family members to be effective, they too need education about mental health resources and an active support community.

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See Page 39 or visit: www.mhnews.org

Trauma and Addiction from page 16

psychologist in the Veterans Affairs Healthcare System; clinical associate at McLean Hospital), Seeking Safety is an evidence-based counseling model that guides people to attain safety from trauma and substance abuse. It focuses on the present, meaning patients are not required to review any disturbing traumatic memories in their pasts.

The Seeking Safety philosophy incorporate both one-on-one counseling and group counseling. Intense group sessions with other trauma survivors can provide an environment especially conducive to opening up, connecting with others and healing.

Part of building safety is to detach from emotional pain, which is often called *grounding*. Grounding techniques can be mental, physical or soothing in nature. These techniques can be used when an individual has a painful memory or flashback and feels triggered to abuse drugs or alcohol, as well as in group therapy settings. For example, a therapy group may work on the mental technique of describing the room in which they are sitting in detail. A soothing technique may be to mindfully eat an ice cream cone and think about how it feels and tastes. An example of a physical technique is to go out for a walk or run, and again be mindful of how the activity engages the senses. By focusing on the present, the individual is distracted, and in 10 to 20 minutes, the memory and craving should pass.

Uniformed professionals with trauma backgrounds also tend not to recognize when they need help or understand how to ask for it. Counselors can provide guidance and strategies to patients on how to be aware of the need and ask for help from their support networks.

Anger is another common trait in those with co-occurring addiction and PTSD. By exploring anger as a valid and inevitable feeling, patients see that anger

can become constructive instead of always destructive.

In group therapy, patients are also guided to change their thinking through exercises that make them re-envision their future in a positive way. For example, a patient facing a job interview may be inclined to assume that it will go poorly and that rejection is inevitable. Using the recovery thinking technique, that same person changes the scenario by envisioning how he or she will prepare for the interview, get a good night’s sleep, make a genuine effort to connect with the interviewer and be proud of those actions regardless of the outcome.

Other challenges that uniformed professionals contend with throughout recovery include complex family dynamics, the accepted subculture of their professions, losing some control as they transition from a position of leadership to one as a patient, learning how to normalize their responses to stressors and coping with death and dying. A well-balanced treatment program includes counseling and therapeutic activities for each of these topics.

The connection between addiction and trauma is not a new concept, but we now have a better understanding of how powerful that connection is and how to effectively treat it. To continue moving forward, addiction and mental health professionals should take advantage of opportunities to train in this integrated approach. With the guidance of trained professionals, individuals struggling with both addiction and trauma can learn to be aware of trauma symptoms as well as to develop effective coping skills in order to live a more peaceful, sober life.

Robert Olinitz, MS, CADC, is the Inpatient Counseling Coordinator at Marworth. William Poray, LCSW, CAC, is the Outpatient Counseling Coordinator at Marworth. Marworth Alcohol and Chemical Dependency Treatment Center is located in Waverly, Pennsylvania. Visit us online at www.marworth.org.

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Treatment Choices on page 26

population. When the process of transitioning to civilian life is occurring, denial, hopelessness, loneliness, self medication with alcohol and drugs, domestic violence, overcontrol of children and anxiety about their safety can be quite evident (DeAngelis, 2008). In addition we have become much more skilled, in working with survivors guilt, and the veterans feelings that the whole purpose of life is now gone (Reeder, 2013). We must first decrease the ongoing factors that lead to treatment resistance and the low mental health utilization in military families. A 2008 VA study found that only 41% from the Iraq and Afghanistan wars do not enroll in any treatment. In order to provide essential, compassionate therapeutic care we must first overcome the obstacles that interfere with pursuing and maintaining treatment.

Although we know that there have been significant treatment advances, we still have found that nearly ½ of patients who enroll in treatment either drop out or remain symptomatic (Defife, 2012).

Treatment Resistance

There is a fear that medical records will ruin careers, there is a low perceived need for treatment and a lack of confidence in the efficacy of mental health treatment due to such factors as cost, embarrassment, and being stigmatized by members of one’s unit (Esposito, et al., 2011; Gorman, 2010; and Hoge, 2004). Utility and safety are essential in building the treatment frame. There has already been too much trauma, loss, anxiety, dysphoria, pain and hopelessness that interferes with the risk associated with trusting clinical provider.

Treatment must be easily accessible

and inviting so that the barriers to seeking therapy are extinguished. Time is of the essence, long waiting lists for initial evaluations, treatment programs and research will undermine the therapeutic mission. Knowledge about emergency medical services must be transmitted, safety is paramount. The National Suicide Prevention Lifeline (1-800-273-TALK) is commonly used.

Excellent pharmacological treatment is beneficial. The FDA, for example, has already approved Sertraline (Zoloft) and Paroxetine (Paxil) for PTSD (Defife, 2012).

Resick (2012) has done some important research on impressive long-term outcomes of Cognitive Behavioral Treatment and the benefits of prolonged exposure therapy. Mastering stressful situations through breathing exercises that have been learned in session and Cognitive Processing Therapy and Cognitive Restructuring are frequently used as well as prolonged exposure therapy (Tomasulo, 2012) and EMDR (Eye Movement Desensitization and Response) in individual treatment (Grbesa, 2010). Dialectical Behavior Therapy (Linehan, 2009), Mindfulness (Kabat-Zinn, 2003) and Mindfulness Based Stress Reduction (Kearney et al., 2011) have been effective in the treatment of adolescents as well as adults. The innovative treatment strategies of self-acceptance, commitment, awareness, willingness to experience emotional distress and attention to the present can be extremely useful therapeutic tools (Chodron, 2013). It is our privilege and obligation to pursue our ongoing work in strengthening our military families (Petzel et al., 2014). Continuing to fulfill this clinical and research mission will enhance the functioning of our nation.

Awards Reception from page 6

Mayor's Office of Jewish Community Affairs. Prior to his stint in government, Mr. Saperia was a public and private school teacher, administrator and government and community relations specialist for several agencies, including the American Jewish Committee, the American Jewish Congress, where he directed its Metropolitan New York Region and HIAS, the international refugee and migration agency, where he was Associate Executive Vice President.

Mr. Saperia has been active in community organizations and Democratic politics in the brownstone neighborhoods of Brooklyn. A former Democratic Committee person from the 50th Assembly District, he was a long time member of the local Community Board and President of The Carlton-Willoughby Block Association. He serves on the Executive Committee and Board of Directors of the former Brooklyn AIDS Task Force (Bridging Access to Care) in Brooklyn.

TGCW from page 28

the University of Connecticut. She achieved a post-graduate certificate in Social Work Administration from Hunter College. She is a licensed certified social worker, a certified alcoholism and substance counselor and a certified instructor for social work field placements. Ms. Ohanesian is a published author as well as an Adjunct Professor at Columbia University, elected Chair of Drugs and Soci-

Peer-Led Programs from page 15

make the present and future better than the past; learn to trust; take good care of their body; get help from safe people; heal fully from PTSD, and become substance-free — living by the adage that if one method doesn't work, try something else... and, never, never, give up.

Treatment Services from page 4

determine if the caller is a veteran or a veteran's friend or family member. Clinicians are trained to make referrals for treatment with providers who have veteran-specific programs in the state. The HOPE-line is a confidential, toll-free, telephone service help line available at 1-877-846-7369 that people suffering from alcohol abuse problems or substance use disorders can call 24 hours a day, seven days a week to access help. Family members can also take advantage of this call-in line.

The Path Ahead:

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NYS OASAS remains committed to supporting and fostering the development of expanded services for veterans with

He is a past President and active member of Congregation Kolot Chayenu, a progressive and inclusive Jewish congregation in Brooklyn.

He serves on the Board of Directors of the Human Services Council of New York City. He also serves on the Community Mental Health Advisory Committee of Visiting Nurse Service of New York. Phillip has been a member of MHNE's Advisory Committee since the newspaper's inception. He and members of his staff at The Coalition are featured in current and past issues of *Mental Health News* and *Behavioral Health News*.

Mr. Saperia graduated with a B.A. in Politics from Brandeis University. He holds an M.A.T. from Harvard University's Graduate School of Education where he was elected to Phi Delta Kappa, the National Honorary Education Society.

He is married to his life partner of 40 years, James R. Golden, and they live together in their homes in Brooklyn and Kingwood Township, New Jersey.

ety Seminars. She also serves as Vice President of the C3 Board for the NY State Association of Alcohol and Substance Abuse Providers.

The Guidance Center of Westchester is an \$11 million multi-service agency. In addition to mental health clinics and substance use services, TGCW offers programs in early childhood education, housing with support, and college and career guidance. For additional information, visit: www.TheGuidanceCenter.org.

Resources:

Najavits, L., Hamilton, N., Miller, N., Doherty, J., Welsh, T., & Vargo, M. (2014). Peer-led Seeking Safety: results of a pilot outcome study with relevance to public health. *Journal of Psychoactive Drugs*, 46(4), 295-302.

Najavits, L. M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

addiction disorders, promoting the use of the effective treatment models and therapies within those services, and ensuring the ongoing clinical competence of its workforce in working with veterans.

Future plans call for the development of clinical guidelines for serving veterans and the delivery of training in advanced topics relating to caring for trauma-afflicted patients. NYS OASAS continues to look for ways to continue to maximize its effectiveness in serving those in New York state who have served in the military and are now battling addiction.

For more information, contact the NYS OASAS Veterans Program at veterans@oasas.ny.gov, call 518-457-5005 or view the Veterans and Military section on the NYS OASAS's webpage: <http://www.oasas.ny.gov/treatment/veteran/index.cfm>.

Art Therapy from page 24

Malchiodi & Spiegel, 2006; Johnson, Lubin, James, & Hale, 1997; Loban, 2014; Morgan & Johnson, 1995). Literature in related fields also emphasizes treatment of symptoms and neglects to deal with the broader psychosocial implications of veteran readjustment. Readjustment is impacted by posttraumatic stress; however, readjustment also carries distinct challenges that are connected to both military and civilian culture. Art therapy provides veterans an alternate, multifaceted approach to address the complex needs associated with posttraumatic stress disorder (PTSD) and readjustment. The treatment model that I developed for the center includes individual art therapy sessions, drop-in studio groups, and veteran art exhibits. Each one of these component services addresses a distinct area of need.

Individual therapy sessions in this model are designed to address mental health symptoms and psychosocial stressors using an approach that builds on the veteran's strengths and operates from an understanding of how trauma impacts an individual's overall psychosocial functioning. I have observed that many veterans may not be ready to talk about their experiences in traditional therapy; the military mindset can reinforce a "soldier on" mentality that protects resistance to disclosure and vulnerability. Rather than putting words to emotions and experiences, they can be expressed through art making. Because expression can be communicated indirectly and through symbolic or metaphoric forms, art making can instill a sense of safety and control. Thus, veterans find they are able to contain painful emotions and experiences within the art work they create. I have witnessed the benefits of individual art therapy first-hand with veterans who have used it to heal from past traumas, improve relationships, develop new ways to manage stress, and start to define themselves with a new identity that is "creative." In my experience, this therapeutic work supports success and achievement in relation to the tasks veterans face when transitioning home and readjustment to civilian life.

Drop-in or open studio group sessions offer the opportunity to mitigate the social isolation often experienced by veterans struggling to reintegrate and readjust. The studio environment and its uniquely creative culture functions as a safe place that inspires creative risk taking through engagement with art materials, the physical environment, image making, and group energy that develops among participants who make art together, and in the presence of a facilitator who models commitment to art making (Allen, 1995; Luzzatto, 1997; McNiff, 1995; Moon, 2010). The studio environment can foster a welcomed sense of camaraderie among veteran participants as they share workspace and materials with others while creating their own individual artwork. Art

making is a way to communicate and share stories among veterans, forming as a culture of support and friendship. Also, in the studio space veterans can normalize and honor each other's struggles and successes with reintegration and readjustment through symbolic and verbal sharing.

Additional benefits are reinforced in the gallery components of art therapy. Gallery exhibits are much more than a formal display of artwork; public exhibition raises awareness and understanding within the general public. Formal art openings validate and legitimize the artwork of veterans by bringing it into the broader art community as well (Howells & Zelnik, 2009). The experience of professionally displaying one's own artwork in a public venue can be particularly validating for populations who feel marginalized from the mainstream (Vick & Sexton-Radek, 2011). As exhibiting artists, veterans self-advocate and inform the public of their experiences, externalizing and taking ownership of their own perspective (Block, Harris, & Laing, 2011). Thus, the gallery becomes another intervention to decrease isolation and disconnection between veterans and the civilian community they call "home."

Based on my experience working with veterans in a community-based setting, I have found that these particular approaches to art therapy target treatment for readjustment that are not addressed in traditional individual and group therapy settings. To further investigate the effectiveness of the art therapy studio and gallery in readjustment, I have initiated a participatory action research study with a group of 10 veteran co-researchers. The study design includes a series of focus groups involving dialogue and art making from which the co-researchers have developed a list of concerns felt to be pivotal to veteran transition. Through exploration of their personal experiences with art therapy treatment, they have begun to identify ways that art therapy can address the particular needs associated with transition from military service to life at home. The research team is currently in the process of collating the data and will be presenting it to the Rochester community in the form of an art exhibition. A common theme among participants thus far is identity loss at the time of separation and the rediscovering or recreating of identity through the art making process in art therapy.

Veterans who are involved in this program routinely remind me of the value and efficacy of art therapy. Many have stated that it has saved their life. Alternative and complimentary treatments can be a lifeline to veterans who are reluctant and unprepared to engage in more traditional forms of therapy. It is our responsibility as providers working with veterans to document and share our outcomes in order to best advocate for these vital services.

Jennifer DeLucia is a Doctoral Candidate at Mount Mary University. The Veterans Outreach Center is located in Rochester, New York.

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Coming Home from page 28

their presentation. Despite their sound base and application, these models are only part of the clinical program that needs to be offered. Wellness and resilience interventions that are proven in literature and experience to assist veterans manage the psychical, cognitive, and emotional dysregulations related to both substance misuse and traumatic exposure also need to be brought to bear to empower individual to manage their inner experience in a more effective, safer way. Mindfulness practice, yoga, acupuncture, and body-based somatic interventions provided in unison with the recovery approaches above enhance recovery and allow veterans to undo the lasting effects of what they have seen and what they have done. Having the capacity to address existential angst and moral injury related to both addiction and combat/military experiences, as well as identity and role issues related to service and reintegration, allow a program to address the wide range of pressures and challenges that may inform one's substance use disorder. Formal and informal access to Chaplains, both Military and civilian, can also be another avenue for exploration of these higher-level concerns.

Pillar Four: Incorporation of veteran-specific peer support and community reintegration: For many service members and veterans struggling with the crisis of addiction and posttraumatic stress, or reintegrating home from deployment, a sense of separation, alienation, and isolation can set in. Family, friends, peers— even society as a whole— can be experienced as not understanding and not supportive. Creating spaces where veterans can begin to relate to and connect with one another is a crucial aspect of recovery. Assisting those in recovery develop “sober social supports” is a goal of most programs; programs that work with veterans must try and take this one step further to provide peer-to-peer opportunities for sharing, for understanding, and for support.

Of particular benefit are programs that allow for intergenerational veteran peer support; a Vietnam combat veteran who has found the road to recovery from post-traumatic stress and addiction has a unique perspective and frame of understanding to pass on to our younger generation of OEF/OIF veterans. The universalities of brotherhood and esprit de corps crosses all generations of veterans, and allowing this to unfold in both clinical groups and less-formal shared spaces can facilitate recovery and growth for all.

Vet2Vet from page 14

it, but for those who went from Zero to Hero in a matter of weeks, and back again, it's really hard.

A Veteran recently said, “When I was in uniform I never had to explain to myself or anyone else who I was or what I was capable of. Now that I am out of uniform and seeking employment I struggle to confidently represent myself or even understand what employers expect of me.”

Protective outer shells don't sweat, nor do they let anything out. Strong stoic military types keep a lot inside their shells. They hang onto stress, fear, anxiety and a variety of feelings most of the

Pillar Five: Family Focused Interventions: When an individual joins the military, their entire family joins as well. The service and sacrifices of our Nation's military is carried squarely on the backs of our military families, and when a service member is suffering from acute behavioral health issues, the family suffers as well. Many family members of wounded warriors are tired from being in a caretaking role, are confused and do not have a clear understanding of what their family members are truly suffering from or dealing with, and are in need to support themselves as they try to keep their families intact. Finding ways to have families members take an active part in the treatment of their service member, and ways to provide education and support to family members so that they and the entire family is more resilient, is truly necessary to maximize inpatient and outpatient treatment gains. Outside of military service and sacrifice, addiction is also best understood in the context of family, and it is best treated in a program that can educate the family about the disease of addiction and the parts each can play in lasting recovery for our veterans.

Pillar Six: Integration of Experiential Modalities into the treatment model for veterans: There are many pathways to recovery for veterans, and not all are based in verbal and skills-building interventions. Allowing for the use of creative, experiential, and non-verbal modes of therapy and expression benefit our veterans by offering them unique opportunities to engage with each other, to make meaning out of their experiences, and to integrate split-off traumatic memory traces (e.g., affect states, body sensations, image fragments, etc) back into declarative, narrative memory networks so that they are more in the volitional control of the service member and carry less intensity over time. Expressive art therapy is a perfect example of a modality that “taps” into stored experience that may not be conscious (i.e., verbally-mediated) yet drives unrest, pain, and addiction. The use of metaphor can allow a veteran to capture in image what he/she can't capture in word and thought, using this as a springboard for healing and recovery. Symbolic work around the nature of addiction itself has been proven effective in promoting increased motivation for treatment, shifts in perceptions of self and the use of substances, and positive outcomes (Collie, Backos, Malchiodi, & Spiegel, 2006; Johnson, 2008). Trauma-informed drama therapy, collaborative song writing, writing workshops, and focused dialogues

between groups of veterans and civilians each, in their own unique way, allow a veteran to learn about themselves in relation to others and apply this experience in their journey of recovery and return.

In conclusion, we are all responsible for the care of our veterans and our military families. For those working with veterans dealing with addiction, finding an informed way to layer traditional recovery-oriented programming with trauma-informed care practices, trauma-informed treatments, complimentary/alternative models of care, and a true understanding of military culture and its impact is what is required to truly support recovery and abstinence for those who have served. Our civic duty is to stand ready to provide care and support where we can, and to do so in a way that honors the service and sacrifice our military gives on behalf of us all.

Michael DeFalco, Psy.D is Director of Military and Integrative Services at Bridge Back to Life Center, Inc. Aynisa Leonardo, BC-LCAT is Clinical Coordinator of Military Services at Bridge Back to Life Center, Inc. Any inquiries or correspondence regarding this article should be directed to Dr. Michael DeFalco at mdefalco@bridgebacktolife.com

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time they are in service. Military personnel don't often complain about pains or injuries for fear of being discharged, or letting down their teammates. Some fear they will lose the best paying job they ever had and let their families finances down. For instance, a level E-5 service member with 5 years in service, living off post in Kingston, NY will make approximately \$4,500 per month. Many Veteran's outer shells often hide medications they are prescribed to cope, the alcohol they drink to cope better and the psychological issues they dare not tell their chain-of-command. When the shell comes off for some, their bodies are pulled earthward by the gravity of life. It

is not any single thing that takes down these individuals who so bravely served their country, it is usually a multitude of challenges the uniform's protective shell shielded them from, and held them together psychologically. Most veterans that hit the streets after they leave the military play a huge game of catch-up, carrying burdens few understand.

Finally, no one left behind! They say crab barrels don't have lids because when a crab tries to get out, the others will pull him back in. This is true for most people on this planet. Shell or no shell, in or out of the military, veterans take care of their own. Governments and communities don't always do so, but veterans always

will. The odds of getting out of the barrel greatly increase when a veteran self-identifies to another veteran. It does not matter how long ago a veteran served, you'd be amazed at how they come together. When men and women who have worn the uniform bond they stand straighter and stretch to fill the shell they once wore. No shell, just pride and camaraderie, and memories.

For more information about MHA's Vet2Vet Program, contact the Vet2Vet Coordinator at (845) 342-2400 Ext. 237 or find the Vet2Vet of Orange County on the internet at www.mhaorangenyc.com/pg/vet2vethp.html



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