MENTAL HEALTH NEWS™

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FALL 2003 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 5 NO. 4

Depression in Children and Adolescents

National Institue of Mental Health
Washington, D.C.

Depressive disorders, which include major depressive disorder (unipolar depression), dysthymic disorder (chronic, mild depression), and bipolar disorder (manic-depression), can have far reaching effects on the functioning and adjustment of young people. Among both children and adolescents, depressive disorders confer an increased risk for illness and interpersonal and psychosocial difficulties that persist long after the depressive episode is resolved; in adolescents, there is also an increased risk for substance abuse and suicidal behavior. Unfortunately, these disorders often go unrecognized by families and physicians alike. Signs of depressive disorders in young people often are viewed as normal mood swings typical of a particular developmental stage. In addition, health care professionals may be reluctant to prematurely "label" a young person with a mental illness diagnosis. Yet, early diagnosis and treatment of depressive disorders are critical to healthy emotional, social, and behavioral development.

Although the scientific literature on treatment of children and adolescents with depression is far less extensive than that concerning adults, a number of studies—mostly conducted in the last four to five years—have confirmed the short-term efficacy and safety of treatments for depression in youth. Larger treatment trials are needed to determine which

treatments work best for which youngsters; and studies are also needed, however, on how to best incorporate these treatments into primary care practice.

Given the challenging nature of the problem, it is usually advisable to involve a child psychiatrist or psychologist in the evaluation, diagnosis, and treatment of a child or adolescent in whom depression is suspected.

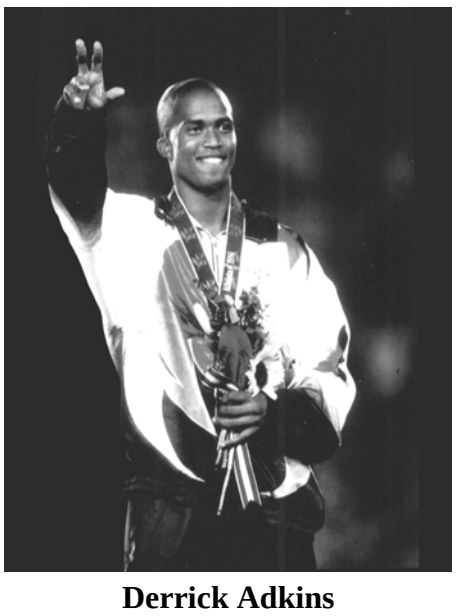
This fact sheet, prepared by the National Institute of Mental Health (NIMH), the lead Federal agency for research on mental disorders, summarizes some of the latest scientific findings on child and adolescent depression and lists resources where physicians can obtain more information.

see NIMH on page 34

Olympic Gold Medalist Helps Alert Teens About The Dangers Of Depression

Mental Health Association
of Nassau County, New York

The epidemic of teen depression is of deep concern to the Mental Health Association of Nassau County. This disorder does not discriminate and its impact can be felt in every school throughout New York. Research demonstrates that a significant way to combat depression is through information and awareness. In response to this urgent need, the MHA has developed a classroom video and teaching guide entitled *Real Hurdles: Helping Young People Understand Depression*. This educational effort was developed to help young people identify depression in themselves and to help them understand that this illness may be severely interfering with their lives.



Derrick Adkins

Real Hurdles tells the story of Derrick Adkins, 1996 Olympic Gold Medalist in the 400-meter hurdles, who experienced a serious episode of clinical depression which threatened his life. Mr. Adkins' personal adversity sends a clear message...it is crucial to recognize and seek help for depression. The video, which is accompanied by a teaching guide, is designed for middle and high school students for use by health teachers, coaches, guidance counselors, social workers and psychologists.

Three million American teenagers suffer from major depression. They go through the day-to-day of their young lives feeling sad, anxious, phobic or fearful. Some come across as defiant, while others appear compulsive, irritable, unable to concentrate or make friends. Twenty percent of these young people have seriously considered suicide, and yet fewer than one in five teens who need treatment gets it.

Thousands of teens in New York State have been counted in a national survey. Many never get the help they need because they have never been formally identified or lack the self-awareness to reach out for help.

Real Hurdles will be placed in every school district in Nassau County free of charge through a grant from the United Way of Long Island. In addition, the MHA of Nassau County will be conducting teacher-training events to assist teachers and other educational professionals use the materials effectively. It is hoped, with additional funding, that the agency will be able to secure a

see Gold Medalist on page 28

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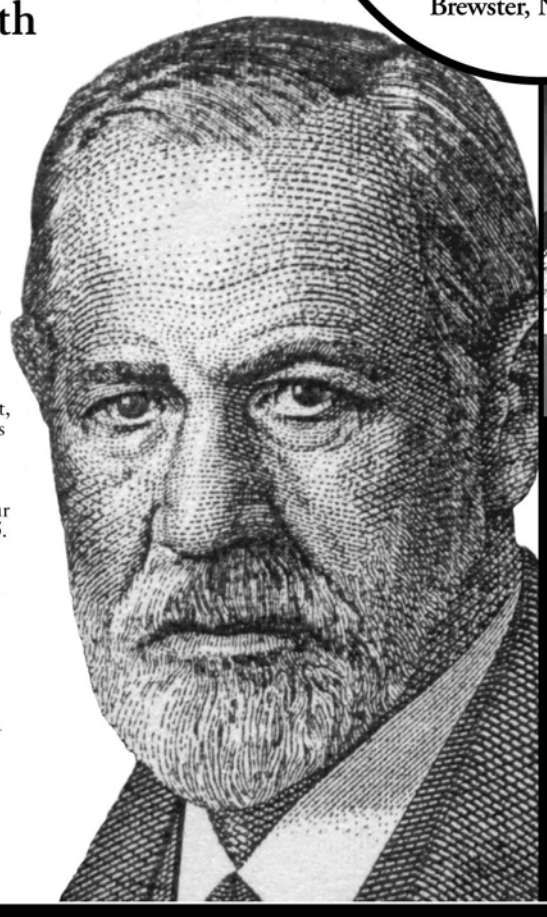

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The Publisher's Desk

By Ira H. Minot, Founder & Publisher Mental Health News

In this issue of Mental Health News, we take a brief look at depression in children and adolescents. We knew from the beginning that we would be unable to thoroughly cover even a fraction of the many correlating illnesses and diagnoses that relate to this broad area of concern in our children.

The President's New Freedom Commission has made its final report, and we must commend this effort on the breadth and quality of its recommendations as they relate to children and adults. Advocates for an improved mental health system in America are not limited to legislative leaders, treatment professionals and service providers. Family members and patients (consumers), as well, have testified that the system has failed to provide the availability, accessibility, quality and quantity of care needed.

With the final report of the New Freedom Commission, President Bush has yet more evidence to call for the funds necessary to make improvements to the mental health system in the United States. In doing so, he knows that *our children are our future*, as reflected in his own words relating to co-occurring disorders:

"... a 14-year-old boy who started experimenting with drugs to ease his severe depression. This former honor student became a drug addict. He dropped out of school, was incarcerated six times in 16 years. Only two years ago, when he was 30 years old, did the doctors finally diagnose his condition as bipolar disorder, and he began a successful program ..."

George W. Bush

Here are some excerpts from the President's New Freedom Commission's Report which relate to children:

If Untreated, Childhood Disorders Can Lead to a Downward Spiral

Early childhood is a critical period for the onset of emotional and behavioral impairments. In 1997, the latest data available, nearly 120,000 preschoolers under the age of six -- or 1 out of 200 -- received mental health services. Each year, young children are expelled from preschools and childcare facilities for severely disruptive behaviors and emotional disorders.

Since children develop rapidly, delivering mental health services and supports early and swiftly is necessary to avoid permanent consequences and to ensure that children are ready for school. Emerging neuroscience highlights the ability of environmental factors to shape brain development and related behavior. Consequently, early detection, assessment, and links with treatment and supports can prevent mental health problems from worsening.

Without intervention, child and adolescent disorders frequently continue into adulthood. For example, research shows that when children with co-existing depression and conduct disorders become adults, they tend to use more health care services and have higher health care costs than other adults. If the system does not appropriately screen and treat them early, these childhood disorders may persist and lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood. No other illness damage so many children so seriously.

Early detection, assessment, and links with treatment and supports can prevent mental health problems from worsening.

Schools Can Help Address Mental Health Problems

Currently, no agency or system is clearly responsible or accountable for young people with serious emotional disturbances. They are invariably involved with more than one specialized service system, including mental health, special education, child welfare, juvenile justice, substance abuse, and health.

The mission of public schools is to educate all students. However, children with serious emotional disturbances have the highest rate of school failure. Fifty percent of these students drop out of high school, compared to 30% of all students with disabilities. Schools are where children spend most of each day. While schools are primarily concerned with education, mental health is essential to learning as well as to social and emotional development. Because of this important interplay between emotional health and school success, schools must be partners in the mental health care of our children.

Schools are in a key position to identify mental health problems early and to provide a link to appropriate services. Every day more than 52 million students attend over 114,000 schools in the U.S. When combined with the six million adults working at those schools, almost one-fifth of the population passes through the nation's schools each day. Clearly, strong school mental health programs can attend to the health and behavioral concerns of students, reduce unnecessary pain and suffering, and help ensure academic achievement.

Ira Minot

People with Co-occurring Disorders Are Inadequately Served

Seven to ten million people in the United States have at least one mental disorder in addition to an alcohol or drug abuse disorder. Too often, these individuals are treated for only one of the two disorders...if they are treated at all.

A substantial number of children and adolescents also have co-occurring mental illness and substance use disorders. If one co-occurring disorder remains untreated, both usually get worse. Additional complications often arise, including the risk for other medical problems, unemployment, homelessness, incarceration, suicide, and separation from families and friends.

Studies show that few providers or systems which treat mental illnesses or substance use disorders adequately address the problem of co-occurring disorders. Only 19% of people who have co-occurring serious mental illnesses and substance dependence disorders are treated for both disorders; 29% are not treated for either problem. For people with less serious mental illnesses and substance dependence problems, the pattern of under-treatment is even worse. Most (71%) receive no treatment; only 4% receive treatment for both disorders. The same pattern of under-treatment holds for youth with co-occurring disorders.

MH Problems Are Not Adequately Addressed in Primary Care Settings

Of all the children they see, primary care physicians identify about 19%with behavioral and emotional problems. While these providers frequently refer children for mental health treatment, significant barriers exist to referral, including lack of available specialists, insurance restrictions, appointment delays, and stigma. In one study, 59% of youth who were referred to specialty mental health care never made it to the specialist.

Finally, it is noteworthy that there is a parallel problem in specialty mental health care. Specialty mental health providers often have difficulty providing adequate medical care to consumers with co-existing mental and physical illnesses. Given that individuals with serious mental illnesses, such as schizophrenia, have high levels of non-psychiatric medical illnesses and excess medical mortality, this is also a troubling situation.

Mental Health News joins with the many organizations who support the President's efforts to tackle the problems evident in our mental health system. We all agrees that without funding we will continue to see communities fail to offer and deliver the kind of mental health services needed to support the crisis of mental illness in America. Here are the sentiments of just two leaders of organizations involved in children's mental health issues that sum up the situation.

"The Federation of Families for Children's Mental Health remains committed to insuring children with mental health needs and their families can count on immediate access to quality services and supports that are community based. It our desire that the President's New Freedom Commission's report reflect the current status of children's mental health. We look for a commitment from this administration to take action and support policy changes with necessary increased funding in order to change the way this nation serves its children with mental health needs and their families."

Barbara Huff, Executive Director
Federation of Families for Children's
Mental Health. (703) 684-7710

"The 1999 Surgeon General's Report on Mental Health described the science underlying the identification, assessment, and treatment of mental disorders, including the disorders of childhood. 'The 20,000 family members of CHADD (Children and Adults with Attention-Deficit Hyperactivity Disorder) hope that the President's Commission Report will result in financing and management strategies that deliver the science to all individuals with mental disorders and their families."

E. Clarke Ross, CEO
CHADD (301) 306-7070

Mental Health News will continue to speak out and report on issues vital to improving access to mental health information, education, advocacy and resources. We urge you to become involved in these efforts in your community. We are all stakeholders because mental health issues effect us all.

Mental Health News appreciates your continued support and enthusiasm for our mission and encourages your participation to keep us abreast of your interests and concerns.

Have A Great Fall Season!
Ira H. Minot, CSW

Editorial to The Publisher

Child and Adolescent Depression: Pharmacological Enigma

An Editorial
By Joseph A. Deltito, M.D.

Joseph A. Deltito, M.D.

Thirty years ago it was dominantly held in the Psychiatric Profession that children and adolescents did not suffer from Major Depressive Disorder. This notion has been robustly repudiated by studies of epidemiology, psychopathology, and pharmacology which demonstrate it to be an illness in childhood, apparently continuous with adults' presentations. Families with adults, who obviously suffer from a Major Depressive Disorder show much higher levels of depression in children as compared to matched controls with no familial adult depression.

It has been estimated that 4.5 % of children ages 6-18 will demonstrate an episode of major depression and that 7% of these children will make suicide attempts. Compared to other childhood diseases Depression is among those with the highest levels of morbidity and mortality.

We know that many children go undiagnosed or misdiagnosed who suffer from depression (aka Unipolar Depression). This is undoubtedly due to numerous factors. Perhaps, most importantly, Unipolar Depression becomes confused with other psychiatric disorders, which in their early phases share more overlapping symptoms than they would in adults who have suffered from these illnesses for longer periods of time.

There are many psychiatric disorders that show their "age of onset" in the childhood or adolescent years. A list of some of the most common would include Unipolar Depression, Bipolar Disorder, Obsessive-Compulsive Disorder, Social Phobia, and Schizophrenia. In the initial months of the presentations of these disorders, there may be a noticeable lack of the more dramatic and characteristic symptoms which more clearly delineate and define these illnesses in adulthood. Well before the schizophrenic shows frank hallucinations, the OCD patients shows eccentric and irrational behaviors, or the Bipolar patient shows marked grandiosity and elevated moods, they may all show a rather similar picture of social withdrawal, lack of interest in their usual pleasurable activities and irritability. It is only with time that these saplings of disorders grow into the mighty trees of illnesses whose taxonomic characterization is obvious when under educated inspection. In my experience, many of the conditions called depression in childhood will reveal themselves in time to be other disorders with different natural histories and responses to specific treatments.

A two-year old Bluefin Tuna (approximate weight 250 lb.) is easily distinguished from a two-year old Anchovy (approximate weight .5 ounces), yet one might be surprised how difficult it is to distinguish a two-day old Anchovy from a two-day old Bluefin Tuna when both weigh as much as a feather on a hummingbird's wing.

The same is true of psychiatric disorders in their infancy; they are challenging to distinguish among themselves during their early stages of development. I will return to this argument when discussing research on treatments for childhood depression.

Other reasons why childhood Depression is oftentimes misdiagnosed or underdiagnosed may have to do with increasing numbers of children getting initially evaluated when exhibiting signs of depression by non-medically trained mental health practitioners. Many are hesitant to make major psychiatric diagnoses preferring psycho-social models of abnormal childhood behaviors, even when these models do not logically apply. In the age of Managed Care and HMOs fewer, not more, children are being initially evaluated by medical experts in childhood psychiatric disorders. Such systems more often employ practitioners with less rigorous training and experience. Fearing "stigma," these practitioners often times illogically fear children being "labeled" with psychiatric illnesses. To mislabel a child with a psychiatric diagnoses is a tragedy, but to properly label (diagnose) a child with a severe psychiatric disorder is the first step towards effective treatment and, hopefully, a life freed from the negative and oftentimes tormenting effects of chronic mental illness.

The "gold-standard" for treatment for Unipolar Depression in adults is most often a combination of Pharmacotherapy (antidepressants) with adjunctive psychotherapy of a cognitive-behavioral or interpersonal variety. Of course there is a large array of agents and techniques which may be particularly useful in certain subsets of depression; these would include electroconvulsive therapy, light therapy, and other forms of psychotherapy.

Whereas there exists a large and convincing body of data from controlled (that is comparing a medicine to placebo under rigorous scientific conditions) clinical trials (experiments) supporting the effectiveness of standard antidepressants in depressed adults, there is surprisingly little data from such systematic research conducted on children and adolescents. Being a consultant to many of the major pharmaceutical companies, as well as a reviewer for many of the psychiatric journals, I am prepared to say that many clinical trials aimed at demonstrating a robust effect of an antidepressant in this age group have failed to generate overwhelming evidence of efficacy. Within scientific psychopharmacological circles, this is a well-known fact; there exists many unpublished studies showing no significant antidepressant effect in this age group. The reason why this may be remains an enigma open to scientific scrutiny, debate and disagreement.

It is my opinion that the main reason this is so has not to do with the inadequacies of antidepressant medications, but has to do with the inadequacies in the diagnoses of subjects who find themselves included in such studies.

I firmly believe that many of the children who superficially meet research criteria for entry into these studies do not truly have Unipolar Depression. I believe many of them have the initial, prodromal or not fully developed features of OCD, Social Phobia, Panic Disorder, Bipolar Disorder, Attention Deficit Disorder, Schizophrenia and other disorders which may not respond to antidepressants in the dosages intended to treat Unipolar Depression. In addition some of these conditions may actually worsen or show the emergence of noxious side effects when treated with antidepressants, most notably in the case of Bipolar Disorder. As these cases are erroneously included in the pool of research subjects for Unipolar Depression in childhood at a higher rate than would occur in studies of adults, we develop a picture which at first glance seem to indicate that antidepressants do not work as well in children as they do in adults. In all likelihood the response rate would be similar once the selection errors based on misdiagnoses are corrected.

Let me state clearly that there does exist strong data from controlled clinical trials of depressed children and adolescents showing efficacy for Fluoxetine, Paroxetine, Citalopram, Sertraline and Nefazadone. I do believe that the confines of Unipolar depression are continuous between adults and children and that pharmacological agents shown to be helpful in adults are reasonable choices when judiciously used in children. The main reason for a paucity of data in their support lies in the difficulty in making a correct diagnoses of Unipolar depression in children distinguishing it from other psychiatric conditions in their developing phases. As an advocate for people with mental illness, I urge all parents to demand sophisticated and well trained individuals be employed by their health care networks when diagnosing their children.

Obviously, further study in this important arena is crucial and necessary.

Joseph A. Deltito, M.D. is a Clinical Professor of Psychiatry at New York Medical College and has an office practice for psychopharmacological consultations and forensic psychiatry in Greenwich, Connecticut. Dr. Deltito serves on the Clinical Advisory Board of Mental Health News.

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MENTAL HEALTH NEWSDESK

James L. Stone Leaves NYS-OMH Appointed Deputy Administrator of SAMHSA

SAMHSA
E-news

Substance Abuse and Mental Health Services Administration (SAMHSA) Administrator Charles G. Curie today announced that James L. Stone has been appointed deputy administrator of SAMHSA.

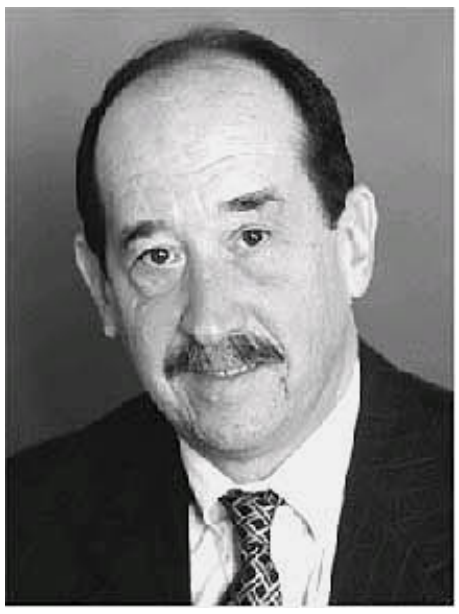
SAMHSA, a component of the U.S. Department of Health and Human Services, is dedicated to providing prevention and treatment services that build resilience and facilitate recovery from substance abuse and mental illness.

Prior to joining SAMHSA, Stone was Commissioner of the New York State Office of Mental Health. There he supervised the New York State public mental health system, which includes 27 psychiatric centers serving over 6,000 inpatients and 20,000 outpatients. As Commissioner of Mental Health he worked with local government to assure effective services and proper regulation and licensure of over 2,500 programs across the state.

"James Stone will further our vision of a healthier U.S. by addressing the mental illnesses and substance abuse that disable millions of Americans," Health and Human Services (HHS) Secretary Tommy G. Thompson said. Those who suffer from mental illness or substance abuse deserve to be treated with the same compassion and medical attention as those who suffer physical ailments. James Stone's stellar record in New York shows we have the right man for the job."

SAMHSA Administrator Charles G. Curie said, "I am truly excited to have James Stone on SAMHSA's executive team. His proven leadership and extensive experience in strategic planning for mental health services; his ability to encourage collaboration among advocacy groups, provider groups and government agencies; his experience in addressing co-occurring substance abuse and mental disorders; and his management expertise will propel SAMHSA into a new era of responsiveness and efficiency."

Stone positioned New York State as a leader in addressing co-occurring mental health and substance abuse disorders, a major priority of SAMHSA under Curie. He authored the concept of service coordination by severity of disorders and location of care which is the standard in the field for determining the level of treatment for those with co-occurring substance abuse and mental disorders. He oversaw development of an assessment instrument to aid clinicians in diagnosing co-occurring substance abuse and mental health disorders, and was instrumental in creating collaboration between mental health authorities and the New York Office of Alcoholism and Substance Abuse. This cooperation led to the funding of 12 specialists in co-occurring disorders assigned to local county mental health offices to facilitate collaboration among substance abuse and mental health professionals.



James L. Stone

Under Stone, state mental hospitals were all fully accredited, and he achieved the only statewide correctional mental health system to be fully accredited. He also successfully reduced restraint and seclusion of mentally ill patients by 65 percent. He is a supporter of performance indicators and evidence-based-practices, as well of developing data to support service enhancement.

During the crisis of 9/11/01, he worked with SAMHSA and City of New York officials to establish a command center to provide mental health and substance abuse services to those affected. He also created Project Liberty to focus on services to special populations and a media campaign to address the general public.

He holds a B.A. and an M.S.W. from Syracuse University and is a recipient of the "Distinguished Alumnus Award" of the Syracuse University School of Social Work. He has also been published in several behavioral health journals.

SAMHSA, a public health agency within the U.S. Department of Health and Human Services, is the lead federal agency for improving the quality and availability of substance abuse prevention, addiction treatment and mental health services in the United States. Visit our website at www.samhsa.gov.

Study Reveals Fewer Than Half With Serious Mental Illness Are Receiving Treatment

CMHS Consumer Affairs
E-News

Fewer than half of adults with a serious mental illness received treatment or counseling during the past year, according to the 2001 National Household Survey on Drug Abuse. Serious mental illness is defined as having a diagnosable disorder that meets the criteria of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

The findings were announced by Substance Abuse and Mental Health Services Administration (SAMHSA) Administrator Charles Curie, saying: "Too many Americans are unaware that mental illness can be treated and that recovery is possible." Curie said. "Fewer than half of the 15 million adults with serious mental illness in the United States are receiving treatment. The data show racial disparities and educational differences as well. The consequences of untreated mental illness can be shattering, leading to unnecessary disability, homelessness, unemployment, incarceration and even suicide."

Whites were more likely than African Americans or Hispanics to have received treatment or counseling during the past year, according to the Household Survey. There were 51.4 percent of whites who received treatment or counseling compared to 38.4 percent of African Americans and 27 percent of Hispanics. College graduates were more likely than those with lower levels of education to have received treatment or counseling.

The data indicate that younger adults, aged 18-25, received less counseling or treatment than 26-49 year olds. The persons receiving the most treatment or counseling in the past year were age 50 or above. Only 32.7 percent of adults age 18-25 with serious mental illness received treatment or counseling, compared to 50 percent for 26-49 year olds, and 53.3 percent of those age 50 or older.

Curie added, "There are many reasons why people do not seek help for mental health problems. This is one of the many issues the President's New Freedom Commission on Mental Health is expected to address in its final report ."

To tackle the problems in mental health treatment, SAMHSA is helping to build community-based systems of care for children with serious emotional disturbances and their families. SAMHSA's Community Mental Health Services Block Grant Program provides funds to states to provide comprehensive community mental health services to adults with serious mental illness and children with serious emotional disturbances. SAMHSA's PATH Program is bringing an estimated 147,000 homeless people into treatment for mental disorders and substance abuse, as well as providing referrals for housing.

SAMHSA is also working on a national project to promote the widespread adoption of six evidence-based practices to improve treatment by giving practitioners the tools they need to generate positive outcomes for adults with serious mental illness.

The Household Survey is conducted annually by SAMHSA. In 2001 approximately 70,000 people aged 12 and older participated in the survey. For the first time in 2001, the Household Survey included questions for adults that measure serious mental illness. Survey participants aged 18 and older were asked questions used to assess serious mental illness during the year prior to the survey interview.

MENTAL HEALTH NEWSDESK

Kudos For Freedom Commission Final Report But Without Funding System Remains On Critical List

Bazelon Center, NAMI, NASMHPD, NMHA Call on Bush and Congress to Take Action

The President's New Freedom Commission on Mental Health today released its long-awaited report, including recommendations to improve America's broken mental health system. Together the Bazelon Center for Mental Health Law, NAMI, National Association of State Mental Health Program Directors and National Mental Health Association commend the Commission for its work. Our organizations call on President Bush and Congress to now take the bold steps needed to realize the Commission's recommendations and make mental health a national priority.

"Mental health advocates today call on the nation's leaders to capitalize on this historic opportunity to address the growing crisis in public mental health systems," said Robert Bernstein, executive director of Bazelon Center for Mental Health Law. "Policymakers have a choice - they can put this report on a shelf and continue the past policies of hopelessness, or they can act on its recommendations and make recovery-focused services a priority for millions of Americans with unmet mental health needs."

In its interim report, the Commission found America's mental health system to be "in shambles," resulting in millions of people with mental illnesses not receiving the care they need. The final report calls for transforming fragmented public mental health services into a system focused on early intervention and recovery. Such a system would provide people with mental health needs the treatment and supports necessary to live, work, learn and participate fully in their communities.

Research shows that people with - or at risk of - mental health disorders need access to a range of advanced treatments, early interventions and supports that are both culturally appropriate and consumer- and family-centered. Without broad access to such services and supports, people with mental illnesses can face school failure, unemployment, substance abuse, homelessness, arrest, incarceration, increased reliance on emergency facilities, and suicide.

"We cannot wait another day, another year or another decade for real progress," said Richard Birkel, Ph.D., national executive director of NAMI. "We do not want another Presidential Commission, Surgeon General's report, state audit or newspaper expose telling us what we already know too well. Let today be the turning point. Let today begin the transformation of a broken system of care to one that provides recovery-oriented, community-based treatment and services that we know will work."

In April 2002, the president established the Commission to help eliminate inequalities in mental health care. The Commission was to conduct a comprehensive study of mental health delivery systems and recommend policies that - if implemented by federal, state and local governments - would improve the mental health system and, in turn, improve the services that millions of adults and children with mental health problems need.

"The stakes are too high for us to continue with business as usual," said Robert Glover, executive director of the National Association of State Mental Health Planning Directors. "Our organizations are joining together to demonstrate the urgency of need, to underscore the promise of effective services for millions of Americans with mental illness, and to work with federal officials to make those services available to all who need them."

The Campaign for Mental Health Reform was founded by the Bazelon Center, NAMI, NASMHPD and NMHA to serve as a focus for federal policy advocacy for the mental health community. Twelve other mental health advocacy organizations have joined the Campaign as partners. The Campaign's goal is to work directly with federal policymakers to make access, quality and recovery in mental health services the hallmark of our nation's mental health system.

"The Commission's report is a prescription meant to fix a mental health 'system' that is on the verge of plunging from crisis to catastrophe," said Michael Faenza, president and CEO of the National Mental Health Association. "It offers a great chance for advocates, consumers and family members to work with federal leadership towards fundamental change. But without commitment, action and funding this report is worth no more than the paper it is written on."

The Bazelon Center for Mental Health Law is the leading national legal advocate for people with mental illnesses or mental retardation. Through precedent-setting litigation and in the public policy arena, the Bazelon Center works to advance and preserve the rights of people with mental illnesses and developmental disabilities. For more information, visit www.bazelon.org.

As The Nation's Voice on Mental Illness, NAMI leads a national grassroots effort to transform America's mental health care system, combat stigma, support research, and attain adequate health insurance, housing, rehabilitation, jobs and family support for millions of

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Gene More Than Doubles Risk Of Depression Following Life Stresses

National Institute of Mental Health Washington, D.C.

Among people who suffered multiple stressful life events over 5 years, 43 percent with one version of a gene developed depression, compared to only 17 percent with another version of the gene, say researchers funded, in part, by the National Institute of Mental Health (NIMH). Those with the "short," or stress-sensitive version of the serotonin transporter gene were also at higher risk for depression if they had been abused as children. Yet no matter how many stressful life events they endured, people with the "long" or protective version experienced no more depression than people who were totally spared from stressful life events. The short variant appears to confer vulnerability to stresses, such as loss of a job, breaking up with a partner, death of a loved one, or a prolonged illness, report Drs. Avshalom Caspi and Terrie Moffitt, University of Wisconsin and King's College London, and colleagues, in the July 18, 2003 *Science*.

The serotonin transporter gene codes for the protein in neurons, brain cells that recycle the chemical messenger after it's been secreted into the synapse, the gulf between cells. Since the most widely prescribed class of antidepressants act by blocking this transporter protein, the gene has been a prime suspect in mood and anxiety disorders. Yet, its link to depression eluded detection in eight previous studies.

"We found the connection only because we looked at the study members' stress history," noted Moffitt. She suggested that measuring such pivotal environmental events — which can include infections and toxins as well as psychosocial traumas — might be the key to unlocking the secrets of psychiatric genetics.

Although the short gene variant appears to predict who will become depressed following life stress about as well as a test for bone mineral density predicts who will get a fractured hip after a fall, it's not yet ready for use as a diagnostic test, Moffitt cautioned. If confirmed, it may eventually be used in conjunction with other, yet-to-be-discovered genes that predispose for depression in a "gene array" test that could help to identify candidates for preventive interventions. Discovering how the "long" variant exerts its apparent protective effect may also lead to new treatments, added Moffitt.

Everyone inherits two copies of the serotonin transporter gene, one from each parent. The two versions are created by a slight variation in the sequence of DNA in a region of the gene that acts like a dimmer switch, controlling the level of the gene's turning on and off. This normal genetic variation, or polymorphism, leads to transporters that function somewhat differently. The short variant makes less protein, resulting in increased levels of serotonin in the synapse and prolonged binding of the neurotransmitter to receptors on connecting neurons. Its transporter protein may thus be less efficient at stopping unwanted messages, Moffitt suggests.

Moffitt and colleagues followed 847 Caucasian New Zealanders, born in the early l970s, from birth into adulthood. Reflecting the approximate mix of the two gene variants in Caucasian populations, 17 percent carried two copies of the stress-sensitive short version, 31 percent two copies of the protective long version, and 51 percent one copy of each version.

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MENTAL HEALTH NEWSDESK

NAMI Testimony Claims House Subcommittee Out of Step On Children's Mental Health

NAMI
E-News

Statement of Darcy Gruttadaro, Director, NAMI Child & Adolescent Action Center

The May 6th hearing by the Committee on Education & the Workforce Subcommittee on Education Reform in the House of Representatives on "Protecting Children: The Use of Medication in our Nation's Schools." represents yet another exercise that will generate sensational headlines and alarm parents, while obscuring the true nature of a public health crisis- in a way that trivializes mental illnesses in children and the need for early identification and treatment.

This is the third House hearing on the topic, skewed against science, against treatment, and against principles of partnership in communities.

On September 29, 2000, the oversight subcommittee of the House Committee on Education & the Workforce held a hearing on the alleged "overmedication" of children with ADHD. On September 26, 2002, the full House Government Reform Committee held a hearing on the same topic. Today, it is the Subcommittee on Education Reform. Here we go again.

Unfortunately, all these hearings are focusing on largely anecdotal and unsubstantiated claims that our nation's children are being overmedicated with psychotropic medications - when well documented reports and studies show that the overwhelming majority of children with mental illnesses are never identified and fail to receive treatment.

That is the concern of the U.S. Surgeon General. It also is the concern of President Bush, who last year declared: "Millions of Americans, millions, are impaired at work, at school, or at home by episodes of mental illness. Many are disabled by severe and persistent mental problems. These illnesses affect individuals, they affect their families, and they affect our country."

President Bush also declared: "Remarkable treatments exist. Yet many people - too many people - remain untreated. Some end up addicted to drugs or alcohol. Some end up on the streets, homeless. Others end up in our jails, our prisons, our juvenile detention facilities. Our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve excellent care. Political leaders, health care professionals, and all Americans must understand and send this message: mental disability is not a scandal - it is an illness. And like physical illness, it is treatable, especially when the treatment comes early."

Unfortunately, the Subcommittee seems not to have heard the President's message nor to have reviewed well-documented reports that show the tragic consequences of the nation's failure to identify and treat children with mental illnesses. Suicide remains the 3rd leading cause of death for our nation's 10-24 year old children and young adults and research identified in the U.S. Surgeon General's report shows that up to 90% of those young people have a diagnosable mental illness.

If the Subcommittee wishes to protect children – it should focus on the unmet needs of children with mental illnesses and their families and the real crisis that currently exists in this country. Congress should heed the call of the U.S. Surgeon General to address the need for the early identification of mental illnesses in children and intervention with appropriate treatment. Partnerships should be fostered at the federal, state and local levels between the education system and other child serving agencies and families to ensure intervention and treatment for early onset mental illnesses.

The Subcommittee should reject legislation that would restrict school professionals from communicating with families about legitimate mental health concerns and recognize that lack of communication inevitably hurts children and families. The importance of open communication between school professionals and families about the health and well-being of children, and if necessary, the freedom to recommend comprehensive medical evaluation cannot be overstated.

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New York's *New* Medicaid Buy-in Program Holds Promise For Many

By Sharon Carpinello, R.N., Ph.D.
Acting Commissioner, New York State Office of Mental Health

Sharon Carpinello

The New York State Office of Mental Health is going through an exciting period of progress on the quality front as it retools itself to become more centered around recovery. The last three years have been a period of significant change: the routine clinical landscape is becoming more person-centered and recovery-focused; self-help and empowerment tools are becoming increasingly more important elements; and now with New York State's July 1, 2003 implementation of its Medicaid Buy-in program, New Yorkers with psychiatric disabilities have greater opportunities for employment than ever before in the history of the State.

The Buy-in program, signed into law last year by Governor Pataki, enables individuals to return to work and retain their needed Medicaid coverage. Thanks to the Governor, this program will make it possible for many people with psychiatric disabilities to return to work while keeping the supports necessary to be successful. By empowering them to maximize their own personal potential, the program allows for greater independence by enabling people to achieve meaningful employment and to know the personal satisfaction that accompanies a job well done.

The new Buy-in program is also an example of New York State removing disincentives to employment, as outlined in the goals of the recently released final report of the President's New Freedom Commission on Mental Health.

Employment is ranked number one among goals expressed by recipients of mental health services, but the fear of losing needed Medicaid coverage has been one of the barriers keeping individuals with disabilities from working to their full potential. In fact, the loss of Medicaid has often been a stronger deterrent to work and independence than the loss of cash benefits.

We know that disparities impose a greater disability burden for minority populations, and care is being taken to address the cultural norms and values of the individuals receiving education and training specific to the Medicaid Buy-in.

The new program also enables working individuals with psychiatric disabilities to buy into Medicaid in order to continue treatment. In the past, individuals who returned to work either were not offered or could not afford insurance coverage or medical care that was necessary to help them maintain their ability to work and avoid decompensation. The new Buy-in program is truly empowering because in many cases Medicaid provides for the necessary medical supports that enable an individual to work and to continue working. These supports can include medication, home health care, and medical equipment.

Previous work incentives were somewhat complex and confusing, and the new Buy-in program bypasses much of that. Basically, New York's Medicaid Buy-in program establishes that if an individual is working and hasn't yet reached an established income cap, they can purchase their Medicaid coverage. More specifically, the program extends Medicaid coverage to working individuals with disabilities who have net incomes at or below 250 percent of the Federal poverty level. After exclusions are factored in, an individual could be eligible for the program with annual income as high as $46,170. If required, premiums are based on a percentage of earned and unearned income.

Most individuals who are interested can apply for the Medicaid Buy-in program at their local Department of Social Services; however, if an individual resides in a State-operated community

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Helping Parents Understand Childhood Depression

By Flemming Graae, M.D., Chief Child and Adolescent Psychiatry Westchester Medical Center

When we think of depression, we don't usually think of children or adolescents, except in the sense that they experience moodiness, sadness, or upset as part of growing up. Adolescents, especially, seem to have emotional ups-and-downs, and, while we worry about them, we accept some of this, or try to cope with it when things seem excessive. And we may remember our own adolescence when we thought we could do or experience anything and had intense feelings about things we disagreed with or were upset by. We might even recall periods when we felt overwhelmed, withdrawn, or angry, and had trouble in our relationships or in school. When we see this in our children, we may feel it's something they'll just get over, that it's just hormones raging or that they have to "grow up" and deal with life in a more responsible way. So, how was this "real" depression? Well, some of it was, and we now recognize that children and adolescents can be depressed to a degree, and for a long enough period of time, that we would call it a "clinical" depression, something that has more significant impact over time and that can seriously and negatively affect development and success in life, and that it's not a usual life

Flemming Graae, M.D.

adversity that is normal or will necessarily make us better for having struggled with it.

Anyone would certainly understand that children or adolescents who have suffered serious trauma or losses early in life would be more likely to experience depression, and that is true; and some may be inherently at risk for depression, such as that seen passed down in families, which would increase the risk for childhood depression, especially when coupled with instability or trauma early in life. However, it is only in recent years we have appreciated the extent of depression in children and adolescents, in part because we know more about how it is both similar and different from adult depression, how prevalent it is, and how to treat it.

Current estimates are, at minimum, that between 2-3% of children will experience a depression and that more than 8% of adolescents will. The belief is that the earlier it occurs and the longer it persists, the more negative effect it will have on development and for future problems. And when other serious problems are present with depression, such as learning problems, and other psychiatric disorders, such as Attention Deficit Disorder, Oppositional Defiant Disorder, Conduct Disorder, or an anxiety disorder, then the accumulated impact in the present and future can be that much greater. Sometimes, the depressive symptoms can also be part of another mood disorder called Bipolar Disorder, which has more marked mood instability, irritability, or even periods of excessively bright or happy moods, or it can be superimposed on a chronic low grade depression called Dysthymic Disorder. By impact, we mean functional impairment, such as school or academic problems, difficulties in peer relations or getting into trouble with authorities or becoming involved in drugs and other self-injurious behavior...even suicidal behavior.

In many ways, childhood depression is similar to adult depression, but it is often expressed in developmentally different ways because of relative physical, emotional, and cognitive immaturity and how children show, rather than say, what they're feeling and thinking. Like depressed adults, children can be sad, withdrawn, or lose interest in their usual activities; and they may have low energy or fatigue, more irritability, and they may have difficulty sleeping (too much, too little, interrupted) or aren't eating properly (losing or gaining excessive weight). Children may express more physical complaints, such as headaches, stomach or muscle aches, and nausea than adults. Younger children may sometimes also say things that reflect how unhappy they are; such as that they wish they were dead or that no one loved them or no one wanted to be their friend or that people were always mean to them. And sometimes children and adolescents can say things that indicate they feel inadequate, unworthy, or hopeless about being able to do things right. Like adults, children may increasingly struggle with their work, such as concentrating in class or on school work or refusing to go to school, and with relationships (fighting, arguing, and being more sensitive and reactive to actual or perceived social difficulties). At home they may have more tantrums, irritability, impulsive or reckless behavior, and oppositional behavior than adults might show, yet also have separation anxiety, such as unwillingness to sleep alone, or separate from a parent to go to school or

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Adolescent Depression: Helping Young People Find and Alternative

By Mindy R. Appel, ACSW, LMFT
Juni Bowes, NCC, LMFT

The suicide rate for adolescents has increased more than 200% over the last decade. Recent studies have shown that greater than 20% of adolescents in the general population have emotional problems and one-third of adolescents attending psychiatric clinics suffer from depression. (Maurice Blackman, MB, FRCPC, The Canadian Journal of ME, May 1995) Depression was considered to be the major psychiatric illness of the 20th century, affecting nearly 8,000,000 people in North America alone. Depressed people are 20 times more likely to die from accidents or from suicide than are people with any other psychiatric disorder. Since the onset of major depression (including bipolar disorder) often occurs during teen years, early recognition of these conditions is the best defense in ensuring a long and healthy life for teenagers affected by such disorders.

One of the biggest problems is that depression in teenagers is often misdiagnosed, leading to serious difficulties in school, at work, and with personal adjustment and relationships. These difficulties often continue into adulthood if not treated. One of the major reasons for the misdiagnosing of the problem is that adolescence, in and of itself, is a time of major emotional upheaval, mood changes, gloomy feelings, histrionic (dramatic) behavior, and heightened sensitivity. The real challenge is separating out what is normal adolescent development from behavior that is potentially self-destructive.

Diagnosis, therefore, must rely not only on observation but on reliable conversations with parents, teachers, and people in the community . It is important to establish each adolescent's pre-crisis personality, and take into account recent stressors or traumas which have occurred preceding the current clinical state. Significant stresses include school issues, peer relationships, parent or family arguments, divorce, physical or sexual abuse and alcohol or substance abuse. It is important to note that though some stressors may seem insignificant to the adults, they may be of great significance to the teen. Of ultimate importance, however, is establishing a climate of trust in which the adolescent will truthfully discuss his/her feelings with someone who is essentially an adult stranger. How successful you are in accomplishing this task will often determine the level of effectiveness of therapeutic intervention.

Depression in adolescence is slightly different from adult depression and may be recognized by certain unique characteristics. ***It is important to note, however, that these same characteristics represent perfectly normal adolescent behavior as well.*** Pervasive sadness in adults may be manifested in adolescents by wearing black clothing, writing poetry with morbid themes, drawing pictures with graphic representations (daggers, dripping blood, gravesites, etc.), or being preoccupied with violent music. Sleep disturbance in adolescents may result in watching television all night, talking on the phone all night, difficulty getting up for school, and falling asleep in class. Teenagers in middle and high school often begin to skip classes and exhibit a marked drop in grades due to loss of concentration and distraction. Adolescents who were generally "picky eaters" may go that extra step and become anorexic or bulimic. The key to diagnosis is in recognizing radical changes in behavior over a relatively short period of time. One of the reasons that adolescent depression is so hard to diagnose is because it can masquerade as many things: behavior or conduct disorder, substance or alcohol abuse, or family confrontations and rebellion which seem totally unrelated to depression.

According to David Capuzzi (***Suicide Prevention in the Schools: Guidelines for Middle and High School Settings)***, there are as many as eleven possible behaviors which are symptomatic of

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Adolescent Depression: Is It Affecting Your Teenager?

By Wade Anderson, Ph.D.
Clinic Director, Northern Westchester Guidance Clinic of the Mental Health Association of Westchester

Cutting classes, difficulty keeping up with academic demands, moodiness, irritability, frequently crossing over your parental limits, difficulty making decisions, poor concentration, dropping out of sports activities or hobbies: Does this sound anything like your adolescent? If your answer is "yes" or even "sort of," your adolescent may have a depressive disorder. Surprisingly, it is not that unusual for adolescents in the United States at this point in our history to experience a form of clinical depression. The incidence of adolescent depression has dramatically increased over the last 15-20 years. A number of recent epidemiological studies have reported that as many as one in twelve adolescents suffer enough symptoms of depression to meet criteria for one of the multiple clinical syndromes of depression. NIMH research supports that up to 4.9 percent of adolescents have Major Depression Disorder.

Adolescent Depression: Not Easy to Handle or Identify

Adolescent depression, like childhood depression is determined by the same array of symptoms as adult depression. However, the actual presenting picture of an adolescent with a depressive disorder may be difficult to recognize or diagnose. It is frequently mistaken for the "typical" adolescent roller-coaster ride: ups, downs, high & low activity levels and destructive personal choices. What comes to mind when one thinks of "major depression" often includes: sad mood, low energy, difficulty getting out of bed, flat, emotionless expression, indifference to once pleasurable activities, apathy, crying spells, slowness in general, and thoughts of death or even suicide. Some depressed adolescents present with this kind of picture, but far more frequently teens present with depressions that are far more dramatic, energetic and volatile. Adolescents are developmentally not well equipped to handle or verbally express highly distressed internal states. Typically teens express distress with considerable irritability, impulsivity, and acting out in destructive ways, like experimentation with substances and sexual promiscuity. Destructive behaviors are often a diversion away from confronting extremely difficult emotions.

Recent brain research has shown that up until 21 or 22 years of age, adolescent brains are still completing development in the primary brain areas responsible for executing planned courses of action, understanding cause-effect relationships and controlling impulses. These are the very areas that go awry with the depressed adolescent. Our high-paced, illicit-information-packed, stress-and-pressure-filled society might be increasingly overwhelming the biology of our teenagers and young adults. Other factors associated with teenage depression include stress, substance use, lack of communication with parental figures, and isolation from peers.

Indications for Professional Help

How do you know if the things that made you say "yes" or even "sort of" above about your own adolescent are serious enough to seek help from a mental health practitioner? If any two of the following have been prominent, consistent and persistent over a two-week period, then a professional consultation should be considered: 1) Increased academic struggles, 2) reduced performance with extracurricular demands, 3) significant conflicts in family expectations and/or peer relationships, 4) reduced self-care and/or hygiene, 5) disturbed sleeping or eating, and 6) bizarre, inexplicable behavior. Certainly, if you are aware that your adolescent is experiencing thoughts of suicide or obsessive thoughts of death, then an immediate consultation with a mental health provider is imperative.

The danger of teen suicide is alarmingly real: Suicide has risen to the third leading cause of death among adolescents and the second leading cause for college-age adolescents. Recent research indicates that as many as 7% of adolescents who develop a Major Depressive Disorder may kill themselves in their early adulthood. There is some good news, however: recent literature suggests that in many cases, prior to a teen suicide attempt, warning signs were given. Up to 80% of teens who attempted suicide, also gave clear warning signs that include:

- Direct or indirect suicide threats
- Obsessive thoughts of death
- Irrational actions, bizarre in nature
- Severe drop in school performance
- Creative expressions involving themes of death in writings, drawings, poems
- Overwhelming feelings of guilt, shame or rejection

Pay attention to warning signs—get professional advice immediately—this help may save your son or daughter's life!

What to Expect When First Meeting a Mental Health Professional

A Certified Social Worker, Licensed Psychologist or Board Certified Psychiatrist all are credentialed by the State of New York, trained to competently conduct a full clinical evaluation for adolescent depression. The assessment would very likely include clinical interviews with the adolescent, parents, or other important figures in the adolescent's life, and possible later contact with key school personnel. The trained mental health professional will use the information gathered from these detailed interviews to first assess for the level of risk to safety, and then determine what level of intervention or care is required at that point in time.

If the risk of suicide is a significant concern based on the assessment, very likely, that professional will recommend an immediate examination at an emergency room. At the ER, a trained psychiatrist will determine if the safety risk merits inpatient stabilization. If suicide risk is not high, then one of various outpatient levels of care will likely be recommended. The following list is an example of increasing levels of outpatient care recommended for a depressed adolescent: 1) once weekly Cognitive-Behavioral Therapy (CBT) or Interpersonal Therapy (IPT) without medication therapy, 2) twice weekly CBT or IPT with monthly psychiatric follow-up, 3) five-day per week Partial Hospitalization with close medication management. Thus, depending on the nature, frequency and intensity of the depressive symptoms, an appropriate level of care can be offered.

Luckily, Westchester County has an abundance of mental health service agencies and hospitals ready to help you and your family. Any adolescent, who exhibits any possible presenting face of depression can be helped to recover with the assistance of one of our local facilities. MHA of Westchester provides outpatient treatment for adolescents and their families through our New York State Licensed clinics; The Northern Westchester Counseling Center located in Mount Kisco (914) 666-4646 and the Sterling Center with offices in White Plains and Elmsford (914) 345-5900 ext.240. For more information about depression and a list of mental health providers in Westchester County, the following resources will be helpful.

MHA Of Westchester, Information and Referral Service – 914- 345-5900 ext. 240

MHA Of Westchester, Mental Health Website – www.mhawestchester.org

National Institute of Mental Health (NIMH), - Office of Communications and Public Liaison, 301-443-4513, www.nimh.nih.gov

MHA
The Mental Health Association of Westchester

A Place To Turn For Help

Information and Referral

Mental Health Issues
Availability and Locations of Services Nationwide
Educational, Financial, Legal, Social, and Other Support Services

MHA Services

- **Child Adolescent and Adult Counseling**
- **Individual, Family and Group Therapy**
- **Senior Counseling and Support**
- **Domestic Violence Services**
- **Educational Outreach**
- **Vocational Services**
- **Volunteer Opportunities**
- **Consumer Advocacy**
- **Housing Alternatives**
- **Rehabilitation Services**

914-345-5900

Visit Our Website At

www.mhawestchester.org

2269 Saw Mill River Road, Bldg. 1-A, Elmsford, NY

Adolescent Substance Use: A Clear Approach to a Cloudy Issue

Harris B. Stratyner, Ph.D., CASAC
Director, The Retreat at Westchester
New York-Presbyterian Hospital

Allow me to begin by stating I am a licensed psychologist specializing in the field of addiction, but I am also the parent of an adolescent.

Adolescence, that complicated period when an individual is neither child nor adult! It can start as early as ten or perhaps if parents are lucky age 12, and last until 18 or even extend to 20 or beyond, but that is for another article.

Some of you may be picking up a slightly humorous tone, and while humor can serve as a wonderful defense mechanism for parents dealing with adolescents, when you find the words "adolescent" and "substance use" in the same sentence, it is no laughing matter!

Researchers discuss various benchmarks of adolescence which range from moving away from the family, placing more importance on peers, a desire to chart new territory, just to name a few. If these changes weren't enough, they are set against the backdrop of burgeoning puberty—a time when parent's children begin to become capable of reproducing children of their own.

Charting new territory often involves "experimenting" with alcohol and other drugs. Reviewing the literature on adolescent substance use can be confusing—some studies imply that there is a decline in use, while others clearly show an increase. This body of literature is complicated by which substances one is talking about (e.g., alcohol, marijuana, cocaine, heroin, ecstasy, mushrooms, etc.), as well as demographics (e.g., age, gender, socioeconomic status, etc.). Additionally one must consider variables such as family history of addiction.

There is a recent body of evidence that has shown that the adolescent brain continues to go through developmental

Dr. Harris B. Stratyner

stages throughout adolescence—what does this mean? One way to interpret this research is that alcohol and other drugs may be metabolized differently by adolescents, at different stages of adolescence. According to some studies, adolescents may have an ability to be less sensitive to the effects of alcohol and other drugs (e.g., with regard to sedative effects), which would allow them to consume larger amounts of substances, which in turn could produce greater amounts of damage to their developing brains.

Suddenly, one begins to question whether it is simply okay to see adolescence as a time when it is permissible for "experimentation" with alcohol and other drugs. Both as a psychologist specializing in the field of addiction, as well as a parent of an adolescent, I certainly would not want to see adolescents, including my child, risk damaging their brains, which leads me to a zero tolerance stance—but here's where it gets cloudy. If a doctor, counselor or parent is trying to prevent their adolescent from using drugs and alcohol, and they have a zero tolerance perspective, how do they engage the adolescent in a dialogue?

The clear approach is concealed in the question and comes down to the word "dialogue." Mental health professionals have known for many, many years how important it is to communicate with adolescents. Indeed, in a recent study it was shown that one of the most important elements in determining an adolescent's success in getting into a prestigious university had to do with the simple process of the family eating dinner together. One does not have to give their imprimatur to their adolescent(s) that it is okay to "experiment" with alcohol and drugs in order for their adolescent to listen to them. Parents can make it clear to their children that it is not acceptable to experiment with drugs and alcohol in order to have a "normal" adolescence; however, they must also let their adolescents know that they are there for them no matter what occurs.

Some of you may be saying what an obvious approach, but yet parents constantly fall into a trap of trying to show their adolescents that they are "hip" and "cool" (words at least from my generation). I for one, believe that it is especially important during adolescence (when both the mind and body are going through radical changes), for parents to set boundaries and make it clear that they are not their teenagers "buddy or friend," but their parent. It has been my experience that adolescents actually appreciate boundaries, but it is the way the boundaries are discussed that keeps them engaged with their parents.

In my work with adults with co-occurring disorders, I utilize an approach of "carefrontation." Simply defined, carefrontation treats an addicted mentally ill individual without shaming or blaming them, but instead, treating them with respect and dignity while holding them responsible for dealing with their disorders. Shouldn't parents treat their adolescents the same way? If an adolescent is going through a tough developmental period, when they are not only being "attacked" from within by their developing mind and body, but are also having to struggle with peer pressure, parents must be understanding and show what Rogers termed "unconditional positive regard." This does not mean that parents simply say it is okay to use drugs and alcohol—it is not! However, while setting firm boundaries that drug and alcohol use will not be tolerated as the "standard," the adolescent still knows that they can come to their parents and seek guidance and advice from an authority figure that is there for them.

Treating adolescents by establishing clear boundaries and yet being available to them is hard work. It requires time, effort, and perhaps, most importantly, leading by example. I know, if you have read this far, you are saying to yourself, what if my child sees me engaging in the consumption of an alcoholic beverage, for example? The first thing I would say is you are an adult and, although hopefully your mind is open to new information, it is not still undergoing a developmental process. As an adult, if you are 21 or older and do not have a problem with alcohol you have the legal right to consume it. Don't get caught up in the "but you do it Dad," or "you do it Mom" game! However, if you are engaging in illegal activities and your adolescent is aware of these behaviors, you are simply not doing your job as a parent. Certainly, an individual who smokes marijuana cannot turn to their adolescent, and with a clear conscience say, "but I am an adult," when they are breaking the law (I am not here to debate whether or not marijuana should be legalized). So, as parents we need to be clear, firm, but approachable.

In conclusion the most important thing you can do to help your adolescent

see Cloudy Issue on page 46

Westchester County Launches Public Education Campaign to Help Fight Depression

Mary DeVivo, C.S.W.
Coordinator of Community Education

Westchester County launched a public education campaign in May of this year to help residents learn more about depression. The County Executive, Andy Spano, wanted to reach out to individuals suffering from depression to provide information and help. He said, "It is important to recognize that depression is an illness just like diabetes, asthma, or heart disease--it can be treated." This year alone, approximately 16,000 children and adolescents ages 10-18 will be affected in Westchester County.

Depression in adolescents can be difficult for parents to recognize since teens may act "moody" at times and are not always willing to share their feelings. They themselves may not be aware of their own symptoms of depression and may think they are just unmotivated, sad, angry, not good enough or lazy.

Depression in adolescents is increasing at an alarming rate according to the National Mental Health Association and is a serious problem that should be treated promptly.

The Department of Community Mental Health, as part of its public education campaign, has established a special phone line to give out information and make referrals to treatment providers, if needed.

Parents, teens and caregivers concerned about themselves, a friend or loved one should call the Depression Support Network at (914) 995-5236 (English speaking) or (914) 231-2925 (Spanish speaking).

In addition to our phone line, we have also established a new website at www.westchestergov.com/mentalhealth. This site contains information about depression (with a separate link to address signs and symptoms unique to depression in adolescents) as well as information on how to encourage someone to get help.

We have established a free Speaker's Bureau available to schools, recreation centers, religious groups, organizations and businesses. If you are interested in having someone speak to your group, call 914.995.5236. Speakers are also available for Spanish speaking groups.

In The News...at the Office of Mental Health News

Dr. Alan Siskind Elected Chairman of the Board of Directors

Staff Writer
Mental Health News

Mental Health News is pleased to announce that Alan B. Siskind, Ph.D., has been elected Chairman of the Board of Directors of Mental Health News Education, Inc., the parent organization to Mental Health News.

According to Ira Minot, Mental Health News Founder and President, "Dr. Siskind has been a mentor and an inspiration to me from the very early beginnings of Mental Health News. His experience, knowledge and compassion for the mental health community is unsurpassed. Under his leadership, and with the support of our wonderful new Board of Directors, Mental Health News has matured into a growing, non-profit organization that has a promising future and a solid direction."

Dr. Alan Siskind

Dr. Siskind has had an extensive and distinguished career in social work and mental health as a clinical practitioner, administrator, teacher and author. He is Executive Vice President and CEO of the Jewish Board of Family and Children's Services, the nation's premier voluntary mental health and family service agency, which serves over 65,000 clients annually in 185 programs in New York's five boroughs and in Westchester.

Dr. Siskind is called upon frequently as an expert on family issues and the treatment of adolescents and young adults. He has served on numerous human services advocacy groups and special commissions.

Dr. Siskind is the Chair of the Human Services Council of New York and Past President of The Coalition of Voluntary Mental Health Agencies. He is, and 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 and the Council of Family and Child Caring Agencies. He is an adjunct Professor at Columbia University School of Social Work and the Smith College School of Social Work. He has been named a Distinguished Practitioner by the National Academies of Practice.

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

NYS Senator Suzi Oppenheimer Funds Mental Health News Multimedia Project

Staff Writer
Mental Health News

New York State Senator Suzi Oppenheimer, 37th Senatorial District, has notified *Mental Health News* that it has been awarded a Legislative Initiative Grant. The funds will be used for a multimedia project.

The funding will allow *Mental Health News* to design and create informative educational presentations on mental illness, mental health education and advocacy in a format that the organization can bring to conferences, meetings, and special events. Funds will enable the newspaper to acquire a multimedia projector, laptop and supporting software needed for this purpose.

According to Oppenheimer, "*Mental Health News* plays an important role in the community life of Westchester, and I support this organization's vital mission of bringing mental health education to countless individuals and families in need of information, resources and hope."

Janet Segal, Vice Chairman of the Board of Mental Health News Education, Inc., stated: "Senator Oppenheimer has always been a staunch advocate and supporter of mental health causes throughout the State of New York. On behalf of our entire Board of Directors, I wish to ex-press our deepest gratitude to her for helping us acquire the funding needed to bring mental health education directly to the community through this multimedia project."

Board Treasurer, Donald M. Fitch, commented: "Mental Health News began as a "paste-up" newspaper, and has evolved into a digital format over the past several years—giving our graphics much greater clarity. Thanks to Senator Oppenheimer's support, we will now be able to make the leap from digital print media into the latest digital multimedia formats which incorporate audio, video and graphic arts—for visually exciting multimedia presentations."

Senator Suzi Oppenheimer

Your ideas for multimedia projects on the subject of mental health information, education, resources and advocacy are now being collected, and you may mail your suggestions to *Mental Health News, 65 Waller Avenue, White Plains, New York, 10605*.

Graphic Artists interested in volunteering their skills to help design multimedia projects related to mental health education are invited to call *Mental Health News*, at (914) 948-6699 or send us an E-mail at mhnmail@aol.com.

Mental Health News Publisher Floats Vision for *Harbor of Hope* Program: Unique Opportunity for Consumers to Gain Self-Reliance and Test Potential on the Water

Staff Writer
Mental Health News

Consider this. Many people with mental illness spend much of their week working on their recovery. With the help of community and hospital-based clinical services, drop-in centers and vocational programs, consumers are encouraged to regain their place in society. These vital steppingstones are at the heart of mental health services, which provide clinical oversight, therapeutic insight, and group interaction—designed to break the damaging cycles of mental illness.

Outside of this week-to-week routine, however, there are few opportunities for people with mental illness which are outside of the clinical milieu—certainly not one that combines fresh air, builds self-reliance, and taps the potential of people with mental illness to succeed at something they would have thought too difficult to attempt, piloting a cabin cruiser or *tacking* a sailboat out of Mamaroneck Harbor on the waters of New York's Long Island Sound.

It's called *Harbor of Hope*, a concept being floated by Mental Health News Founder and President, Ira Minot, who hopes to interest others with the idea of combining boating and mental health.

"I grew up near Mamaroneck Harbor and have always been drawn to the serenity of being on the water. Prior to my own battle with depression, I had always loved sailing and found it to be an especially challenging activity—one that tested my potential and gave me a feeling of self-reliance. I want to share that experience with fellow consumers to give them a chance to succeed at something they would never consider or might not have the opportunity to try. I believe that we all have untapped potential that can surface by way of a unique event or by someone's belief in their ability to succeed."

With his vision for *Harbor of Hope*, and his own funds, Minot is restoring a vintage cabin cruiser and a small sailboat. He plans to test the waters for funding and ideas to promote *Harbor of Hope* from individual donors and the corporate community.

"My ultimate dream for *Harbor of Hope* is to some day obtain a sloop similar to the *Hudson River Clearwater*. The *Harbor of Hope*, however, would be used to promote mental health education and understanding towards people with mental illness."

Readers who like the idea or who have funding suggestions are urged to contact Minot at the office of Mental Health News at (914) 948-6699.

In The News...at the Office of Mental Health News

Mental Health Leaders Join Mental Health News Board of Directors

Some of the Board: Marge Klein, Alan Trager, Alan Siskind, Donald Fitch, Janet Segal and Michael Friedman

Staff Writer
Mental Health News

Some of the mental health community's leading decision makers from the New York metropolitan area have joined together to form the first Board of Directors of the Westchester based *Mental Health News*, a publication founded in 1999 by Ira Minot of Harrison, New York, a survivor of a ten-year battle with depression.

Mental Health News, a quarterly newspaper devoted to providing vital information, education and resources about mental illness, has become an award winning publication which is distributed to thousands of individuals and families throughout the tri-state region. Unique in its format and content, *Mental Health News* has served to unite service providers, advocates, legislators, as well as the corporate and civic community to support the challenges and hardship of everyday people with mental illness—a segment of our community which is often stigmatized, feared, and misunderstood.

The newspaper's new Board of Directors include: Dr. David Brizer, Chairman of Psychiatry, Norwalk Hospital; Donald Fitch, Executive Director, Center for Career Freedom; Michael Friedman, Public Policy Consultant; Mary Hanrahan, Director of Treatment Services, NY Presbyterian Hospital - Payne Whitney Division; Dr. Carolyn Hedlund, Executive Director, Mental Health Association of Westchester; Richard Hobish, Executive Director, ProBono Partnership; Marge Klein, Executive Director, The Guidance Center; Andrea Kocsis, Executive Director, Human Development Services of Westchester; Margaret Moran, Vice President of Administrative Services – Behavioral Health Services, St. Vincent Catholic Medical Centers; Lisa Rattenni, Vice President of Behavioral Health Services, Westchester Medical Center; Janet Segal, Chief Operating Officer, Four Winds Hospital, Dr. Alan Siskind, Executive Vice President and CEO, Jewish Board of Family and Children's Services; Alan Trager, Executive Director and CEO, Westchester Jewish Community Services; and Dr. Jonas Waizer, Chief Operating Officer, FEGS – Behavioral and Health Related Services.

According to *Mental Health News* Board Chairman, Dr. Alan Siskind, "We are all delighted to join together to help advance the vital educational mission of *Mental Health News*, and we will be focusing our efforts to build a bright future for this organization so that communities throughout the tri-state region can benefit by its message of hope and understanding for individuals and families whose lives have been disrupted by mental illness."

The newspaper has recently acquired a small office in White Plains and is participating in a development project designed by the *Management Assistance Program* at the United Way of New York City. According to Ira Minot, *Mental Health News* Executive Director, "Thanks to the Unite Way's Management Assistance Project, *Mental Health News* will be able to reach out to many funding sources that will be interested in our mission of bringing vital mental health education to the community. This project is a vital first step for our future."

Mental Health News is available free of charge at many mental health organizations in the region, and each quarterly issue is available to read at no cost online at www.mhnews.org.

For more information about becoming a delivery site or to participate in an upcoming issue, contact *Mental Health News* at (914) 948-6699.

Kaplan Family Foundation Awards Grant to Mental Health News

Staff Writer
Mental Health News

The Rita J. and Stanley H. Kaplan Family Foundation has awarded a grant to *Mental Health News* in support of its mission to provide mental health education to individuals and families throughout the New York City region.

Dr. Alan Siskind, *Mental Health News* Board Chairman announced the grant stating: "The Rita J. and Stanley H. Kaplan Family Foundation has always been at the forefront of supporting the arts, medicine, health care, social service/social justice, and Jewish studies. Their generosity is equally felt by myself and the entire Board of *Mental Health News*."

Rita J. Kaplan is a graduate of the University of Wisconsin, Summa Cum Laude, received her Graduate Degree in Social Work at Columbia University and advanced training in family therapy at the Ackerman Institute. Her dedication to human service spans several decades, and her service on boards of many organizations attests to her belief and abilities to help others.

According to Mrs. Kaplan, "Mental Health News was launched by the courage and vision of a survivor of mental illness who was determined to help others who struggle find their way out of the darkness. We believe this is a most worthy project and that the mental health of every community will be better served by this organization's endeavors."

Mental Health News Receives Grants From Westchester & Orange County DCMH

Staff Writer
Mental Health News

Mental Health News has recently received the support of two County Departments of Mental Health, in the form of annual grants, through the New York State Office of Mental Health.

The Westchester Department of Community Mental Health in White Plains, New York and the Orange County Department of Mental Health in Goshen, New York have earmarked annual funds which will support the efforts of *Mental Health News* in its mental health education mission.

According to Alan Siskind, *Mental Health News* Board Chairman, "We are extremely grateful to Jennifer Schaffer, Commissioner of Westchester County's Department of Community Mental Health, and to Chris Ashman, Commissioner of the Orange County Department of Mental Health, for their involvement and support of the newspaper's efforts to bring hope and vital mental health education to the region."

Both Schaffer and Ashman have expressed that their support reflects a desire to enhance the ability of all members of the community to have news, information and education about mental health. By supporting *Mental Health News*, the two County Departments have made a valuable contribution to providing a free and readily available guide to mental health services in the region to individuals and families whose lives are affected by mental illness.

Commissioner Jennifer Schaffer of Westchester County and Commissioner Chris Ashman of Orange County

Mobile Training Team Bridges Digital Divide

Staff Writer
Mental Health News

The Center for Career Freedom is reaching out to its neighboring community agencies to bridge the digital divide by providing an opportunity for the disadvantaged and disabled to advance their education and acquire work skills to become employed at self-sustaining levels.

The program, which began in January, has provided computer resource rooms at the Grace Church Community Center's Open Arms Program for homeless men in White Plains and at NYS Office For Mental Health, Rockland Psychiatric Center, Mt. Vernon Service Center outpatient program.

"The response has been excellent," said Sharon Freeman-Cady, Deputy Director of the Mt. Vernon Service Center. "They are excited to have this opportunity to develop valuable work skills, and we already have a waiting list." In addition to scheduled training sessions, the computer resource room is available for client use 30 hours per week.

The program is operated by the Mobile Training Team from the Center for Career Freedom in White Plains. The Center Team installs and maintains the computer hardware and software, supplies Microsoft certified NYS Education Dept. registered trainers, and provides ongoing technical support. The equipment can be purchased or leased by the contracting agency. Classes offered in computer basics, keyboarding, Internet access, GED preparation, ESL, and Microsoft Office applications, Word, PowerPoint, Outlook and Excel, Access and community resources, games and more.

As word of this unique program began to circulate in Westchester, other community agencies contacted the Center for Career Freedom to inquire about setting up training at their sites. "We're pleased to be able to offer educational and jobs skill classes to our neighboring community agencies at very affordable prices on an "as needed" basis and to provide competitive employment to our graduates" said Donald Fitch, Executive Director. The Center for Career Freedom uses its government and corporate grants and in-kind donations to off-set the program costs.

The Mobile Training Program is an extension of the four years the Center has worked with persons with chronic psychiatric disabilities. In the past 12 months, the Center has trained more than 150 students, and has helped over 75 individuals find employment and transition from government disability to self-sufficiency.

A student completing the Center's training course is certified as a Microsoft Office User Specialist, a rating recognized and accepted internationally. Each student, however, takes a different path to achieving that goal with training tailored to the individual's skill level and learning speed. Pre-tests are routinely given to familiarize students with the testing format and to alleviate the stress associated with the testing process. Some less challenged students become certified within six months; other students may take as long as two years.

In addition to being a Microsoft Certified Training Provider, the Center for Career Freedom is a New York State Registered Business School, a Department of Social Services One-Stop Training Center, a Social Security Ticket-to-Work Employment Network and VESID job placement provider. The staff of the Center operates from a unique perspective on psychiatric rehabilitation since all personnel are themselves survivors of mental illness. Founded five years ago, the Center also serves as a Westchester County Department of Mental Health Drop-in Center and provides case management to more than 350 persons monthly including assistance with housing, food, clothing and transportation. For more information the E-Mail address is donfitch@freecenter.org.

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Columbia TeenScreen Moves Into National Arena

Staff Writer
Mental Health News

With the goal of making mental health check-ups for teenagers in the United States as routine as vision and hearing tests, the Division of Child and Adolescent Psychiatry at Columbia University College of Physicians & Surgeons has launched a campaign to implement the Columbia TeenScreen Program nationwide. TeenScreen offers evaluation and treatment for youngsters contemplating suicide or suffering from other mental illnesses and has been successfully established in schools in the New York City area and in 66 communities in 27 states over the past two years.

"Suicide is the third-leading cause of death among young people aged 15 to 19," says Leslie McGuire, Director of the TeenScreen Program. The program sponsored a recent poll surveying parental attitudes toward, and knowledge about, teenage depression and suicide. The poll found that 80 % of parents with children aged 18 or younger are concerned about depression and suicide among teenagers in general as well as in their own children. They are also concerned that their children might be harmed physically or psychologically by another depressed or suicidal teen. A majority of parents sampled think schools must play an important role in identifying students at risk and would consent to having their own child screened or tested. They also believe that funding depression and suicide prevention programs is as important as funding drug prevention programs.

Early Intervention Essential

The wide parental acceptance of screening and increased media attention to acts of violence in the schools are important factors driving the current campaign to establish Columbia TeenScreen on a national basis.

"It is time to challenge the American public to squarely confront the right of every youngster to a mental health check-up," says Laurie Flynn, National Director for implementation of the TeenScreen Program at the Carmel Hill Center for Early Diagnosis and Treatment, a privately funded public health advocacy center within the Columbia Division of Child and Adolescent Psychiatry. Flynn believes the knowledge gained over the past two years from implementing the program provides a solid basis for devising strategies to engage those at the highest levels of educational policy making.

The Center will work with school districts, national educational policy organizations, legislators at the state and federal level, and the media to raise awareness and gain support for the program. "Poor grades, experimentation with substance abuse or behavioral difficulties in the classroom may be attributable to a clinical depression or severe anxiety that could be treated," says Flynn. "If these problems are identified early, we can improve not only these children's lives but the future of society as a whole."

The Origins of TeenScreen

The Columbia TeenScreen Program was developed from the research of David Shaffer, MD, Director of Child and Adolescent Psychiatry at Columbia and Director of Pediatric Psychiatry at NewYork-Presbyterian Hospital. In 1992, dissatisfied with the outcomes of traditional suicide prevention programs, Shaffer evolved a simple but effective diagnostic tool that could identify youth at risk for suicide and ensure that they received treatment.

The school-based screening process that resulted has two phases: First, students complete a brief questionnaire that assesses for psychiatric symptoms. Those who screen positive continue to the second phase, a computerized diagnostic interview that can diagnose a full spectrum of mental disorders. Youngsters identified as having suicidal thoughts or who meet criteria for a disorder are evaluated further in an interview with a mental health professional. After discussion with the student and parents, a referral may be made for additional evaluation or treatment. The technology for the program and training in its use are offered free of charge by Columbia to schools that have staff available to administer it.

Enhancing a Teen-ager's Outlook

One young woman's experience illustrates the difference early mental health intervention can make. Hilda, a student who was tested by TeenScreen in 1998 as a Bronx high school sophomore, participated reluctantly when the program was first offered at her school. Although she was unhappy, had few friends and was troubled with suicidal thoughts, she was uncomfortable about revealing her private feelings during the screening. However, with encouragement from the TeenScreen team, Hilda completed the process and was referred for a year of counseling. During that year, she developed confidence in her therapist, with whom she devised practical ways to deal with her problems. Most important, she gained a more hopeful perspective on life.

"I don't think I would still be alive today if I hadn't gone through with the program," Hilda said recently. She continues to stay in close touch with the staff at TeenScreen. Currently a sophomore in college and planning to become a psychologist, Hilda would encourage every high school student to take advantage of the program.

For further information about the Columbia TeenScreen Program, call toll-free (866) 833-6727; e-mail teenscreen@childpsych.columbia.edu; or visit the web at www.teenscreen.org.

NewYork-Prebyterian Psychiatry

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The Westchester Division

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The psychiatric services of NewYork-Presbyterian Hospital are ranked among the nation's best by *U.S. News & World Report*®.

To make a referral or for further information, please call:

Columbia Psychiatry (212) 305-6001

Weill Cornell Psychiatry (888) 694-5700

www.nyppsychiatry.org

NewYork-Presbyterian
The University Hospitals of Columbia and Cornell

Columbia Psychiatry

Columbia Presbyterian Medical Center
622 West 168th Street
New York, NY 10032
212-305-6001

The Allen Pavilion
5141 Broadway
New York, NY 10034
212-305-6001

Affiliate

New York State Psychiatric Institute
1051 Riverside Drive
New York, NY 10032
212-543-5000

Weill Cornell Psychiatry

The Payne Whitney Clinic
525 East 68th Street
New York, NY 10021
888-694-5700

The Westchester Division
21 Bloomingdale Road
White Plains, NY 10605
888-694-5700

Depression in Gay and Lesbian Teens Addressed At Westchester Jewish Community Services *Center Lane Program*

By Sara Braun, Program Director WJCS, Center Lane Program

Social isolation is the antithesis of healthy adolescent development. It is not normal for teenagers to spend time alone, to be disconnected from peer groups and to be uninvolved in romantic relationships. However, the reality is that society's stigma against gays and lesbians can thwart normal, healthy adolescent development and lead to serious depression. Homophobia—the irrational fear or hatred of homosexuality—and Heterosexism—pervasive societal messages that heterosexuality is superior or the norm—contribute to internal conflicts for adolescents who, by nature of their developmental stage of life, are more vulnerable to social pressures. If the increased sexual and romantic feelings that occur in adolescence are homosexual in nature, they compete with an intense need to be socially accepted. The challenge of adolescence is to develop an integrated, unique sense of one's identity within a social context. For younger adolescents, "fitting in" with friends is the most important thing. As adolescence progresses, it becomes increasingly important to feel that one is unique - individuated from parents and somewhat different from friends, but still loved and approved by all. If a young person's family, community or school is particularly homophobic—or even unaware of the presence and needs of gay youth—then their options for a successful integration of identity can be compromised.

Imagine this: "Eric S." attended a very homogenous high school in Westchester. Diversity of any kind was not well tolerated at his school by students or by faculty. There were no "out" gay or lesbian students that Eric knew of, and no "out" gay or lesbian teachers. Kids in the school openly taunted the one teacher who was rumored to be gay. Homosexuality was not mentioned in the academic curricula; there was no mention of famous gay and lesbian people in history; no discussion of the Gay Civil Rights movement. The only reference to homosexuality that Eric could recall was in the context of a discussion about AIDS in his health class. In addition, Eric was a starting player on a major varsity sports team at his school and heard anti-gay language from his teammates on a daily basis. (GLSEN estimates that the average student hears the word FAGGOT over 25 times each day at school). At times, Eric himself used anti-gay slurs with his teammates so that they wouldn't suspect that he was gay.

But Eric was gay. His same-sex crushes and desires were growing stronger all the time in proportion to his resentment of these feelings. The challenges facing Eric were many. How would he maintain a positive sense of self in a homophobic environment as it became clearer to him that he was gay? Who, if anyone, could he trust with his feelings? Could the people who he grew up with still be his friends if they didn't know one of the most important things about him? Would he get physically hurt if people found out about him? And, if he could somehow manage to feel safe and somewhat good about himself, who would he date?

The development of depression under these conditions can be rapid and debilitating. Because adolescence is spent intensively in the "here-and-now," many teenagers lack the perspective that life could be better in the future. Many studies have shown that gay and lesbian teenagers are at significantly higher risk of attempting suicide than are their heterosexual peers.

Center Lane, a Program of Westchester Jewish Community Services, was created almost eight years ago to address the social and mental health needs of gay, lesbian, bisexual, and questioning (glbq) youth in Westchester County. The services provided by Center Lane can offer rapid relief to gay and lesbian teens who suffer from depression caused by feeling isolated and "different." Weekly support groups offer adolescents a chance to share common struggles about coming out to family, questions about sexual identity, school pressures and dating. Social activities offer these youth an opportunity to have fun and fit in with a group of peers. Individual counseling and advocacy are tailored to the needs of clients and their families.

Because it is important to address the societal causes of isolation and rejection of gay and lesbian youth, Center Lane has an educational component with the goal of raising awareness in the community about the needs of gay and lesbian people. The program employs a Community Educator, who goes to schools, social services agencies, and parent groups, offering tailored workshops on gay and lesbian issues. Center Lane also co-sponsors *Healing the Hurt*, an annual full day conference that explores ways to create more accepting communities, schools, and social services for gay, lesbian, bisexual, and transgender youth.

see Center Lane on page 40

Noted Filmmaker Reclaims Her Past In Documentary About State Hospital Stay During The 1960's

By Alan Menikoff, MSW, MBA Mental Health Cosultant

Before deinstutionalization was a phrase in the mental health field, before civil rights legislation offered legal protection to the less powerful (youth, minorities, etc., thousands of Americans were detained under the name of "psychiatric care." We now refer to this as "warehousing," but in the 1950's and into much of the 60's, tens of thousands of young and not so young men and women were forced into such a hospitalization...often in state psychiatric hospitals. (In the 1950's, in New York State alone, the average daily census of the state inpatient facilities numbered 90,000+; it is now well below 15,000.)

There have been first-person written accounts of such coerced—and often unnecessary—hospitalizations. But few if any, histories are told in the first person, or on film by an accomplished filmmaker. Lucy Winer is preparing just such an account.

Lucy Winer is a noted documentary filmmaker who was diagnosed with schizophrenia as a teenager in the 1960's, committed to a state psychiatric hospital - Kings Park, now closed - and moved about to several other institutions. She is now in the process of revisiting Kings Park, making a film about her recollections and those of key persons who were, or are currently involved - such as her admitting physician, attendants, other patients, local politicians, townspeople, and others - who were part of the fabric of the experience.

Filmmaker Lucy Winer at Building 21 where she was once hospitalized

Lucy's saga began after attempting suicide in 1967 at age 17. What followed was a two-and-a-half year period of incarceration. Misdiagnosed as a chronic schizophrenic, Lucy has not shown any symptoms consistent with such a diagnosis in the intervening years . She was committed to a series of institutions culminating with a harrowing stay on the violent ward at Kings Park. This was at a time when state and county asylums were organized as warehouses, rather than treatment facilities, for the acutely and chronically ill.

In this harsh setting Lucy met Phyllis, the only other young patient on the ward. They became fast friends, then fell in love, only to be forcibly separated and humiliated when their relationship was discovered. Two and a half years later, when she was finally released, Lucy put away this painful chapter of her life, not able to look back. It wasn't until she turned fifty, with decades of a life outside to bolster her confidence, that Lucy decided, in her words, "…to face my past and reconcile with the troubled teenager I left behind. Why exactly had I attempted to end my life, and why were the consequences so extreme? When so many others were defeated by the system, by what means did I manage, after so long in incarceration, to reenter the world and ultimately lead a productive life. 'Kings Park' follows my struggle."

In an effort to reclaim her past or perhaps understand that remote period, Lucy gained access to the grounds and buildings of the now abandoned state hospital and the psychiatric records of her stay there.

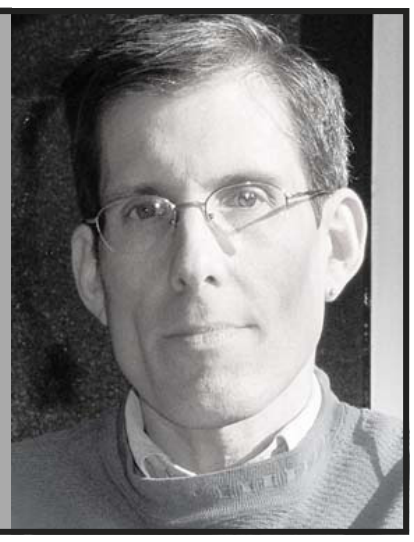
But this film goes beyond one woman's struggle to understand a very difficult period of her life. What emerges is a social statement as well.

On camera and off, Lucy captures the spirit, frustration and attitudes of former staff and patients. They all contribute to a (re) creation of individuals' experiences of this hidden and often unspoken world.

see Filmmaker on page 40

A Voice of Sanity

A Column by Joshua Koerner
Consumer Advocate and Executive Director,
CHOICE, New Rochelle, New York



The Truth About Compliance

Let's play Who Said It? "Wouldn't life be easy if all patients followed prescriptions to the letter? What stops a patient from complying? Why won't they listen to sage advice?"

Was it Dr. E. Fuller Torrey, America's leading advocate for forced treatment? The president of NAMI? My mother? Actually, it's a quote from an article in Progress in *Transplantation*, the journal of the North American Transplant Coordinators Organization.

Noncompliance is a serious problem for people who receive other people's organs; immunosuppressant and antiviral medications need to be maintained throughout the course of the patient's life, and yet medication compliance has a tendency to worsen over time. This will inevitably lead to organ rejection, and, if another organ cannot be found, death. Yet even this reality is not enough to ensure compliance.

Let's look at a completely different area of medicine. According to the *Journal of Clinical Hypertension*: "Despite the fact that we have in excess of one hundred drugs for the treatment of hypertension and that billons of dollars (12 billion in the United States alone) are spent on the treatment of hypertension annually, blood pressure control is achieved in less than one quarter of hypertensive patients. There are multiple reasons for these poor blood pressure control rates, but one of the most important remains patient compliance."

The title of yet a third article says it all: "Barriers to Colorectal Cancer Screening: Part 1 – Patient Noncompliance."

Noncompliance is a factor throughout all medical specialties, not just mental health. Indeed, the impact is enormous, according to the *American Journal of Health-System Pharmacy*: "Medication nonadherence poses a major threat to the health and well-being of the US population and is financially very costly. It is estimated that nonadherence to prescribed medications causes nearly 125,000 deaths per year. Ten percent of hospitals and 23% of all nursing-home admissions are linked to nonadherence. A third of all prescriptions are never filled, and over half of prescriptions that are filled are associated with incorrect administration."

That's a third of *all* prescriptions unfilled, half of *all* prescriptions used incorrectly, not just those for psychotropic meds. One of the great canards of mental health treatment is that mental patients don't take medications properly because they are mentally ill. That's demonstrably false; if they don't take medications properly it's because they're no different from transplant patients, hypertension patients, cancer patients or any other kind of patient.

That's a very, very significant reality because mental patients are treated differently from other kinds of patients. There are no laws mandating the treatment of high blood pressure, no Kendra's Laws that compel people to submit to colorectal cancer screening. Noncompliance for those patients is potentially deadly, and yet we allow them to resist treatment. This is not so with people diagnosed with mental illness.

The very word "noncompliance" is stigmatizing. Again, from the *American Journal of Health-System Pharmacy*: "Although 'adherence' is generally recognized in the medical community, 'compliance' has more frequently been used. Patient compliance is not synonymous with adherence. Compliance may suggest a passive approach to health care on the part of the patient. This paternalistic view of the patient may not encourage the patient to take an active role in his or her health care and may limit the responsibility the health care practitioner accepts for a less than optimal outcome."

That's certainly true of many mental health practitioners, in spades. Repeatedly we are given the message that we need to listen to them, they know best, and if we don't, they'll chase after us with Assertive Community Treatment teams, take us to court, have us committed to locked inpatient units or placed under supervision in the community.

What's wrong with that approach? Even if mental patients aren't different from other patients, every one of these articles makes the case that nonadherence is dangerous, damaging, potentially life threatening. Aren't we mentally ill the lucky ones because our system cares enough to compel us to comply?

Not exactly. To understand why, it's necessary to understand why so many people, with so many illnesses, don't do what their doctors tell them to. Again, from *Progress in Transplantation*: "Strong evidence exists showing that resistances are also a healthy part of the person's attempt to cope with life circumstances—even when the resistance pattern is maladaptive. These resistances protect the patient from experiencing cognitive and emotional reactions (unconsciously) deemed to be more threatening than the situation in which he or she already is."

That means that it's difficult to be a patient of any kind: difficult to be sick, difficult to have someone else's heart beating inside your chest, or face the possibility of cancer. It is that much more difficult to have an illness toward which there is widespread cultural fear and approbation. "Lunatic," "whack job," "nut job," "mental case," "head case," "basket case;" the list of epithets goes on and on. What sane person wouldn't resist the idea of belonging to society's lowest caste?

Now then: if noncompliance is an effort at self-protection, what's the worst way to respond? That's right: coercion, the number one response of the mental health system.

In the case study described in the journal article, a heart transplant recipient actually started smoking! And why? The study states: "All too often, well-intentioned efforts to help patients resolve their noncompliance prematurely override their protective defenses and thrust them into greater perceived jeopardy. In response to this new and unwanted assault, patients will resort to oppositional action – an even more entrenched noncompliance."

What's the solution? In article after article, "patient involvement in their treatment" is highlighted. Whether it's called "shared decision making" or "providing an environment of cooperation," the research is clear: power and conflict only leads to resistance.

How ironic that power, conflict, force, coercion, and involuntary treatment lie at the heart of the mental health system. Let's put aside for a moment the sheer unfairness of it, the lack of due process, and the fact that people with mental illness are treated differently from all other patients because the facile response to that argument is, "Well, if it saves one life, it's worth it." It doesn't save lives, not in the long run. It drives people away from help, and makes them more likely to resist treatment in the future. Coercion causes noncompliance. We have the proof.

My next column: A Better Way!

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By J. David Seay, J.D.
Executive Director
NAMI-NYS

J. David Seay, J.D.

New York State Office of Mental Health Commissioner James L. Stone has left for Washington, D.C., to be Deputy Director of the Substance Abuse and Mental Health Services Administration. He has been a good friend to NAMI in his many years at OMH and we wish him well in this important position. Another NAMI friend, Sharon Carpinello, was appointed Acting Commissioner, and we are pleased to see that OMH remains in professional and competent hands; we also wish her well and express our support.

This past legislative session in Albany was one for the record books. With multi-billion dollar deficits, dueling executive and legislative budgets, vetoes and overrides, it has been quite a year. NAMI leaders began early to lead the fight for mental health care on many fronts. "Fight for research," "fight for housing," "fight for a plan," "and fight for parity" were our battle cries. The proposed budget would have seriously damaged New York's mental health research capacity, shuttering the Nathan Kline Institute for Psychiatric Research (NKI) in Rockland County and cutting deep into the Psychiatric Institute in Manhattan. The need for more supported housing continues, even in the face of Clifford Levy's Pulitzer Prize-winning New York Times series on the adult home scandal and psychiatric hospital closures being proposed even without a long-term plan. And New Yorkers, both adults and children, continue to suffer under inadequate insurance coverage for mental illnesses that are highly and effectively treatable. Other policy issues of concern to NAMI included efforts to save Medicaid dollars by restricting access to medications and a movement to outlaw the use of "special housing units" in state prisons, the 23-hour solitary confinement cells known as the "box" or "hole" for persons with mental illness.

When the smoke cleared, NKI and the cuts to PI were saved and hospital closures halted. A small budget hike was won for 1,000 new housing units, coming from the work of the State's adults homes work group. There were some successes in the planning area, too. Due to the eagle-eye of Founding President Muriel Shepherd, at the last minute language was re-inserted into the reinvestment part of the budget bill that would continue county mental health subcommittees – which include consumer and family members – as part of the planning process. And the Mental Health Services Council, an advisory body to OMH, held hearings on this year's "Statewide Comprehensive Plan for Mental Health Services," required by section 5.07 of the Mental Hygiene Law. NAMI-NYS supports thorough, fair and balanced long term planning for mental health housing, programs and services, and looks to OMH for leadership.

And the fight for mental health parity through TLC—Timothy's Law Campaign—has gained momentum. With the arrival on the scene this year of the courageous couple from Rotterdam, Tom and Donna O'Clair, parents of Timothy, whose young life was sadly lost to suicide and inadequate health insurance, the parity movement has grown by leaps and bounds. The newly crowned Miss New York State, Jessica Lynch, has also joined forces with TLC pressing her campaign platform on teen depression. All New Yorkers are now looking to Senate Majority Leader Joseph Bruno to do the right thing and let the Senate vote on the bill when the Legislature returns.

Other news is that Michael Hogan, Chair of President Bush's New Freedom Commission on Mental Health, will give the keynote address at our Annual Meeting and Educational Conference, "The Mental Health System of Tomorrow: Making the Future Better than Today," September 19-21, 2003, at the Clarion Riverside Hotel in Rochester. The Commission just issued its report, "Achieving the Promise: Transforming Mental Health Care in America," and Dr. Hogan will comment on it with reaction to it from the President and others. A number of scholarships (including registration and hotel) will be offered to NAMI-NYS family and consumer members on a lottery basis, and free bus transportation will be offered to downstate residents, with pick-up locations on Long Island, New York City and Rockland County.

The events start with "Mental Illness & Criminal Justice: Making the System Work Better," on Friday, September 19th. Discussion panels on mental health courts and jail diversion programs and on Project LINK in Rochester, which brings together service agencies to meet the needs of persons with mental illness facing the criminal justice system, will be featured. There will also be a session on dual diagnosis recovery programs.

Saturday the NAMI-NYS Annual Business Meeting and a plenary session with special guests will take place. OMH officials will provide a presentation on the new Medicaid-funded "Personalized Recovery-Oriented Services" or PROS. Luncheon speaker will be Dr. Steven B. Schwarzkopf, Clinical Director of the Rochester Psychiatric Center, on "The Consumer Gets the Facts: Accurate Measures of Symptoms, Cognition, Awareness of Illness and Brain Electrical Activity Enhance Treatment at Rochester Psychiatric Center."

Workshop topics include: schizophrenia, depression, bi-polar, cognitive dysfunction, housing options, family involvement, legislative advocacy, legal issues, child and adolescent issues, school curricula on mental illness and consumers' experiences on the road to recovery.

Sunday closes with a medical session featuring, "Identifying Biological Predictors of Anti-Psychotic Drug Response," "Newer and (Hopefully) Better Medications: The Present and Future of Effective Psychopharmacology" and the ever-popular, "Ask the Doctor." For more information call (800) 950-FACT.

NAMI-NYS proudly continues and expands our Family-to-Family and Peer-to-Peer Training Programs, pursues advocacy and outreach through our Criminal Justice Program, and begins a new project to help smaller affiliates incorporate and obtain tax-exempt status. In all this NAMI-NYS is blessed with a strong grassroots movement, including our dedicated Board of Directors and other volunteers, 58 affiliate organizations and 5,000 members across New York, all working to improve the lives of all whose lives are affected by mental illness. This is our calling; our mission.

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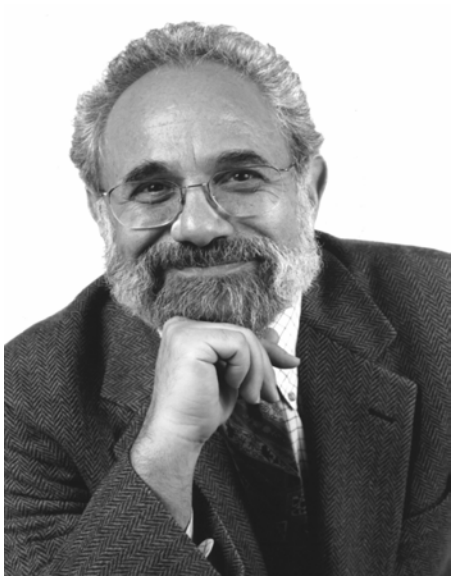
POINT OF VIEW

POINT OF VIEW

By Michael B. Friedman, CSW



Michael B. Friedman

Advocate NOW For Mental Health Funding For Next Year in New York State

Now is the time to begin to advocate for a decent budget for mental health in 2004-5. That may seem strange since the current year's budget passed just a couple of months ago. But state departments are currently working on budget proposals for next year that potentially will have a vast impact on people with mental illnesses. They will submit their proposals to the Governor and the Division of the Budget in early Fall, and the Governor will submit his budget request to the NYS Legislature in mid-January.

What are the key issues for next year?

No cuts for community mental health services

Since New York State still faces substantial economic challenges, the Governor will probably take the position that state spending cannot grow, indeed that there will have to be some cuts. We need to fight against cuts to community mental health services, and in doing so we should insist on two general principles.

- First, we need to be clear that lack of funding to enable community mental health services to keep pace with inflation is a cut. If the cost of living goes up—and it will—and funding for mental health services does not increase accordingly, mental health services will have to be cut. For health care, the state administration presents failure to keep pace with inflation as a cut. It does not use the same analytic approach for mental health services. We should provide the correct analysis, and we should advocate for enough mental health funding to maintain current services.
- Second, not all funding for community mental health services is in the budget of The Office of Mental Health. For example, last year cuts to psychiatric services provided by general hospitals were contained in the budget of the Department of Health, and some cuts to services for children with serious emotional disturbance were in the Department of Education budget. Community mental health advocates should fight for adequate funding for the entire community mental health system including: community mental health agencies, outpatient and community support services provided by general and state hospitals, inpatient services provided by general hospitals, and other mental health programs supported by various state agencies.

Reinvestment, reduced census, and hospital closures

With the exception of the infusion of funding that the Governor provided when Kendra's Law was passed, during the past decade, the growth of mental health services and some funding increases for current programs have depended on reinvestment of savings from reductions in state hospital beds or state hospital closures.

It is important to continue to fight for the principle of reinvestment. But we also need to be cautious about the impact of reductions in the state hospital system. Last year the Legislature rejected the Governor's proposal to close more state hospitals largely because his proposal did not include a clear plan about how alternative services would be provided, what the fate of state workers would be, and how local communities would be helped to deal with the economic impact of the closures.

We should support full funding of Reinvestment in the coming year, but we should also insist that the administration engage in a meaningful public planning process prior to closing more state psychiatric centers.

Housing

Residential programs are at the core of NYS's system of helping people with serious mental illnesses and children with serious emotional disturbances to live in the community. Unfortunately, funding for existing programs has fallen well behind inflation over the past decade. This has resulted in rapid staff turnover, high staff vacancy rates, and potentially hazardous conditions. It is critical to provide increased funding to stabilize existing programs.

In addition there are substantial unmet housing needs. Homelessness is at its highest level in history in New York City. Last year's revelations about the scandalous conditions in some adult homes have made it clear that at least 6000 units of community-based housing should be substituted for inappropriate living arrangements in adult homes. People leaving state and local hospitals need adequate housing in the community. And the children's mental health system has an inadequate supply of residential alternatives to institutional care. Both capital and operating funds are needed to expand residential opportunities in New York State.

Children's Mental Health

The need for expansion and reorganization of mental health services for seriously emotionally disturbed children and adolescents has been documented repeatedly over the past twenty-five years. There has been limited growth of community-based mental health services for this population, but not at the pace planned by the state ten years ago. The coming year's budget should provide for further growth of traditional mental health services for children and adolescents and at a more rapid pace.

Adult Homes

Adult home reform in NYS is imperative. In addition to the housing development noted above, there needs to be substantial improvements regarding mental health and medical services, medication management, oversight and enforcement, assistance moving to the mainstream community, funds to meet personal needs, etc. The coming year's budget should address these issues.

Substituting Medicaid for State Aid

In recent years, the State has held funding for mental health services constant by substituting Medicaid funding for state aid to localities. This approach has been beneficial, but this year two key issues need to be confronted.

- First, OMH has proposed a new form of licensure called "Personal Recovery Oriented Services" (PROS). It has aroused controversy regarding impact on service delivery. Will there be enough money? Will good programs be forced to drop effective, non-medical models? Answers are not yet available; therefore, the state should be cautious about predicating a budget on PROS.
- Second, the federal government is pushing for a major change in Medicaid, which would limit future federal financial support. Is it wise to continue to expand reliance on Medicaid at this time?

It may seem foolish to call for increases in spending on mental health services and to question the expanded use of Medicaid as a device to preserve services at a time when New York State is experiencing vast financial problems. How can advocates ask for more when overall cutting appears likely?

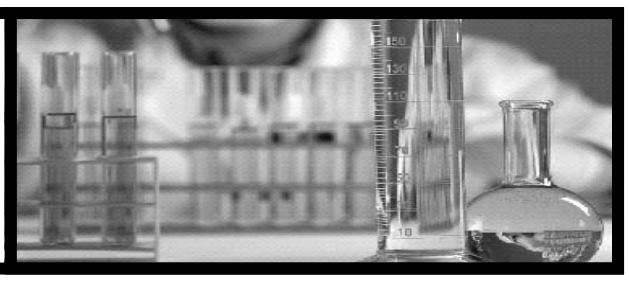
There are two responses. The next budget will be an election year budget, and election years are generally more generous the non-election years. More importantly, given the instability of the current mental health system and vast continuing unmet needs, how can we ask for less?

Michael Friedman is the Public Policy Consultant for the Mental Health Association of NYC and the Mental Health Association of Westchester. The opinions expressed in the article are his own and do not necessarily reflect the views of the MHAs.

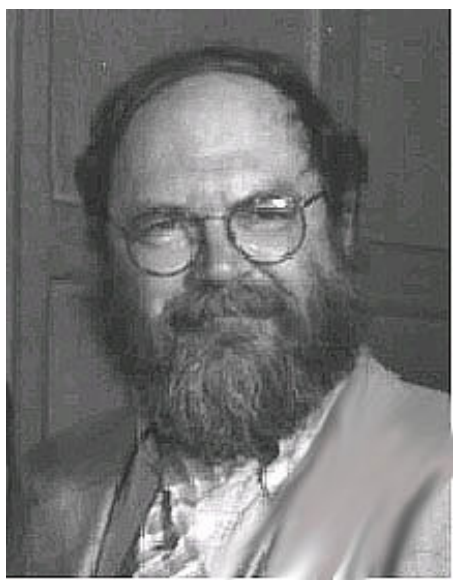
Send a Message of Hope to Someone in Need With a Subscription to Mental Health News: See Page 59

WORKING WITH MEDICATIONS

How Do Doctors Choose Medications? Part 3. The Place Where Treatment Takes Place



By Richard H. McCarthy M.D., C.M., Ph.D. Comprehansive NeuroScience



Dr. Richard H. McCarthy

In previous columns, I have tried to address some of the many factors which influence a physician's choice of medication for a given patient. Thus far we have discussed issues related to the patient and the problem that the patient has. Obviously, who the person is and what the problems and symptoms are have a major influence on medication choice. In the last column we discussed issues related to the pill itself. Some of the specific pharmacological properties of a drug will have a direct influence on medication selection. Drugs which have a rapid onset, or stay in the body for a short period of time are useful for some problems but useless for others. There are still other factors that impinge upon the choice of a medication, such as the treatment setting. It should not be a surprise that the choices of medication that are made will have something to do with where the medication will be given.

People can receive medications in either the inpatient or outpatient setting. People who are on an inpatient unit are generally there because they cannot be anywhere else and receive treatment. This can be because they are in a very severe phase of their illness and are unable to adequately take care of themselves. Alternatively, safety can be a major concern. Sometimes, there is the real possibility that a patient's judgment is so impaired by his illness that he may become aggressive towards others or even suicidal. These violence and severity level issues tell us something about who gets admitted to inpatient units; it says little about how long they stay there. In New York, as in the rest of the country, the operating hypothesis is that the fastest treatment is also the best treatment. A primary goal when people are so severely ill is to establish control over the illness and the violence and to help that person return to the community. As a result, physicians usually use medications which are very rapid in their onset and often in doses that would be considered to be quite high outside of the hospital. Since hospitals are relatively well staffed, patients can be closely observed when they are on such intense medication treatments. Since most psychiatric medications take a long time to work, there is also a tendency for physicians to use several medications simultaneously. There is rarely a good clinical rationale for withholding treatment and needlessly prolonging patient suffering as we wait for the medications to become effective. Moreover, it is imperative that sufficient control of the violence and illness be obtained rapidly to prevent harm to the patient and those around him. The medications that are useful in establishing such control may have little to no utility in helping the patient recover from his illness. In the inpatient setting, the patient is expected to be passive and accepting of medication as it is prescribed. On the inpatient unit, the patient's preferences about medication selection are important but not decisive. Those patients who resist or refuse will either find themselves discharged or in court. While everyone prefers to avoid it, it is possible for the physician to obtain a court order for mandated medication. Virtually all hospitalizations are shorter than the time it takes for psychiatric medications to work. As a result, almost every patient will be discharged only partially recovered, and often, on a good deal more medication than may be needed to simply control the illness.

In the outpatient sector, patients are generally less ill. They can be less ill because they could be leaving the hospital, partially recovered; or they could be deteriorating from a higher level of function, i.e., they are getting sick; or they can be chronically ill and involved in the process of recovery. Treatment usually takes place at a much slower pace. A primary goal of outpatient treatment is to prevent deterioration and relapse, and the easiest way to have a patient relapse is to make frequent and major medication changes.

The patient, the family, and the treating physician tend to want the patient to remain at the highest level of function in the least restrictive setting as possible. There are four such outpatient settings where treatment can take place. They are: partial hospitals, continuing day treatment programs, clinics, and assertive community treatment programs.

Patients who need to be seen on a daily basis during the week but do not need to sleep in the same place where they receive treatment can attend day programs. There are two kinds of such programs, and they are differentiated from one another based on the patient's phase of illness. People who are actively relapsing, but still safe and cooperative and people who are recovering from a recent hospitalization often go to partial hospitals. In general, the people who attend such programs are among the more ill of the outpatient sector, but are less ill than inpatients. The expectation is that patients in a partial hospital are acutely ill but are quite likely to rapidly return to their normal behavior. Medications tend to be used a bit more aggressively here to foster this return. Patients are expected to cooperate with treatment and to work hard to stay safe and get better.

Continuing day treatment programs work with a different clientele than partial hospitals and have a somewhat different treatment goal. Patients who attend continuing day treatment programs are chronically ill. For many years, it was thought that chronically ill individuals never recovered. This is false. Almost all patients recover to some degree. Unfortunately, they recover very slowly and sometimes not completely. In fact, chronically ill patients have a much slower rate of recovery in all phases of their illnesses, even when they become acutely ill. In continuing day treatment programs medication changes are made very slowly, if at all. Rather than use a pill for every problem, these programs try to teach these people new skills. The aim of treatment is to help people move forward with their lives.

Clinics are for patients who do not need to be seen on a daily basis or are so uncomfortable with groups that they can not attend either a partial or continuing day treatment program. Usually, clinics are for people who are among the least ill in the outpatient sector. Often clinic patients are sufficiently recovered so that they are able to manage their own self care and the ordinary stressors of their lives. Many patients who have returned to work or school attend clinics because they are simply too busy to participate in any other more frequent level of care. Patients are typically seen once a week by their treating physician. As patients recover, they are usually seen less frequently.

All of the aforementioned outpatient forms of treatment rely on the patient showing up for the appointment. Either the patient does so on his own or someone must bring him in. For many years people could not get care because they could not or would not go near a hospital or any other treatment facility. Today, such people are best served by assertive community outreach teams. The teams take treatment to the place where the patient is. These outreach programs have been quite rare in the past, but are becoming increasingly more common. Assertive community treatment teams are also used for people who simply can not comply with the demands of day treatment programs or clinics. Not all people can conform to the scheduling requirements of outpatient treatment systems. It is surprising, but not unusual, to find that a person who has not been able to get out of bed by noon is given a clinic intake appointment on the other side of town at 8 a.m. When the patient does not show up, he is discharged and said to have been non-compliant with treatment. Curiously, these patients are often among the most ill patients in psychiatry. Often they are more ill than people who are in hospital!

The values that drive treatment also change based on the venue. Inpatients are less involved in their treatment decisions than outpatients. Everything is moving faster; many and large doses of medications are being used simultaneously for a multiplicity of problems. Dramatic changes in medication can take place rapidly on the inpatient unit because the patient can be closely monitored around the clock for significant adverse effects. In general, patients are discharged from the hospital well before the time it takes for a medication to be fully effective. Physicians respond to this delayed recovery by using higher doses and multiple medications. Even though this is common practice, there is not a good deal of information to suggest that it is helpful. Certainly, raising the dose of medication is not usually associated with faster or even better recovery. In the outpatient sector, things are done more slowly and typically people are removing some of the medications that a person was started on during their last hospitalization. On the other hand, those patients that have not been hospitalized in some time often seem to end up on additional medications. These are slowly added on to the treatment in an attempt to address problems that have emerged over time. This is a debatable practice because there is a tendency to use medication for problems that can not be solved with medication or may not be very helpful for. For example, not every episode of sadness is depression and normal sadness should not be treated with a pill. As outpatients, people are expected to accurately monitor and report not just their symptoms but also their side effects. As such, patients are much more active in treatment and their preferences can, and should, carry more influence than in the inpatient setting. Put otherwise, as an inpatient, one is a passive recipient of services, and as an outpatient one should be an active collaborator in the recovery process.

An oddity of psychiatry is that the most services and the most money tend to be where the fewest patients are. Put otherwise, inpatient settings are terribly expensive, and staff heavy, but most patients are not there. Even when the patients are there, they are not there for long. Psychiatry is the only field in medicine where those who are the sickest actually have the least amount of services made available to them. In the next column I will discuss how some of these inequities in treatment funding influence medication selection, patient care and, ultimately, recovery.

the NARSAD *report*

The National Alliance for Research on Schizophrenia and Depression

By Constance Lieber, President NARSAD

Constance Lieber

Adolescent Depression

Occurring earlier in life than in past decades, depression in adolescents is common, recurrent and associated with significant mortality. Often, depressive disorders in adolescents go unrecognized by families and physicians because the symptoms are viewed as normal mood swings typical of the teenage developmental stage. This can have tragic consequences as mood disorders can affect the functioning and adjustment of teenagers, leading to an increased risk for substance abuse and suicidal behavior.

During the period from 1952 - 1996, there was a tripling of suicide rates among adolescents and young adults—with a 14 percent increase in suicide among adolescents aged 15 to 19. In 1999, suicide alone accounted for 12 percent of all deaths for people in the 10 - 24 age range. These disturbing statistics have prompted the U.S. Surgeon General to recognize suicide as a serious public health problem and develop a National Strategy for Suicide Prevention.

Suicidal thoughts are surprisingly common in high school students as reported in the Youth Risk Behavior Surveillance study:

- 19.3 percent of students in grade 9 – 12 in the U.S. reported suicidal ideation (thoughts of wanting to kill oneself);
- 8.3 percent reported at least one suicide attempt;
- 2.6 percent enacted at least one medically serious suicide attempt within the year of survey.

Many of the adolescents who attempt or commit suicide have depressive disorders. Developing and testing various interventions to prevent suicide in adolescents has been the focus of many studies. Research has shown that early diagnosis and treatment, accurate evaluation of suicidal thinking and limiting young people's access to lethal agents (including firearms and medications) may be the key to suicide prevention. The greatest difficulty lies in identifying and predicting which adolescents will actually commit suicide.

Adolescent Major Depression

Recognizing depression in teens is more difficult than in adults because adolescents express their symptoms differently. A teen with depression is more likely to exhibit decreased interest in formerly pleasurable activities and irritability rather than low energy, sadness and increased sleep as is typically seen in adults.

Emerging treatment studies indicate that adolescents with depression respond differently than do adults. Depressed adolescents do not show evidence of hypercortisolemia (excessive production of cortisol) as is frequently reported in adults. Also, most depressed adolescents fail to respond to tricyclic antidepressants (TCA). Since there are differences in the mechanism of action of selective serotonin reuptake inhibitors (SSRIs) and TCA medications, researchers hope this may provide valuable insights into the underlying neurobiology of early-onset depression.

Treatment of Depression

Treatment often combines short-term psychotherapy, medication, and targeted interventions involving the home or school environment. As initial treatment for mild to moderate depression, psychotherapy teaches adolescents and their families to cope with interpersonal conflict and the social, familial, academic and occupational problems that are associated with depression. One study found cognitive-behavioral therapy (CBT) to have a 65 percent remission rate in adolescents with depression and a more rapid response rate than either supportive or family therapy. CBT is based on the premise that depressed patients have cognitive distortions in their views of themselves, the world and the future. Approximately 15-20 CBT sessions are required–at first weekly, but as the symptoms abate, monthly. Continuing psychotherapy is important even after the symptoms have remitted because it can help teens to better understand how their thoughts and behaviors can contribute to a relapse.

Medication as a first-line course of treatment should be reserved for those adolescents:

- with severe symptoms that would prevent effective psychotherapy;
- unwilling or unable to undergo psychotherapy;
- who are psychotic;
- who have chronic or recurrent episodes.

Several studies have found SSRIs to be safe and effective for the short-term treatment of severe and persistent depression in adolescents–specifically,

see NARSAD on page 58

NARSAD
RESEARCH

National Alliance for Research on Schizophrenia and Depression

A Unique Partnership of Scientists and Volunteers To Conquer Mental Illness

- **NARSAD is the leading donor-supported organization funding brain and behavior research worldwide.**
- **Since 1987, NARSAD has funded 1,695 researchers at 212 universities and medical research centers in 20 countries.**
- **Three NARSAD-funded scientists are Nobel Prize Winners.**
- **Grants are awarded by our 75-member all-volunteer Scientific Council which includes three Nobel Prize Winners, four former directors as well as the president director of the NIMH.**
- **Contributions to support NARSAD's programs go *100% to Research*.**
- **All administrative costs are paid by two family foundations. NARSAD receives no government funding.**

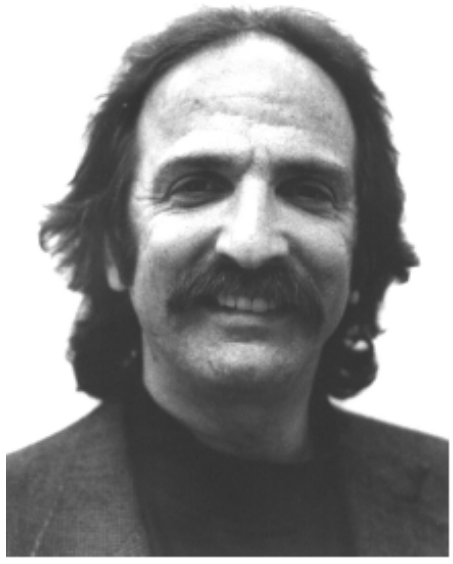
***** A free symposium on Basic Science, Affective Disorders and Schizophrenia will take place on October 17 - 18 at Le Parker Meridien Hotel in NYC. Our Annual Gala Dinner, with prizes awarded for research, will be on October 17. For information and/or reservations for both events, please call NARSAD. *****

60 Cutter Mill Road, Suite 404
Great Neck, NY 11021

1-800-829-8289 **www.narsad.org**

THE NYAPRS ADVOCACY WATCH

By Harvey Rosenthal
Executive Director, NYAPRS
New York Association
of Psychiatric Rehabilitation Services



Harvey Rosenthal

Some Reflections on This Year's Statewide Budget and Legislative Advocacy

Despite another legislative session marked by great rancor and gridlock, the NYAPRS mental health advocacy community had another successful year. Capping several years of efforts in many instances, we were able to advance most of the budget and legislative goals established by almost a thousand of our members at 10 local fall forums across New York State and highlighted at an April 15 Legislative Day that drew over 700 members to Albany.

The following is a brief review of our priorities and the outcomes of our advocacy on their behalf:

BUDGET PRIORITIES

- Implementation of a Cost of Living, Medicaid Fee Hike for Community Mental Health Agencies: despite fears that state budget troubles would take down one of last year's victories, the NYS Office of Mental Health made good in January on the 2.5% COLA and 10% Medicaid fee hike for community mental health agencies.
- Restoration of Community Reinvestment: responding to appeals by our members and friends in New York's mental health advocacy community, state legislators overrode the Governor's objections and restored the landmark program effective April of this year. However, since the Governor had claimed the savings from the scant amount of state hospital bed downsizing this year for budget relief and since legislators blocked any facility closures, there'll be no new Reinvestment funding available until (hopefully) next year.
- Implementation of Medicaid Buy-In Work Incentives Program: after a 3 month delay, the Buy-In's long anticipated start began in July! Call our Training Collective's Stephanie Mitchell at 518-436-0008 to schedule an informational session on the Buy-In in your area.
- Expansion of and Increases for Mental Health Housing: While there was no funding to add new beds or enhance the rates for existing housing, we did, as a prominent member of the NYS Coalition for Adult Home Reform, negotiate a commitment for 2,000 new beds to come on line in 2006-7 and did get the Assembly to pass a bill requiring OMH to publicly establishing a housing waiting list.
- Adult Home Reform Service Initiative: After the Governor proposed an $8 million initiative, the legislature took back $4 million to restore an Incentives fund for Adult Home operators (called 'QUIP') and then added $2 million on top of that. Combined with $500,000 pledged by the Governor in April 2002, that left $2.5 million for new case management and peer support services, resident needs assessments and the like.
- SSI COLA Protection
- Another victory to cherish, a victory rejecting the Governor's plans to make savings by lowering the state's share of the SSI COLA that was essentially won the day our members joined with our friends in the AIDS/HIV and physical disability community to ring the Legislature's budget hearing with protestors!
- Maintain Open Access to Medicaid Drugs
- Intense discussions by negotiators for the Governor, Assembly and Senate did not yield an agreement on the establishment of a prior authorization program that would restrict access to some Medicaid drugs while ostensibly lowering the cost of those put on a 'preferred drug list.' Special protections for our community were offered by all parties. The Governor proposed to exempt 6 atypical anti-psychotic drugs (Seroquel, Abillify, Risperdal, Zyprexa, Clozaril, Geodon) and all anti-depressants from these restrictions. Assemblyman Gottfried pushed to exempt entire groups, including New Yorkers with psychiatric disabilities, from the program while Assembly Mental Health Chair Peter Rivera opposed the whole concept of Medicaid drug restrictions.
- Under a prior authorization program, doctors would have to call to get approval for their patients to fill Medicaid prescriptions for drugs not included on the preferred drug list, which would be established by a special 'P&T' committee. Before the clock ran out on negotiations, the 3 sides had apparently agreed to make such committee meetings public and to add 3 consumer representatives.

LEGISLATIVE PRIORITIES

- Electroshock Reporting Legislation Approved by the Legislature
- The Legislature approved a reconciled version of legislation requiring "facilities which administer electroconvulsive therapy to report to the Office of Mental Health on a quarterly basis on the use of such therapy" and requiring OMH to submit an annual report to the Governor and Legislature. Slightly differing Assembly and Senate bills were reconciled following discussions between sponsors and Mental Health Community Chairs Assemblyman Peter Rivera and Senator Thomas Libous, amidst strong advocacy by NYAPRS members.
- Timothy's Law Stalled in Senate; Advocates Have Kept Vow to Work All Summer
- The extraordinary campaign aimed at ending decades of mental health insurance discrimination produced approved legislation in the Assembly and, despite an unprecedented 35 Senate Republican majority sponsors, a stalemate in the Senate.
- The good news: the bill has never gained this much support in the Senate, leaving it on the 'A' list of measures that Senate Majority Leader Bruno has committed to negotiate in the future.
- Look for the inspiring O'Clair family to work with tenacious advocates all summer long to press the Senate to negotiate a bill with the Assembly, to be considered when the Legislature is expected to return this September 16th.
- Adult Home Reform Legislation: 3 bills, No 3-way Discussions
- Both the Governor and Assembly had submitted legislative proposals that would boost penalties and bar referrals to negligent adult homes, raise 'character and competence' standards for operators, enhance medication supervision practices, require appropriate cooling and heating standards and a variety of other reform measures.
- The Assembly proposal (and freestanding bills sponsored by Assemblyman Rivera) also included the establishment of an OMH Housing Waiting list (a high priority for NYAPRS members) and a legal right for residents to seek court action replacing negligent operators. Towards session's end, the Senate majority issued its own proposal, closely resembling the Governor's bill.
- All of this apparently for naught, since, there was no 3-way discussions on the measures.
- Albany will have much to answer for here, with disgracefully little being done to address the adult home scandal profiled a year ago by a Pulitzer Prize-winning Times investigation.
- SHU-Diversion for State Prison Inmates with Psychiatric Disabilities
- A group of legal rights, prisoner and mental health advocates (including NYAPRS and NAMI) have pressed for legislative action to address the alarming use of and rising suicide rate in inhumane solitary 'Special Housing Units' for prisoners with psychiatric disabilities. Assembly Corrections Committee Chairman Jeff Aubrey has responded by introducing A. 8849.
- The bill won't be considered this year by either house, but will lead to a series of fall hearings by the Assembly that should focus public attention on this deplorable tragedy and lead, hopefully, to legislative remedies next year.
- Special thanks to our Public Policy Co-Chairs Venture House's Ray Schwartz and Community Access' Lauren Bholai-Pareti for their overall leadership and special efforts on adult home (along with Immediate Past President Jody Silver of Community Access), to Westchester Independent Living Center's Susan Perr and the Mental Health Association in Essex County's Bill Sullivan for their persistence on ECT advocacy, to Lauren again for her leadership on prison reform, to our redoubtable lobbyist Kevin Cleary for his guidance and pluck and to all of our regional coordinators for getting out 700 on April 15 and keeping those calls coming in all session!

NYAPRS 2003
Budget/Legislative Scorecard

Budget

Community Reinvestment Restoration: *Approved*; Housing Enhancements, Expansion: *$65 million for 2,000 new beds to come online starting in '06*; Adult Home Service: *$2 million case management and peer support services*; SSI COLA Restoration: *Protected*; Open Access to Medicaid Drugs: *No agreement*; Trended PROS Rates: *To be resumed next year*; COLA and Medicaid Fee Hike: *Implemented in January*; Medicaid Buy-In Work Incentives Program: *Implemented in July*

Legislation

Electroshock Reporting Bill: *Approved*; Adult Home Reform: *Passed Assembly -- no deal for now*; OMH Housing Waiting List, Receiver Bills: *Passed Assembly*; Timothy's Law: *Passed Assembly -- Possible deal later this year?*; Prison Solitary Confinement Diversion For Inmates w/ Psychiatric Disabilities: *Introduced in the Assembly with Hearings to Follow in Fall.*

NYAPRS - 21st Annual Conference
'Recovery & Rights for All: Every Single One'
September 17-19, 2003
Nevele Grande Hotel, Ellenville, New York
(Free Copies of Mental Health News will be Provided To All Participants)

The NYSPA Report

By Barry Perlman, M.D., President
New York State Psychiatric Association

Barry Perlman, M.D.

By now all New Yorkers know that the recently concluded session of the New York State Legislature was a particularly contentious and difficult one. While the legislature restored billions of dollars for healthcare, including mental health, certain areas failed to gain necessary restorations with serious potential consequences for persons with serious mental illness.

For the first time in the long struggle for mental health insurance Parity in New York State, both houses of the legislature introduced identical bills. The eponymous bill, called "Timothy's Law," was named after Timothy O'Claire, a youngster whose life sadly ended in suicide. The bill passed the Assembly by an overwhelming majority and was supported in the Senate by 33 of 37 Republican Senators. As such, NYS clearly moved a step closer to realizing a "parity" mental health benefit for all citizens of our state.

Unfortunately, on another front NYS took a regressive step away from equal insurance coverage for persons with mental illness. As a result, access to private psychiatric care for persons insured by Medicare and Medicaid, that is the elderly poor or seriously disabled, is imperiled. Individuals covered by such "cross over" insurance are referred to as "dual eligible."

These are the facts. Until this year, when dual eligible persons covered by Medicare and Medicaid received medical care in NYS for a physical or mental illness, their treating physician would be compensated at a rate allowed by Medicare with a portion of the payment coming from Medicaid. It worked in the following way. If the doctor was treating a physical illness, Medicare paid 80% of the fee and Medicaid paid the remaining 20%. If the physician were a psychiatrist treating a mental illness on an outpatient basis, Medicare paid 50% of the fee and Medicaid paid the remaining 50%. In both cases the treating doctor received the entire rate allowed by Medicare from the combination of insurances. As such, New York State¹s Medicaid program enabled parity reimbursement for care of mental illness despite the discriminatory payment policy of the Medicare system.

Here is what occurred during this year¹s legislative session. The Governor, faced with an enormous shortfall, proposed a budget calling for the end of Medicaid payments to doctors treating dual eligible persons. The result, had this proposal passed, would have been a 20% decrease in payments for those treating persons with physical illnesses but a 50% reduction for those treating mental illnesses. In the ensuing struggle the legislature made a 20% restoration to the Medicaid part of the crossover payment. As a result, those treating general medical diagnoses will receive 80% of the fee from Medicare and 20% of 20% or 4% from Medicaid with a resulting 16% reduction in fee. Psychiatrists treating mental illness will receive 50% of the allowed fee from Medicare and 20% of 50% or 10% from Medicaid resulting in a 40 % reduction.

The question then raised is who is impacted and what are the likely consequences of this ill-advised budgetary decision? First, it should be noted that approximately 15,000 persons age 64 and younger are dual eligibles treated by privately practicing psychiatrists. This group includes many in the community falling within the category of seriously and persistently mentally ill and subsumes many residing in adult homes. The other impacted group of dual eligible persons receiving psychiatric care are the more than 35,000 aged 65 and older. While many of these individuals reside in the community, a substantial number reside in nursing homes. Overall dual eligible individuals received over 350,000 psychiatric contacts annually.

As a result of the budget passed, many psychiatrists face a 40% reduction in the already discounted Medicare fee they receive and may feel forced to discharge dual eligible persons from their practices. The decision will be a difficult one confronting the psychiatrist with a tension between a sense of duty to those they serve and a punitive pay cut. How many of us could or would continue at our present work if confronted with a 40% pay cut? I dare say, not many! It would have taken just a small additional restoration of state funding of Medicaid to avoid this situation and thus preserve the parity long enjoyed in NYS between payment for physical and mental illnesses under the cross over arrangement. Doctors deciding that they must discharge dual eligible persons should effect such discharges in a legal and ethical manner.

As a result of these cuts, dual eligible persons requiring private psychiatric care may be denied access, and others currently receiving care may be discharged from such care. Consequently, many seriously ill persons may not be able to obtain necessary psychotropic medications such as antipsychotics or antidepressants, without which relapse becomes a near certainty. Those discharged or unable to gain access may turn to the licensed mental health clinics for care but will find access difficult as the demands on them exceeds capacity in many areas of the state. Failing to find treatment through clinics, individuals may be expected to turn to already overburdened emergency rooms. Either way, the cost to Medicaid will substantially exceed the amounts paid when the persons were treated in private practices and is certain to be less well coordinated. Sadly, if persons are unable to receive timely treatment and medication, they may well experience clinical relapse requiring costly inpatient hospitalization.

It is clear that the path chosen in the budget adopted by the legislature is sure to be costly in both human and monetary terms.

Those with an interest in the way our state concerns itself with issues related to the treatment of the elderly, the poor and those with serious mental illness should immediately contact their legislators, legislative leaders and the Governor seeking restoration of the funds cut from Medicaid for care of dual eligible persons. Only through budgetary restorations will equality between the payment for treatment of physical and mental illness be reinstated for persons insured under Medicare and Medicaid and, thus, equality of access to the health and mental health systems. This fight must be viewed as an important part of the larger fight to secure parity for mental illness in all health insurance plans covering New York State citizens.

Readers wishing to contact NYSPA may write to: New York State Psychiatric Association, 100 Quentin Roosevelt Blvd., Garden City, NY, 11530.

New York State Psychiatric Association

Area II of the American Psychiatric Association

Representing 4500 Psychiatrists in New York

Advancing the Scientific and Ethical Practice of Psychiatric Medicine

Advocating for Full Parity in the Treatment of Mental Illness

Advancing the Principle that all Persons with Mental Illness deserve an Evaluation with a Psychiatric Physician to Determine Appropriate Care and Treatment

Please Visit Our Website At

www.nyspsych.org

Center Study Reveals Differences Between SSI and SSDI Recipients

By Donald M. Fitch, M.S., Executive Director
Center for Career Freedom, Inc.

Developing Evidence-Based Practices For Vocational Rehabilitation Programs

SUMMARY

An analysis of over five-hundred intake application forms by persons with psychiatric disabilities to the Center for Career Freedom together with their computer skills training records and employment outcomes suggests persons who receive Social Security Disability Income (SSDI) are four times as likely to return to competitive employment as persons who receive Social Security Income (SSI) or Public Assistance (PA).

Implications include a need for more precise definition of research variables, alignment of vocational training program practices with the consumer's abilities, and government policy reform regarding the economics of recovery.

BACKGROUND

While our mission is the rehabilitation and recovery of persons with severe and persistent mental illness leading to competitive employment, we're aware that most jobs, like most disabilities, are not alike.

As consumer/survivors with a long and varied work history ourselves, we knew from experience we had to have sufficient, demonstrable skills to get beyond a high turnover, minimum wage entry-level job to a satisfying economically viable career. The economics of recovery dictated giving up $600-$800/mo. in Government disability, $500-$700/mo. in rent subsidy, $120 in food stamps and $200 for prescription drugs if you were on SSI/Medicaid. The cost to replace these benefits for our students averaged over $1,400/mo. (about $17,000/yr.) We estimated our graduates would have to acquire sufficient skills to gross $12/hr., full time. Twice the minimum wage.

Job market research and labor statistics for Westchester County showed employers would pay this rate for persons proficient in MS Word, Excel, PowerPoint plus 45 wpm in keyboard skills. Proficiency in QuickBooks and medical billing (ICD-9) would pay more.

In order to achieve this goal we chose to become a NYS Dept. of Education Business School and Microsoft Office Applications Specialist Authorized Testing Center as an integral part of our Drop-in Center.

One of the prerequisites to survival in business is information. You're constantly refining your business as your knowledge of your consumer's needs, competition, economic trends, compliance, etc. grows. Our applicant/student/employee outcome tracking system was never an option and began with our first Drop-in.

METHODOLOGY

Five hundred seventeen intake application forms collected over a four year period were first tabulated by type of government assistance program. The incidence (%) at the Center and government program summaries appear below.

GOVERNMENT PROGRAM	SUMMARY ELIGIBILITY/BENEFITS/EARNINGS RETENTION FOR CENTER POPULATION
SSI: (30%)	Medically disabled persons who generally have much less than 10 years work history. Typical monthly benefits include: Cash income ($639), Food stamps ($120), Medicaid (includes prescription drugs) and Section 8/Shelter Plus rent subsidy (70%). Current government policy allows recipient to keep the first $85/Mo. plus ½ of all earnings over $85/mo., up to $1,350/Mo.
SSDI: (30%)	Medically disabled persons who generally have more than 10 years of work history. Typical benefits include: Cash income ($778), (avg. @ the Center,), no Food Stamps, Medicare (does not include meds), Section 8/Shelter Plus rent subsidy (70%). Government policy allows recipient to keep up to $800/Mo.
SSI & SSDI: (16%)	See above.
Public Assistance: (6%)	Needy but not medically disabled e.g. able bodied homeless. Usual benefits include: cash income ($140), food stamps ($120), Medicaid and shelter/housing allowance.
None/Applied: (18%)	Not enrolled in any benefit program or application pending.

The five groups were first tabulated by some fifty characteristics contained in the Center's application form.

Second, attendance and Microsoft certification records were examined for those students who regularly attended the Center over the four year period. (198 of the 517)

Third, employment outcome records; Microsoft certification by program, hours, title, and earnings were examined for all known employed members/graduates. (56)

Finally, all available data for the fifty-six; application forms, training records and employment outcomes were examined. Analysis of the data includes comparisons between the five assistance program groups and across the three populations; "applicants," "students" and "employees." Statistically significant differences are noted. *Note: For detailed tables go to www.freecenter.org/research.*

A chart: "Monthly income of SSI and SSDI, recipients at the Center for Career Freedom" was prepared to provide a pictorial summary of the economic history and recovery patterns of SSDI and SSI recipients before and after joining the Center.

The aggregate lifetime earnings, tax contribution, savings, training expense and return on investment for the fifty-six Center graduates/employees was also calculated.

FINDINGS

The summary characteristics of all 517 applicants are presented below. All data are self-reported. The "diagnosis" was verified and refined according to information supplied by the care-giver and prescribed medication.

Demographics; age (41 yrs. mean), gender (52% female), ethnicity (76% Caucasian, 15% African American, 4% Hispanic), education (61% some college or more), cash income ($564/mo. avg.) and food stamps (26%), currently working pt (22%).

Diagnosis;

- Depressive/Anxiety Disorder(40%)
- Bi-Polar Disorder (25%)
- Schizophrenia (22%)
- Schizoaffective Disorder (21%)
- Borderline Personality Disorder(12%)
- Co-occurring disorders; MICA, MRDD, TBI, etc. (10%)
- All others (12%)

Other Characteristics:

- Psychiatric hospitalization (50% ever, 29% past 2 years) and history of alcohol/substance abuse (32%).
- Employment history (78% have not worked in past 2 years or more) last job title; clerical (25%), retail (17%), maintenance (10%), food service (8%)
- Driver's license (53%), computer at home (39%), registered to vote (56%).

SSDI VS. SSI RECIPIENTS

Among all applicants at the Center, recipients of SSDI and SSI were found to be significantly different * on eight variables:

	SSDI	SSI	Difference vs. SSDI
Avg. Monthly Cash Income	$778	$565	($213)
Some College or More	66%	47%	(19)
Depression/Anxiety Disorder	35%	23%	(12)
Bi-Polar Disorder	28%	15%	(13)
Drivers License	63%	50%	(13)
Registered to Vote	61%	48%	(13)
Clerical Positions (Last)	33%	21%	(12)
Retail Positions (Last)	10%	21%	11

*+/-10 Points; 95% Level

PUBLIC ASSISTANCE VS. TOTAL SAMPLE

Compared to all applicants, statistically significant characteristics of persons on public assistance at the Center include:

	Total	Public Assistance	Difference vs. Total
Avg. Monthly Cash Income	$564	$138	($426)
Food Stamps*	26%	82%	(56)
History of Alcohol/Substance Abuse	32%	66%	34
Depressive/Anxiety Disorder	40%	69%	29
Schizoaffective	21%	2%	(19)
Computer Ownership	39%	21%	(18)
African-American	15%	32%	17
Schizophrenia	22%	7%	(15)
Drivers License	53%	37%	(14)
Some College or More	61%	48%	(13)
Registered to Vote	56%	43%	(13)
Borderline Personality Disorder	12%	--	(12)
Not Worked in Past 2 Years	78%	90%	12

*Not All Eligible

GRADUATES/EMPLOYED VS. TOTAL SAMPLE

Fifty-six students successfully completed the Microsoft Certification Program and returned to competitive employment. Compared to the total sample, this group was found to have a significantly different proportion of people on seven of the study variables:

	Total	MS Certified/ Employed	Difference vs. Total
SSDI Recipients	46%	84%	38
SSI Recipients	46	22	(24)
Public Assistance Recipients	6	-	(6)
Some College or More	61	78	17
Computer at Home	39	56*	17
Schizophrenia	22	11	(11)
Bi-Polar Disorder	25	35	10

*this is an inflated incidence due to a performance incentive offered by the Center; a refurbished Pentium computer for Microsoft certified students who retain employment for 6 months.

Compared to SSI recipients who are Microsoft certified employees, SSDI recipient Microsoft certified employees tended to:

- Have a work history of higher earning rates and more senior job titles.
- Were more self-reliant and proactive in their job search
- Sought positions in small business with less structure and more responsibility
- Required less job coaching and fewer job supports

SSDI graduates were significantly different from SSI graduates on two important dimensions:

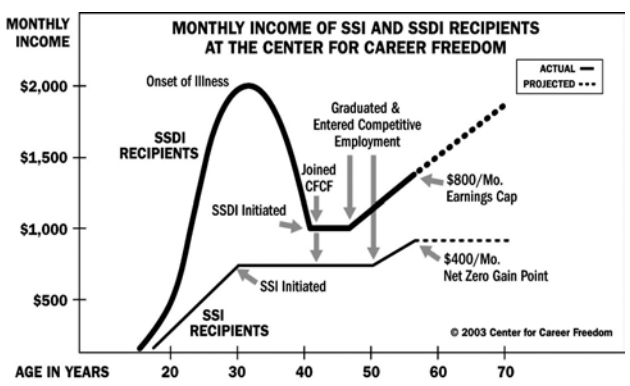
- They earned twice as much as our SSI graduates (18,000 vs. 9,080).
- They completed the MS certifications in half the time (1 yr. vs. 2 yrs.).

The chart summarizes a sample of our students/graduates monthly income for SSDI and SSI recipients at various stages in their lives:

- A rise in income before the onset of their illness.
- For SSDI recipients only, a decline in income following the onset.
- Stabilization following initiation of SSI and/or SSDI benefits.
- 1-2 years training at the Center.
- And a rise in actual and projected income for those graduating and entering competitive employment.

Plotting our population's economic behavior over time, then, overlaying key events in their lives to explain them, unlocked the dynamics of our disability in a new way. Our level of emotional functioning could be viewed as related to our level of earnings. Age and income are more objective standards, easily recalled and verifiable. The dynamics are typical of the Center's population and represent the majority of recipients.

A dramatic difference between the two groups is the significantly greater income across all life stages and events of the SSDI recipients. While the SSDI recipient's income rose quickly in their 20's, it rapidly declined in their 30's following the onset of illness. The initiation of their SSDI benefits halted the free fall and clearly provided a safety net and economic stabilization. (We also knew from our intake assessment Satisfaction Survey that most of these recipients reported satisfaction with their psychiatrist, medications, therapist and housing.)



see Center Study on the next page

Center Study from the previous page

For most SSI recipients, their income actually improved with the initiation of SSI benefits. According to this data, initiation of benefits occurred almost ten years before SSDI recipients—perhaps due to the earlier onset of illness with greater functional impairments.

At about fifty years of age, students graduate and enter competitive employment. The economics of recovery for SSDI recipients allow for a transition or work hardening phase of part-time employment. Their earnings can approach up to $800/mo. and they can still receive their disability checks. At the Center, the average of 778 would yield a total maximum income of about $1560/mo.; $12/hr for about 30 hrs. of work/week. A few dollars over the $1,400/mo. self-sufficiency goal.

On the other hand, the certified SSI recipients are faced with a daunting, if not impossible hurdle. The sharp reductions in benefits; even with the Medicaid buy-in, results in a net zero gain point of $400/mo. Put another way, an SSI recipient grossing $400/mo. takes home nothing. All their incremental income are eaten up by earnings penalties stipulated by each of the four government programs.

The SSI recipient profile generated by the data and powerfully illustrated by the chart paints a grim picture. The earlier illness onset and more severe impairment appears to result in less years of education, less years competitive employment and less lifetime earnings.

What is not plotted on this chart are the overwhelming majority who have chosen not to pursue MS certification and/or competitive employment, at this time. (They would have been represented by a flat line).

STUDENT DATA

Prior to our SSI/SSDI research, we learned through experience, conferences and analysis of intake assessment and staff notes that we were challenged by three student tracks: 1) over 2 years to obtain certification 2) 1-2 years 3) under 1 year. Key characteristics of each group are:

Group 1

- Fragile SPMI
- Hospitalized <1 year (ECT)
- Methadone (MICA)
- Sober (MICA) < 1 year
- Mild MR/DD
- Moderate cognitive dysfunction
- Moderate learning disabilities
- Poor/No work History

Group 2

- Moderately stabilized, may need housing, medications adjusted
- Moderate work history
- Poor ego strength
- High School/ some college
- Mild learning disabilities

Group 3

- Stabilized: Meds, $, Housing, Transportation, etc.
- 10+ years work history; types, computer at home
- Some college or graduated

We have found Group 1 requires intensive one on one instruction, Group 2; a mix of both teaching methods and Group 3; small classes.

RETURN ON INVESTMENT

Simply put, ROI asks the question "What am I getting for my money?" Increasingly, the current administration is asking this question about the social services it funds. In some instances more information about the quantity and quality of services delivered is sought e.g. PROS Medicaid Outpatient Program. In other cases its already been decided it would be more efficient to outsource the service e.g. Maximus; Ticket to Work, One Stop, etc.

With the Federal tax cut, NYS budget shortfall, zero increment in Federal funds (President's Commission Report) and an estimated one-third reduction in government personnel due to retirement in the next five years, increases in the efficient delivery of Social Services e.g. agency consolidation, computerized outcome tracking, per capita cost data, etc. will become the norm.

The average per capita cost for training a student through several Microsoft Certifications and job placement at the Center is about $9,000. This compares favorably to the 12-15K/person/job spent by local federally funded vocational/ employment programs.

Our average MS graduate's gross annual first year/ earnings is about $17,000. That's a return on investment of over 200% the first yr. The numbers get very big, very fast when we calculate the contribution of all 56 graduates/ employees:

• Annual Gross Income:	972,144
• Taxes Paid:	155,500
• SSDI/SSI Savings:	512,304
• Total contribution; year 1:	1,639,948
• Less total Expense:	504,000
• Net Annual Gain	1,135,948

Over an average work-life of 24 years, the total earnings of these 56 people without any raises, cola, etc, is about 23,000,000! The SSDI and SSI savings together add another 10,000,000 for a total contribution of 33,000,000!

If we were forced to shut our doors tomorrow, we would feel we have fulfilled our mission.

CONCLUSIONS:

The study goal was to identify and profile those characteristics associated with the various populations contained within the Center's recovery spectrum. We felt if we could identify the significant variables, we would then be in a better position to create and test program refinements in order to improve the Center's success rate.

At first glance, our four year tracking study of five hundred persons with a fifty variable multivariate analysis revealed the somewhat obvious conclusion that past performance and future success were correlated. The data revealed the SSI, SSDI & Public Assistance "handles" were the tip of the iceberg; a number of other variables were correlated with these three government assistance programs codes.

Further examination showed because SSDI recipients have been engaged in competitive employment for at least ten years; they have the experience, proven work skills, interpersonal skills, a full resume with references and a driver's license. They knew how to dress, how to interview and what's appropriate office behavior. For the majority of SSDI recipients their track record of achievement began before employment; with their attendance or graduation from college. They come to the Center to update their keyboard skills and Microsoft certification; Word, PowerPoint, Excel, etc., for career counseling and job placement assistance. They're on a fast track and our role is their vocational "stepping stone".

The tougher challenge we quantified was how to refine the training program, career counseling, job placement and supported employment for SSI recipients.

SUMMARY OF FINDINGS

- Microsoft Certified SSDI recipients are four times as likely to return to self-sustaining competitive employment, as SSI Microsoft Certified recipients.
- Study variables which may explain this are significant differences in the years of education and competitive employment, severity of functional impairment/ diagnosis and barriers of government policy regarding economic recovery.
- Analysis of the economics of recovery for SSDI recipients demonstrated the feasibility of transitioning off disability to self-sustaining taxpayer status following the acquisition of sufficient marketable skills to earn at least $12 hr. and the endurance to work at least 29 hr./ wk.
- SSI recipients, in addition to being challenged to overcome their fewer years of schooling and work experience and, their severity of symptoms, are faced with a net zero gain of gross earnings a the $400/mo. level, even with the Medicaid buy-in elimination of the spend down.
- The overall contribution to the economy and return on investment of the Center's Microsoft Office Specialist and employment program is exceptional.
- Charting income over time and overlaying key life events to explain the variations offers new insights into the dynamics of our disability and recovery.

IMPLICATIONS

- Insure all intake, client tracking, supported employment, academic research, etc. include data on the various government benefit programs; SSI, SSDI, Section 8/Shelter Plus, Food Stamps/ Medicaid/Medicare, etc. and earnings/work history. (Re) run these data using analysis of variance, multiple regressions and mapping where possible. (Mining Social Security's lifetime earnings tracking system data base presents an excellent research opportunity).
- Be aware that combining the SSI and SSDI populations, whether in research or recovery, averages out their dynamics. The increased clarity in understanding their uniqueness has enabled us to tailor our training, techniques, staff assignments, expectations and timetables to optimize our limited funds.
- Legislation to remove significant economic disincentives for SSI recipients is still critical. The Medicaid buy in, Pass Plan, 1619b, Ticket to Work, etc. do not address the enormity of this issue.
- Include some of the business persons who create $6-12/ hr. jobs on the committees that plan and administer vocational programs to provide real world criteria and training needs.
- Encourage the university based research centers that are funded to research our population to expand the scope of their studies to include perspectives and professors from their adjoining Economics and MBA departments. Multi-disciplined studies could include social program economics, bridging caregiver and employer value systems, the effectiveness of various performance incentives commonly used in business e.g. cash bonuses, etc.
- Create a Federal task force comprised of the policy people from the major benefits legislative programs; SSA, HUD, DSS, Medicaid, etc. With the goal of producing an integrated, consumer based viable economic plan for persons on SSI who hope to transition to competitive employment.
- Develop, test and distribute a simple spreadsheet which summarizes the impact on benefits for various earnings scenarios for the majority of SSI and SSDI recipients, to aid in their (caregivers) understanding of the economic opportunities and challenges associated with their recovery.

About The Author

Donald Fitch

Donald Fitch, M.S., is the Founder & Executive Director of The Center for Career Freedom, White Plains, New York. Fitch, 64, earned a B.A. in Psychology from NYU's College of Arts and Science and a Masters in Counseling from L.I.U. His internship was with St. Vincent's Hospital. A survivor of mental illness, Fitch founded the Center in 1998 after fifteen years in administration, fundraising, consultation and direct care in the non-profit sector. Populations served included persons with mental and physical disabilities, substance abusers, children in foster care, the elderly, persons with HIV/AIDS and others. He also spent fifteen years in business as a marketing consultant, head of his own importing company, a marketing manager at the Pepsi Cola Company in Purchase, New York and as their marketing consultant. He is a Vietnam era Veteran, a father of three sons and a grandfather of four granddaughters.

Gold Medalist from page 1

national distributor for this important initiative.

"Many schools have operated for decades without fostering depression awareness in young people," said Steven Greenfield, Executive Director of the MHA of Nassau County. "Our agency is committed to addressing the very real dangers of ignoring teen depression," he added.

We wish to thank Mental Health News for featuring our *Real Hurdles* program in this issue on depression in children and adolescents.

To obtain a copy of *Real Hurdles* please contact Denise Kreitzman at (516) 489-2322, ext. 113 or send in the *Real Hurdles Order Form* that follows a personal interview we conducted with Derick which we are sure you will enjoy reading.

DERRICK GETS PERSONAL:
AN INTERVIEW WITH OLYMPIAN DERRICK ADKINS

QUESTION: How old were you when you first experienced your depression?

ANSWER: I know now that I had some of the signs and symptoms of depression that go back as far as my youth, but I didn't start recognizing it as depression until I was about 24.

QUESTION: What were you feeling?

ANSWER: It started with very mild feelings of sadness and grew into irritability and anger. I couldn't sleep and I had no desire to eat or socialize. These symptoms persisted with such an intensity that I was experiencing crying spells for no perceptible reason. Eventually, it seemed as if every waking moment I was in emotional pain. It was a very morbid state and that's why I started contemplating suicide...I just wanted to end the pain.

QUESTION: Did you speak to anyone about getting help?

ANSWER: I didn't decide to seek help until I was desperate. Initially, I felt like my mood would just lighten up and I would get better automatically, but it didn't happen that way. I had to go for help before I started to get better.

QUESTION: How did your depression impact your track and field?

ANSWER: My performance on the track suffered a little bit, but not as much as you would expect. I still did very well during those years. I was ranked as number one in the world in my event, but there were days when I just couldn't run at the level I was supposed to be running.

QUESTION: When were your worst times?

ANSWER: My depression was the worst from 1994-1996. Ironically, those are the years that I did the best in track and field. I would take out a lot of frustration on the track. Actually, running made me feel better, so I would put all my energy and focus into my practices and events. This helped me through, but what I really needed to do was admit that I needed professional help.

QUESTION: What was your reaction when you were diagnosed with clinical depression?

ANSWER: I felt relief when I heard that what I was experiencing was depression and that I could recover with a combination of counseling, medication and nutritional changes.

QUESTION: How did you handle your recovery program prior to and during the Olympics?

ANSWER: That was the most complicated part of my recovery. It was April of '96 that I started taking meds. The Olympic trials were scheduled for June. The medications made me feel great mentally and emotionally, but physically, they made me tired. I was in a quandary - choose my Olympic dream or choose mental health. I decided to stop the meds. I regained my endurance and strength , but inside I was very, very depressed. I remember trying to smile for the cameras, trying to enjoy everything and take it all in.

QUESTION: How did you feel when you won the Gold Medal?

ANSWER: The day I won and that evening were great, I was on cloud nine. But that only lasted a couple of days. Then my mood started sinking and I kind of like crashed and had what I now know was a major depressive episode.

QUESTION: What happened next?

ANSWER: I decided to go back on the medication even though I understood that it could hurt my track career. My state of mind and my stability were just more important.

QUESTION: Tell me about your life now?

ANSWER: Things are great for me now. My track career is not the same, but it's a lot more important to me to have my health than to run fast. I have come to terms with my choices and my outlook for the future is very positive. I continue to compete and I am studying for the ministry.

QUESTION: What would tell someone to do if said they are experiencing something similar to what you felt?

ANSWER: I would tell them that there is help is out there. And just because there's a stigma associated with mental illnesses, you should not hold back from seeking help or feel any shame about your illness.

QUESTION: What do you want people to know?

Long Island Teens Discuss *Real Hurdles* Between Class

ANSWER: I've accomplished some great things in my lifetime and I am very proud of myself. I openly acknowledge that I had depression and I still do have depression, but it is not the end of the world. Professional help was the turning point in my life. It totally turned my life around and now there is a lot of joy and hope where there once was only pain. So that's what I want people to know...that most people who suffer from depression do recover. I did.

ORDER FORM

REAL HURDLES

VIDEO CASSETTE & TEACHING GUIDE
PRODUCED BY THE MENTAL HEALTH ASSOCIATION OF NASSAU COUNTY

DATE: _____

QUANTITY	DESCRIPTION	UNIT PRICE	TOTAL
	REAL HURDLES - VIDEO CASSETTE & TEACHING GUIDE	$89.95	
	PLUS SHIPPING AND HANDLING	10.00	
	TOTAL (EACH)	$99.95	$

SHIP TO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DAYTIME PHONE NO: (____) _____ EVENING PHONE NO: (____) _____

YOUR PURCHASE ORDER NUMBER _____

☐ PLEASE MAKE CHECK PAYABLE TO:
MENTAL HEALTH ASSOCIATION OF NASSAU COUNTY

☐ CHARGE MY ORDER TO: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

NAME ON CARD (PLEASE PRINT): _____

CARD NUMBER: _____ EXPIRATION DATE: _____

SIGNATURE: _____

MENTAL HEALTH ASSOCIATION OF NASSAU COUNTY, INC.
186 CLINTON STREET
HEMPSTEAD, NY 11550
PHONE: 516.489.2322 FAX: 516.489.2784 WWW.MHANC.ORG

FOUR WINDS HOSPITAL

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Adolescents and Adoption

By Gary Silverstein, CSWR, and Brian Gerety, CSW of The Therapy Center, Mt. Kisco and Brewster, New York

Gary Silverstein and Brian Gerety

Navigating the stormy seas of adolescence is arguably the most formidable emotional, psychological and physical task of a lifetime. To undertake this journey as an adopted adolescent, means traveling with additional trauma and stress worthy of some consideration.

There exists no psychological theory adequate enough to explore the impact of separation of mother and infant at birth, on both the mother and the infant. Many theorists have described the essential nature of the mother-infant bond impacting the psychological growth of the child. Freud, for instance, described the importance of the mother as a source of drive satisfaction for the infant. Object relations theorists such as D. W. Winnicott, R. D. Fairbairn, and Margaret Mahler emphasized the role of the mother as an object to which the infant must be fused, or merged for some time in order to develop a core sense of self as they gradually separate throughout childhood and adolescence. These theorists agree with John Bowlby, credited with developing the "attachment theory" and with Rene Spitz, who observed "anaclitic depression" in infants, that the mother is essential from the start of life, and that the infant reacts to the loss of the mother with true mourning.

In an attempt to understand the experience of the adopted child, Nancy Newton Verrier, author of "The Primal Wound" believes that it is impossible to sever the tie between infant and biological mother and replace her with another caregiver, no matter how warm and caring, without psychological consequences for the child and the mother. Although most adopted children form attachments to their adopted mothers, this represents an emotional dependence, which is crucial to survival and not necessarily a profound bond. Some of the manifestations of separating the child from the birth mother (a primal wound) include a sense of loss, basic mistrust, anxiety, depression, emotional/behavioral problems and relationship difficulties.

Research with adopted children indicates that they are to be found on a continuum relative to this trauma; from the severely pathological to the well adjusted with the vast majority of adoptees near the adjusted end of the scale. Virtually all adoptees are located on this continuum as they struggle with issues of self-esteem, abandonment, identity and anger.

Anecdotally, however, most mental health practitioners are aware that a disproportionate number of adoptees are represented in both in-patient and outpatient treatment settings usually at or around the time of adolescence.

The primary themes facing the adolescent adoptee are abandonment and loss. The response to these themes can translate to problems with intimacy, feelings of rejection and shame, need for control, identity confusion, lack of trust and, of course, anger. Anger which may have been suppressed throughout childhood due to conscious and unconscious messages conveyed by parents, (e.g., You are our 'miracle child', or 'chosen child') often emerges in adolescence in the form of acting out. Winnicott identified acting out as a reaction to perceived losses in the early mother-child relationship and a positive sign that the adolescent is simultaneously crying out for attention and expressing an authentic and vital aspect of their true selves.

As the adopted adolescent struggles with feeling different, they must also contend with feelings of powerlessness in the face of family denial regarding the significance of the adoption, and a societal constraint against having access to their past in the form of records which are sealed. These adolescents feel they have been cheated of a right to a past and that they have been manipulated into believing that their lives began at the moment of their adoption. According to Betty Lifton, author of "Journey of the Adopted Self," typical forms of acting out may include lying and stealing. Adoptees report feeling as though they have been lied to and some retaliate in kind. Stealing is an activity some adoptees feel is justified as they feel they have been 'stolen' from their birth mother and that the system has ripped them off. Winnicott saw stealing as not the acquisition of an object, per se, but a symbolic attempt to seek the mother over whom the adopted adolescent has rights. Running away may be seen as a symbolic search for one's true family or the pursuit of a fantasy of finding the birth mother. Some use food as a way of psychologically nurturing themselves or stuffing feelings of anger. Drugs and alcohol are sought in an effort to neutralize inner turmoil presented by emerging feelings of rage. Associating with a drug using or drinking crowd may be seen as an attempt to create a family of one's own choosing for the adoptee.

A small but nonetheless significant number of adoptees seek suicide as the ultimate form of expressing their desperation and sense of being unlovable. Suicidologist Edwin Schneidman identified the predisposing conditions of feelings of abandonment, helplessness and hopelessness in suicidal people while Bowlby concluded that parental loss is a major contributor to predicting suicidal behavior.

A major developmental task of adolescence is identity formation. According to Brodzinsky, Schechter and Henig, authors of "Being Adopted: The Lifelong Search for Self," adopted adolescents are no different from others in the patterns associated with identity formation except when they explore the question, "Who am I?", which has two parts; "Who am I?" and "Who am I in relation to my adoption?". Erik Erickson described the formation of an identity during adolescence as a

see Adolescents on page 32

Four Winds Hospital is the leading provider of Child and Adolescent Mental Health services in the Northeast. In addition to Child and Adolescent Services, Four Winds also provides comprehensive Inpatient and Outpatient mental health services for Adults, including psychiatric and dual diagnosis treatment.

Four Winds Hospital and Foundation

OCTOBER

Community Service
Thursday, October 9, 2003
1:00 – 4:00 pm

National Depression Screening Day

Free Depression Screening for Children, Adolescents and Adults

Take advantage of this free program designed to educate the public about depression. The screening process will include a written "self-test," a consultation with a mental health professional, and an educational presentation (screening is modified for children).

To schedule a ***free and confidential*** appointment, please call 1-800-546-1754 ext. 2413.

Grand Rounds
Friday, October 10, 2003
9:30 - 11:00 am

"The Body Speaks: Eating Problems, Self Mutilation, Body Modifications and Other Self Harm"

Sharon Klayman Farber, Ph.D.
Private Practice, Hastings-on-Hudson and the Founder of Westchester Eating Disorders Consultation Services

When patients speak through their bodies, you should know the language to understand how these symptoms speak for those whose voice has been silenced through trauma. Self- mutilation and eating disorders will be used as prototypes for understanding a spectrum of self-harm behaviors. Using case material, Dr. Farber will present a paradigm to illustrate how addictive attachments to pain and suffering develop as well as the stormy transference/counter-transference issues that often emerge.

Location: Four Winds Hospital Conference Center
800 Cross River Road
Katonah, New York 10536

Fee: $10.00 payable to Four Winds Hospital (reservations required)

Grand Rounds
Friday, October 17, 2003
9:30 - 11:00 am

"Predicting Violence in Adolescents"

Selwyn Juter, MD
Assistant Professor of Psychiatry, NY Medical College, Valhalla, and Private Practice, Mt. Kisco, NY

Can violence be predicted? Listen to Dr. Juter, adolescent and forensic psychiatrist as he discusses the risk factors used to evaluate 'dangerousness' and potential youth violence. The limitations of predicting future violence, management options, and the inherent responsibilities of clinicians, school authorities and community agencies involved in these cases will be reviewed.

Location: Four Winds Hospital Conference Center
800 Cross River Road
Katonah, New York 10536

Fee: $10.00 payable to Four Winds Hospital (reservations required)

Save the Date !

Nursing Career Day

Wednesday, October 22, 2003
4:00 – 7:00 pm

Experience Four Winds firsthand during this informal event.
Join a team that uses a multidisciplinary approach to treatment.
Your voice will make a difference.

Refreshments, Tours,
And an Opportunity to Meet with Nursing Leadership!

Competitive Salaries/Benefits

RSVP by October 15th at 1-800-546-1754 ext. 2413

Four Winds Hospital – Celebrating 25 years of Caring, Healing and Clinical Excellence.

Special Training
Thursday, October 23, 2003
2:30-4:00 pm

Child Abuse Identification and Reporting

Valerie Saltz, C.S.W., Four Winds Hospital

New York State recognizes certain professionals to be specially equipped to hold the important role of mandated reporter of child abuse or maltreatment. These include any child care worker, school officials, doctors, nurses, dentists, podiatrists, EMT's, etc. A State Education Department certificate of completion will be given at the end of the class.

Location: Four Winds Hospital Conference Center
800 Cross River Road
Katonah, New York 10536

Fee: $45.00 payable to the Four Winds Foundation – a not-for-profit organization (reservations required)

Special Event
Friday, October 24, 2003
6:00 – 8:00 pm

"The Art of Children With Special Emotional Needs"

The success of art therapy, a component of the comprehensive inpatient care at Four Winds is easiest to ***see.*** Please join special guest **Debra and Stone Phillips** and HBO Film Maker **Eames Yates** at the Opening Night Reception of The Art of Children from Four Winds Hospital.

Sponsored by: The Four Winds Foundation, a not-for-profit organization

Location: Northern Westchester Center for the Arts
272 North Bedford Road
Mount Kisco, New York 10549
www.nwcaonline.org for directions

Free of Charge * All are Welcome

Calendar Continued on Next Page

Educational Events Calendar: Fall 2003

NOVEMBER

Grand Rounds
Friday, November 7, 2003
9:30 - 11:00 am

"Domestic Violence is Not a Family Thing: 30 Years of Advocacy and Everything's Changed"

Charlotte A. Watson
Executive Director, New York State Office for the Prevention of Domestic Violence

Over the years the hallmarks of domestic violence have emerged as victim safety and offender accountability, with a shift away from why the battered woman stays to why her partner batters her. This presentation will take a look at how our understanding of domestic violence has evolved, with particular consideration given toward the mental health professional's role in addressing issues of domestic violence in treatment.

Location: Four Winds Hospital Conference Center
800 Cross River Road
Katonah, New York 10536

Fee: $10.00 payable to Four Winds Hospital (reservations required)

Grand Rounds
Friday, November 14, 2003
9:30 - 11:00 am

"Cross Cultural Perspectives with Abused Children"

Ofelia Rodriquez-Srednicki, Ph.D., Professor, Montclair State University and Private Practice, Upper Montclair, NJ

This talk will assist clinicians in identifying and addressing the cultural factors involved in the assessment and treatment of abused Latino children. The issues of maltreatment, neglect, discipline and sexual abuse will be addressed using a cultural "lens" with particular attention paid to perceptions within the Latino community.

Location: Four Winds Hospital Conference Center
800 Cross River Road
Katonah, New York 10536

Fee: $20.00 payable to the Four Winds Foundation, a not-for-profit organization. (reservations required)

DECEMBER

Grand Rounds
Friday, December 5, 2003
9:30 - 11:00 am

"Harm Reduction and Addiction: Misconceptions and The Truth"

Harris B. Stratyner, Ph.D.
Director of Addiction Recovery Services and "The Retreat at Westchester", New York Presbyterian Hospital; Assistant Professor of Psychology in Psychiatry, Weill Medical College of Cornell University

Any form of addiction treatment, by definition, is harm reduction. Dr. Stratyner will give the audience a clearer understanding of the distinction between harm reduction and moderation management and the particular importance of harm reduction in the treatment of individuals with co-occurring disorders.

Location: Four Winds Hospital Conference Center
800 Cross River Road
Katonah, New York 10509

Fee: $10.00 payable to Four Winds Hospital (reservations required)

Grand Rounds
Friday, December 12, 2003
9:30 - 11:00 am

"Psychological Testing: What is It... When To Use It...How To Use It"

David Pogge, Ph.D.
Director of Psychology, Four Winds Hospital; Senior Clinical Lecturer, Fairleigh Dickinson University and Visiting Assistant Professor of Psychology and Psychiatry, Albert Einstein College of Medicine

What is psychological testing? What is it used for? When is it indicated? How many tests are there and what do they tell us? These and other questions will be answered by Dr. Pogge in this informative lecture. Parents, educators, physicians, and mental health professionals will learn how psychological testing can contribute to educational planning, mental health treatment, and a better understanding of the individual being tested.

Location: Four Winds Hospital Conference Center
800 Cross River Road
Katonah, New York 10536

Fee: $10.00 payable to Four Winds Hospital (reservations required)

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"Celebrating 25 Years Of Caring, Healing and Clinical Excellence"

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Adolescents from page 29

necessary crisis in which an adolescent, through trial and error, seeks to develop a usable self with characteristics that uniquely fit the individual. It is a time during which one's values, beliefs, gender identification, career choices and personal expectations become more crystallized. Potential pitfalls exist for adopted adolescents who experience uncertainty about what it means to be adopted due to parents not being forthcoming or open, and records containing information about their origins not being available. For these individuals the authors suggest that a "family romance" fantasy persists in which birth parents are imbued with all positive attributes while the adoptive parents are viewed negatively. Other teens may deny that their adoption means much to them and they too easily accept their parent's attitudes without investigating for themselves. They may experience curiosity about their origins as a form of being disloyal to their adoptive parents who have given them so much.

Some adopted teens remain in a state of what Erickson termed "identity diffusion" in which they flounder with no clear direction and unrealistic fantasies about where they have been, where they are going, what they believe in, and who they are. In addition to the normative crisis adolescents experience regarding identity, adopted teens struggle with a pervasive sense of what the authors describe as "genealogical bewilderment," where they feel cut off from their heritage, religious background, culture and race. These teens struggle with a sense of having lost not only their birth parents, but also a part of themselves. When overwhelmed by this crisis some adopted teens regress to an earlier, more concrete cognitive style in which their worlds and their selves, seem to be divided into black and white, good and bad.

There are many adoptees whom Erikson would describe as "identity achievers" hailing from families who promote discussion of adoption and who assist their adoptive sons and daughters in resolving how being adopted does or does not fit into a cohesive attitude about themselves.

It is worth commenting about the world of relationships which becomes more significant during adolescence and how being adopted may complicate matters. From early on an association between love and abandonment is established in an adopted child such that love can equal abandonment. The conflict for the child exists such that the adoptive mother is the one to whom the child most wants to connect yet the person with whom it seems most dangerous. A characteristic ambivalence is a theme that may obstruct the development of intimate relationships for the adopted adolescent. The dictum that one cannot be chosen (adopted) by one parent unless they are first rejected by another is imbedded in their consciousness which makes relationships especially risky for them. In relationships, adopted adolescents may withdraw and isolate. They may test for possible rejection or seek an abusive relationship out of desperation or because they feel they deserve it. Lack of trust in the permanence of relationships may result in destroying a potentially good relationship when a need to control others in the face of anticipated rejection is compensatory in function.

Perhaps the word which best describes the adolescent adoptee's attitude regarding relationships is tentative. Their attitude toward the world around them, cautious. Adoption remains a beautiful gift for both parent and child. Knowledge and understanding of the issues involved with this process are vital to its success.

Gary Silverstein, CSWR is the Executive Director of The Therapy Center in Mount Kisco and Brewster, New York. Along with his partner and Executive Clinical Director, Brian Gerety, CSW, The Therapy Center, a private multidisciplinary mental/behavioral health practice for children, adolescents, adults and families provides a broad range of services in two locations, Mount Kisco, and Brewster, New York. Gary and Brian can be reached at 914-242-0725.

Four Winds FOUNDATION*

Presents

The Art of Children

With Special Emotional Needs

October 24th · 6:00 - 8:00 pm

The success of art therapy, a component of the Comprehensive inpatient care at Four Winds is easiest to *see*.

Please Join Special Guests
Debra and Stone Phillips
And HBO Film Maker
Eames Yates
at the
opening night reception of

The Art of Children from Four Winds Hospital

Location: Northern Westchester Center for the Arts
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visit www.nwcaonline.org for directions

*A not-for-profit organization

Save the Date!
Nursing Career Day

Wednesday, October 22nd
4:00 - 7:00 pm

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Join a team that uses a multidisciplinary approach to treatment.
Your voice will make a difference!

Refreshments, Tours, and an Opportunity to Meet with Nursing Leadership

Competitive Salaries/Benefits

RSVP by October 15th
By calling 1-800-546-1754 ext. 2413

Four Winds Hospital

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of Caring, Healing and Clinical Excellence

The Mental Health News

New York City Section

Lessons About Mental Illness Promote Tolerance

By Janet Susin, Project Director & Co-Author, "Breaking the Silence"

Imagine a class where students talk about mental illness with the same openness and sensitivity as heart disease or cancer. Or picture a classroom where someone calls a classmate a "psycho" and is immediately taken to task by students in the class.

To those of us who have experienced the pain of seeing our children shunned by their classmates or, worse yet, ridiculed and taunted, this seems like a fairy tale. But it isn't. These are actual reports of changes in behavior from real schools that have used "Breaking the Silence: Teaching the Next Generation About Mental Illness" (BTS)in their classes.

This attractive, easy-to-use educational package for three grade levels—upper elementary, middle school, and high school—uses stories to humanize serious mental illness and teach that these illnesses are no-fault brain disorders. Students also examine the role the media plays in perpetuating stigma through its portrayals of people who are mentally ill as either evil or someone to be ridiculed.

Striking posters included in the package, which teach the warning signs of mental illness or in the case of the middle school package, a popular anti-stigma game called "The Brain Game," reinforce the information and messages taught. A "Brains Can Get Sick Too" poster, which features a cartoon character, has also proved particularly popular. In addition, each educational package includes learning activities with cross-curricular ties, annotated bibliographies, web sites, and resource organizations that students can use to delve into the topic in greater depth.

These materials were created by the National Alliance for the Mentally Ill (NAMI) Queens/Nassau Education Committee with the generous support of NAMI and NAMI-NYS. NAMI affiliates around the country as well as Mental Health Associations, hospitals, and mental health agencies continue to promote their use and report that teachers consistently rate them very effective or effective in dispelling myths and stereotypes and educating students about mental illness. To date we have received orders from forty-three states as well as outside the US, including Japan, Australia, and the Virgin Islands.

New Editions of "Breaking the Silence" Expected in the Fall

A new edition of both elementary and high school plans, which will be available in the fall, will feature the story of Miss New York State, Jessica Lynch, who overcame her struggle with depression as a child and adolescent and went on to become this year's Miss America contestant for New York State. Her experience is the classic story of a dramatic change in behavior which went unrecognized as childhood depression. Also typical were the years of inadequate treatment and hospitalization before Jessica was finally on the road to recovery. Her commitment to teaching the warning signs of mental illness so that others will not have to experience the pain she has gone through make her an ideal role model for young people.

Janet Susin

Also featured in the new elementary edition will be a cartoon character puppet, Billy the Brain. Adapted from the popular image of our "Brains Can Get Sick Too" poster, Billy will be available both as a sick and well brain and will come with instructions for how they can both be turned into hand puppets. Role--play scenarios will be included which provide students an opportunity to use Sick Billy to act out symptoms of mental illness and get advice from his well brain counter part about how to recover. Sick Billy can also get advice from Well Billy about how to deal with the stigmatizing behavior of his classmates.

The high school plans will also be updated. In addition to including Jessica's adolescent experience with depression and eating disorders, the plans will include true stories of recovery by people with bipolar disorder and schizophrenia. Up-to-date brain science will round out this more mature look at mental illness and will complement other recent additions to the high school plans, which also include a discussion questionnaire entitled "Are These the Normal Ups and Downs of Adolescence or Mental Illness?" and "Schizophrenia: The Most Misunderstood Mental Illness."

Innovative Ways to Promote "Breaking the Silence"

Visitors to the 30 Friendly's restaurants on Long Island during May and June were greeted by attractive sky blue and white canisters asking customers to join Friendly's in supporting Breaking

see Breaking the Silence on page 52

Pregnant and Troubled Teens: A New Approach

By Deirdre Barrett, Psy.D. and Stephan Quentzel, J.D., M.D.
Beth Israel Medical Center

One in ten adolescents in the United States suffers from a mental health disorder serious enough to cause some significant level of impairment. In any given year, only one in five of these individuals will receive needed treatment. Often, it is the adolescent from a minority or low-income family who will not seek out or receive psychiatric care. This same population is also disproportionately affected by teenage pregnancy, which can be a major crisis for the pregnant young woman, her family, and the child. Frequent reactions include anger, guilt, fear, anxiety, confusion, denial and depression.

Providing effective mental health services to help young women and men function better in the context of pregnancy and parenting is vital. Young mothers require special understanding, medical care, emotional care, and education and especially about nutrition, substance abuse, medical complications of pregnancy, and parenting. Aftercare for young mothers is also important, as postpartum blues and depression are common in this population. Because young parents are often uncertain about their roles and may be frustrated by the constant demands of child rearing, babies born to teenagers are at greater risk for neglect and abuse.

For all of these reasons, in January of 2003, Beth Israel Medical Center (BIMC), in New York City, launched an initiative aimed at addressing the complex medical, social and psychiatric needs of pregnant adolescents and post-adolescents. The initiative, funded by the Klingenstein Third Generation Foundation, is designed to serve a largely poor, minority population of girls and young women presenting at BIMC seeking pregnancy related medical care. This initiative is the most recent outgrowth of BIMC's Primary Care Psychiatry Program, begun in 1997, and designed to increase diagnosis and treatment of psychiatric disorders in the many outpatient medical settings of the hospital's large multi-specialty ambulatory care center. In addition to functioning as a consultation service, the program emphasizes the development of psychiatric skills in the resident physicians and faculty doctors in internal medicine, obstetrics-gynecology, family practice, and pain medicine and palliative care.

Adolescent Program Description

The adolescent program participants primarily are pregnant girls/young women and new mothers between the ages of 13 and 23 and their male partners. Most are referred from within the OB-GYN Department following a psychosocial screening by a social worker. Other referral sources include the BIMC Outpatient Mental Health Clinic, the Pediatrics Department and the General Medicine Clinic. Outside referrals are increasing over time as the program becomes established in the community.

The treatment approach is comprehensive, with an emphasis on one-stop

see Troubled Teens on page 39

ICL Trauma Team's Assessment Principles Help us Understand Many Forms of Adolescent Loss

Larissa E. Golloub, CSW
Director, Children and Family Services Trauma Team,
Institute For Community Living

This segment is designed to increase the awareness of professionals, caretakers, and other concerned adults regarding the many forms of adolescent loss. With adolescents, one often forgets that loss, bereavement, and trauma may be reactions related to circumstances, for example, other than the death of a parent or other than sexual abuse.

Please review the categories below in order to better understand the events that may cause our adolescents to experience loss. As you are reading this list, think of the adolescents with whom you work or for whom you care. How many of the items or events listed below are present in the adolescent's life of whom you are thinking? Can you identify more than one form of loss for that particular individual?

The Many Forms of Adolescent Loss

- **Death of a parent or other loved one:** *violent vs. non-violent death, sudden death, coping with terminally ill loved one.*
- **Family separation:** *placement out of the home, divorce, immigration, incarceration, caretaker is a substance abuser, caretaker has a mental illness, caretaker has a physical illness/disability.*
- **Loss of innocence:** *sexual abuse, physical abuse, domestic violence, emotional neglect, caretaker is a substance abuser, caretaker has a mental illness.*
- **Loss of home and safety:** *immigration, residential relocation, homelessness, economic crisis, community disasters and crises.*

It is important to be aware of the different types of loss in which the adolescent may encounter. During the initial phase of treatment and assessment, it may be difficult to decipher which, if any, of the above losses have affected the adolescent in question. The difficulty of assessing for loss and trauma may be due to the mental health care provider's lack of training/experience regarding loss and trauma, or most likely to the adolescent's and/or caretaker's ambivalence in sharing this information. The adolescent, as well as the caretaker, is laden with feelings of shame, fear, guilt, and in some cases may even be unaware that a trauma or loss has occurred. These feelings and/or inability to identify the precipitating events in one's life promote a barrier, preventing effective communication with the mental health professional.

The Many Guises of Adolescent Bereavement

- **Aggressive and Oppositional Behavior:** *physical altercations, torturing animals, destruction of property, argumentativeness, identification with the aggressor, defies authority figures, trouble with the law, truancy.*
- **Depression:** *withdrawal, moodiness, sleep difficulties, eating difficulties, substance/alcohol abuse, procrastination, socialization difficulties, lethargy, difficulty concentrating, difficulty with memory, tearfulness, overly sensitive to criticism, feelings of hopelessness/fatalism, psychomotor retardation, physical ailments/complaints, risk-taking behavior, and self-injurious behavior.*
- **Anxiety:** *withdrawal, hyperactivity, aggression, moodiness, difficulty sleeping, difficulty eating, substance/alcohol abuse, overcompensation, OCD traits, body image problems, insecurity for the future/ fatalism, difficulty concentrating, difficulty with memory, hypervigilance, exaggerated startle response., physical illness/complaints, risk taking & self-injurious behavior.*

For severely traumatized individuals, there are specific categories for assessment. The adolescent may still present any one of the above symptoms or behaviors, but the following additional descriptions are useful towards understanding when an adolescent needs increased intervention.

- **Acute Stress Disorder:** *experienced event which individual perceived as having been life threatening, recurrent images of the event., avoidance of things related to the event, increased anxiety/arousal, response to the event was intense.*
- **Posttraumatic Stress Disorder:** *experienced event which individual perceived as having been life threatening, recurrent images of the event, avoidance of things related to the event, increased anxiety/arousal, response to the event was intense, feeling as if re-living the event.*

Many variables can influence the adolescent and his/her coping skills during a time of loss. Keep the following variables in mind when you are working with a grieving adolescent. During an assessment, use these variables to understand the adolescent's struggle and how to be supportive.

- **Strengths and Vulnerabilities:** abrupt vs. anticipated loss, violent vs. non-violent loss, prior trauma/ loss, age of prior trauma/loss, reaction to past loss/coping style, successful recovery of prior trauma/ loss, family & social supports, competencies/mastery of developmental tasks, hopes for the future, temperament, family dynamics, cultural variations, economic factors, neighborhood, developmental phase.

It is important to assess the adolescent's strengths and vulnerabilities and to see the child as a whole—rather, to understand the adolescent in the context of cultural background, culture specific to the individual's family, social supports, past history, and physical living conditions.

As adolescence is a time of turbulence, it is also important to take into consideration the current developmental stage of the adolescent, and his/her experience in prior stages of adolescence. Adolescents are especially vulnerable to the experience of loss and trauma due to their tender age, inexperience, bodily changes, and the lack of control over their surroundings. Their general vulnerability can best be understood by the knowledge of developmental stages and tasks that they must master.

Developmental Stages of Adolescents. (P. Blos, 1962)

- **Early Stage of Adolescence (ages 11 - 14):** *child begins to separate from the parent, peer group is high priority, puberty/changed body image.*
- **Middle Stage of Adolescence (ages 14-17):** *continued withdrawal/ separation from parents, emotional ambivalence, intensified emotion, romantic interests become focus, moodiness/self-absorption, search for meaning and direction, defends against depression/aggression/ anxiety, intense need to attach to peers, increased awareness of emotional and sexual self, cognitive skills are increasingly realistic, objective, and analytical.*
- **Late Stage of Adolescence (ages 18- 21):** *emotional stability, behavioral stability, positive feelings and relationship with parents.*

If you know of an adolescent who has experienced any of the aforementioned events, please give Larissa Golloub at (718) 290-8100. Our Children and Family Services' trauma team stands ready to assist parents, caretakers, professional, and others.

NIMH from page 1

Scope of the Problem

A number of epidemiological studies have reported that up to 2.5 percent of children and up to 8.3 percent of adolescents in the U.S. suffer from depression.4 An NIMH-sponsored study of 9- to 17-year-olds estimates that the prevalence of any depression is more than 6 percent in a 6-month period, with 4.9 percent having major depression. In addition, research indicates that depression onset is occurring earlier in life today than in past decades. A recently published longitudinal prospective study found that early-onset depression often persists, recurs, and continues into adulthood, and indicates that depression in youth may also predict more severe illness in adult life. Depression in young people often co-occurs with other mental disorders, most commonly anxiety, disruptive behavior, or substance abuse disorders, and with physical illnesses, such as diabetes.

Suicide. Depression in children and adolescents is associated with an increased risk of suicidal behaviors. This risk may rise, particularly among adolescent boys, if the depression is accompanied by conduct disorder and alcohol or other substance abuse. In 1997, suicide was the third leading cause of death in 10- to 24-year-olds. NIMH-supported researchers found that among adolescents who develop major depressive disorder, as many as 7 percent may commit suicide in the young adult years. Consequently, it is important for doctors and parents to take all threats of suicide seriously.

NIMH researchers are developing and testing various interventions to prevent suicide in children and adolescents. Early diagnosis and treatment, accurate evaluation of suicidal thinking, and limiting young people's access to lethal agents—including firearms and medications—may hold the greatest suicide prevention value.

Clinical Characteristics

The diagnostic criteria and key defining features of major depressive disorder in children and adolescents are the same as they are for adults. However, recognition and diagnosis of the disorder may be more difficult in youth for several reasons. The way symptoms are expressed varies with the developmental stage of the youngster. In addition, children and young adolescents with depression may have difficulty in properly identifying and describing their internal emotional or mood states. For example, instead of communicating how bad they feel, they may act out and be irritable toward others, which may be interpreted simply as misbehavior or disobedience. Research has found that parents are even less likely to identify major depression in their adolescents than are the adolescents themselves.

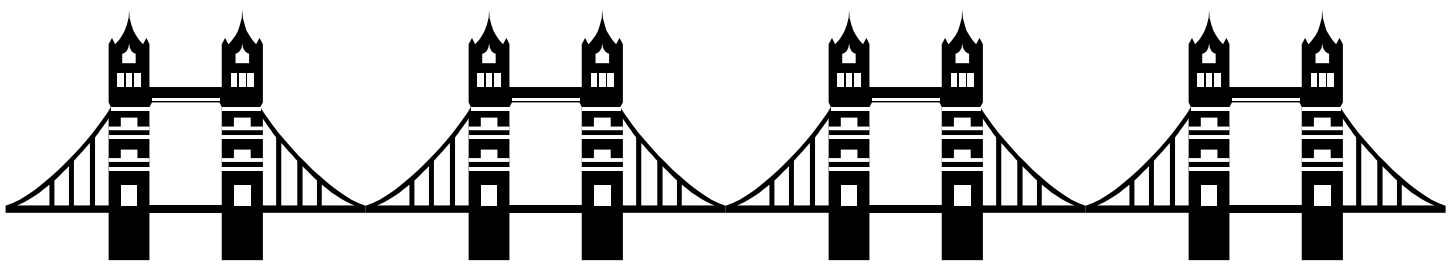
Symptoms of Major Depressive Disorder Common to Adults, Children, and Adolescents

- Persistent sad or irritable mood
- Loss of interest in activities once enjoyed
- Significant change in appetite or body weight
- Difficulty sleeping or oversleeping
- Psychomotor agitation or retardation
- Loss of energy

see NIMH on page 54

Institute for Community Living, Inc

Vocational Opportunities
and
Employment Center (VOEC)



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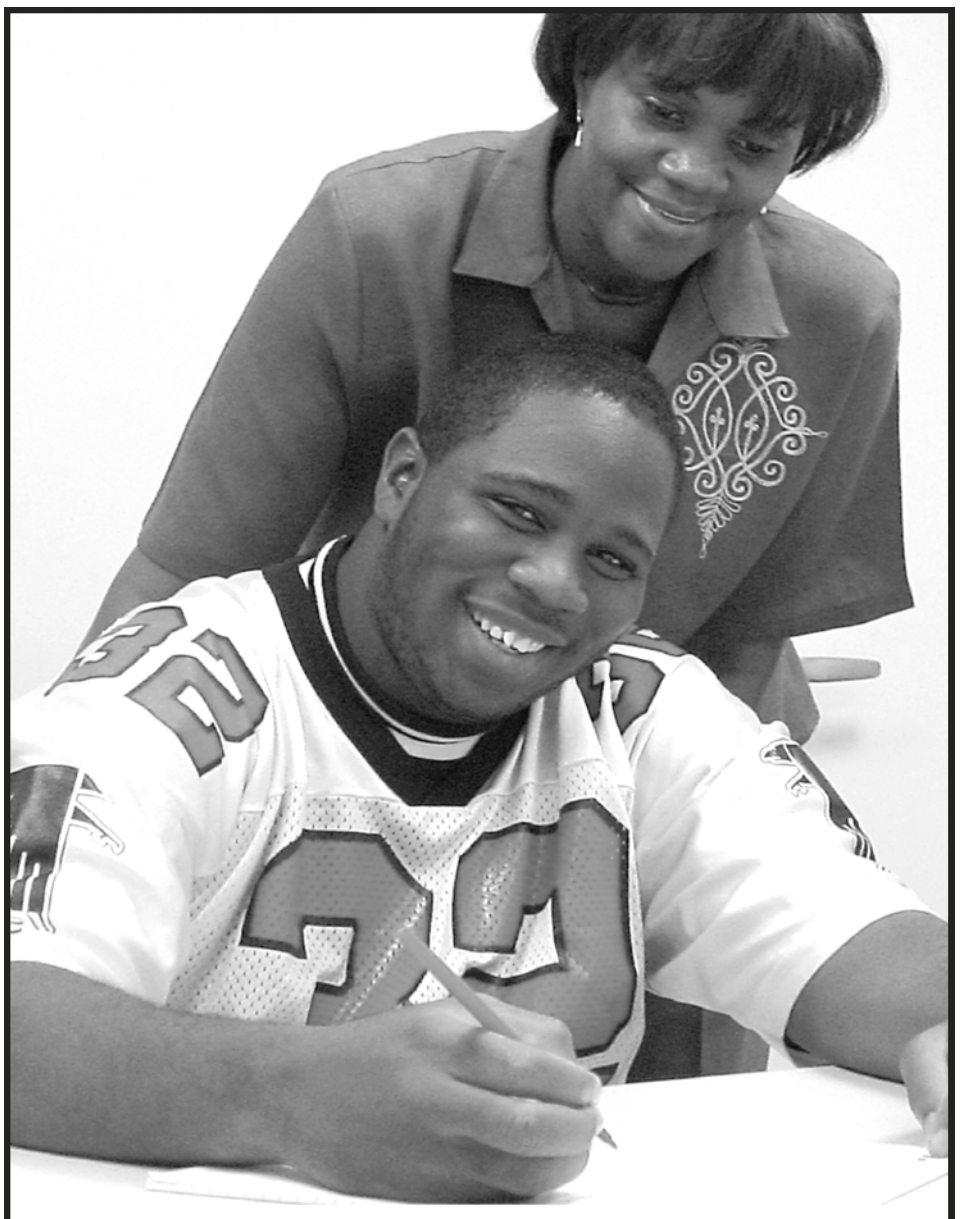

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Treatment at Work For Teenage Depression

By Zvi Yadin, Ph.D., and Carol Jobson, CSW-R, CASAC

Adolescence is a tumultuous and confusing period when teens strive for independence but hesitate to let go of the security of their parents/caretakers. These struggles can cause many undetected problems, including debilitating teenage depression. At the F.E.G.S Counseling and "PASSAGES," Young Adult Rehabilitation Center (IPRT) in Far Rockaway, we help teens and their caretakers/parents understand that recovery is possible from serious and prolonged depression. Our caring rehabilitation professionals have the unique skills to help reduce the symptoms and promote a return to mainstream activities.

Our program serves young adults 15-19 years old who are emotionally challenged and have a strong desire to make a change in their lives. It follows a strength-based, skill-building philosophy, in which staff works with kids to develop a more positive interactive social style. Skill attainment helps improve self-image, decreases depression, and helps kids have positive interchanges with other teens and adults. Behaviors such as sharing, helping, planning, problem solving, giving and getting compliments are universally considered socially desired behaviors. These behaviors are commonly referred to as social skills. In our program, we promote appropriate behavior through modeling, practice, and role-playing. The program's structure is designed to improve self-control. Teens use computers for skill building, resource development and to share their findings with other "PASSAGES" program members. Gradually, desirable behavior replaces undesirable behavior.

At 16 years old, a client we will call Linda, was referred to "PASSAGES." Linda's attractiveness was overshadowed by her obesity and her disheveled appearance. She was socially isolated, unfocussed and unsure of herself. Her mother, who was also suffering from bouts of depression, was not always able to give her the support and nurturing she needed. Her relationship with her father was strained due to his alcohol abuse. Although a bright and capable student, she dropped out of high school in the 10th grade. In attending the program, she became connected to adults and began to make friends. She used painting and creative writing as vehicles to express her thoughts and feelings.

Through participation in the program, she improved her self-care, developed positive relationships, resolved her fears about venturing out of the Rockaways, and became assertive and self-confident. She achieved her High School General Equivalency Diploma (GED) and went on to attend the Art Institute of NYC where she pursued a certificate in Pastry Arts. Having completed that program, she is now working on a degree in Restaurant Management. For Linda, "PASSAGES" became her extended family. Sixteen months after completing the program, she maintains contact with us and keeps us apprised of her achievements. She expresses that her long-term goal is to open her own business.

Linda is one example of how unconditional acceptance in both programs helped to build self-confidence and further reduce depression. When teens begin the program, they often say they feel different from others, they have been ridiculed, ganged up on and rejected by peers and family who show a lack of interest and caring. When our teens discover that they can "fit in," their self-esteem markedly improves, they are more joyful and they are able to move toward more self-fulfilling activities and subsequent self-sufficiency.

We should all be able to recognize the signs of depression: Disturbed sleep patterns, excessive worry, anxiety, inability to complete normal daily routines, irritability, short-temperedness, many physical complaints, lack of appetite, or over-eating, isolation and increased dependence on family.

In some cases, youngsters think about death or become suicidal. These youngsters need to be closely monitored by both clinician and psychiatrist and may need to be on medication for a period of time. Most depressed youngsters are hard pressed to feel good about anything, even if they do well in school, sports or have good interpersonal relationships.

Learning issues. Teens treated in "PASSAGES" often have a secondary problem involving a variety of learning disabilities (LD), which can compound their ability to have a normal social life. Such complications might even contribute to depression; it can also cause poor academic performance and truancy. Despite early identification and educational remedial plans, youngsters who are emotionally challenged seem to need a one-on-one approach delivered in a behavioral health environment. Parents, more often than not, deny and/or try to manage symptoms and behaviors at home avoiding professional counseling services until years later. Teenagers with LD are seen as less popular and often times labeled as social outcasts. When they enroll in our program, they begin to find solace in a peer group that accepts them as they are. In many cases, youngsters with LD tend to be more easily frustrated than students without a learning problem. They can become aggressive at times, which further promotes rejection by peers at school and are at high risk for emotional disturbances. Research indicates that the less an adolescent is involved in learning activities, the greater the chance they will take part in delinquent behavior.

see Passages on page 55

Adolescent Depression: Treatment Challenges

Jewish Board of Family and Children's Services (JBFCS)

The signs of adolescent depression are often those commonly associated with adult depression. Why then can they be so difficult to detect? Because adolescents are already going through significant phases of change, many of the signs of depression may be confused with normal adolescent behavior. For example, adolescents may not be doing their assigned homework, grades are dropping or they are truant at school; they are angry or irritable. These appear to many as "normal" signs of adolescent struggles. but may in fact be signs of a more serious problem called depression.

The computer phenomenon adds to the difficulty of diagnosing depression. Computers make it easier for many teens to isolate themselves by appearing to have a semblance of a life on line through chat rooms and e-mail. These often result in late nights and difficulty getting up in the morning. One of the first signs of depression for adults is insomnia. In adolescents, this is often seen as harmless behavior instead of a symptom of depression.

The Lessons of 9/11

A great deal has been learned of late about adolescent depression, particularly in the aftermath of 9/11 and the focus on understanding its impact on children. Many children were attending school around Ground Zero. As a result of extensive training of both school personnel and parents, there has been greater attention paid to adolescent depression. Thus, schools and parents are doing a better job of recognizing and responding to signs of emotional problems in teens. A continuing distressed economic and political environment has increased the number of adolescents struggling with depression.

The Jewish Board of Family and Children's Services has played a significant role in the 9/11 mental health response, particularly as it relates to children and teens. Training and consultation by its Center for Trauma Program Innovation has been made available throughout the New York City and beyond. JBFCS' Youth Counseling League provides support services at three high schools near Ground Zero in addition to the some 15 other Manhattan high schools where it has an ongoing, on-site mental health support program.

Through generous federal support, JBFCS is conducting extensive surveys to assess the impact of 9/11 on children. Results are already indicating continuing and significant symptoms of distress in high school students in New York City. Thanks to the concern and involvement of parents, they too have become more aware of this issue and are quicker to recognize the signs of depression.

Historic Tradition of Helping Teens

Throughout JBFCS' 112-year history, mental health and social services for children and teens has been a central part of the agency's mission. Founded almost 100 years ago, its Hawthorne Cedar Knolls School continues to be one of the nation's leading treatment facilities for teens. In addition to HCKS and four other residential treatment programs and YCL's high school-based services, JBFCS has extensive community-based programs addressing the problems of teens. These include children's day treatment programs which integrate therapeutic treatment with a specially-designed education program and neighborhood-based counseling centers. The agency's Brooklyn Adolescent Program offers a diverse range of services, including a modified day treatment program for dually diagnosed teens, an on-site school and counseling service for teens and their parents. Services have recently expanded to address the need for adolescent services in the Orthodox Jewish community.

For many years, Brooklyn Adolescent Services (Thomas Askin Youth Programs) has responded to the special needs of émigré teens through its Russian Adolescent Program. In general, these teens are believed to have been more prone to depression. In addition to the expected struggles with adolescent development issues, life is even more difficult for émigré teens adjusting to a new culture and language. They are often homesick and are struggling in school and with their families.

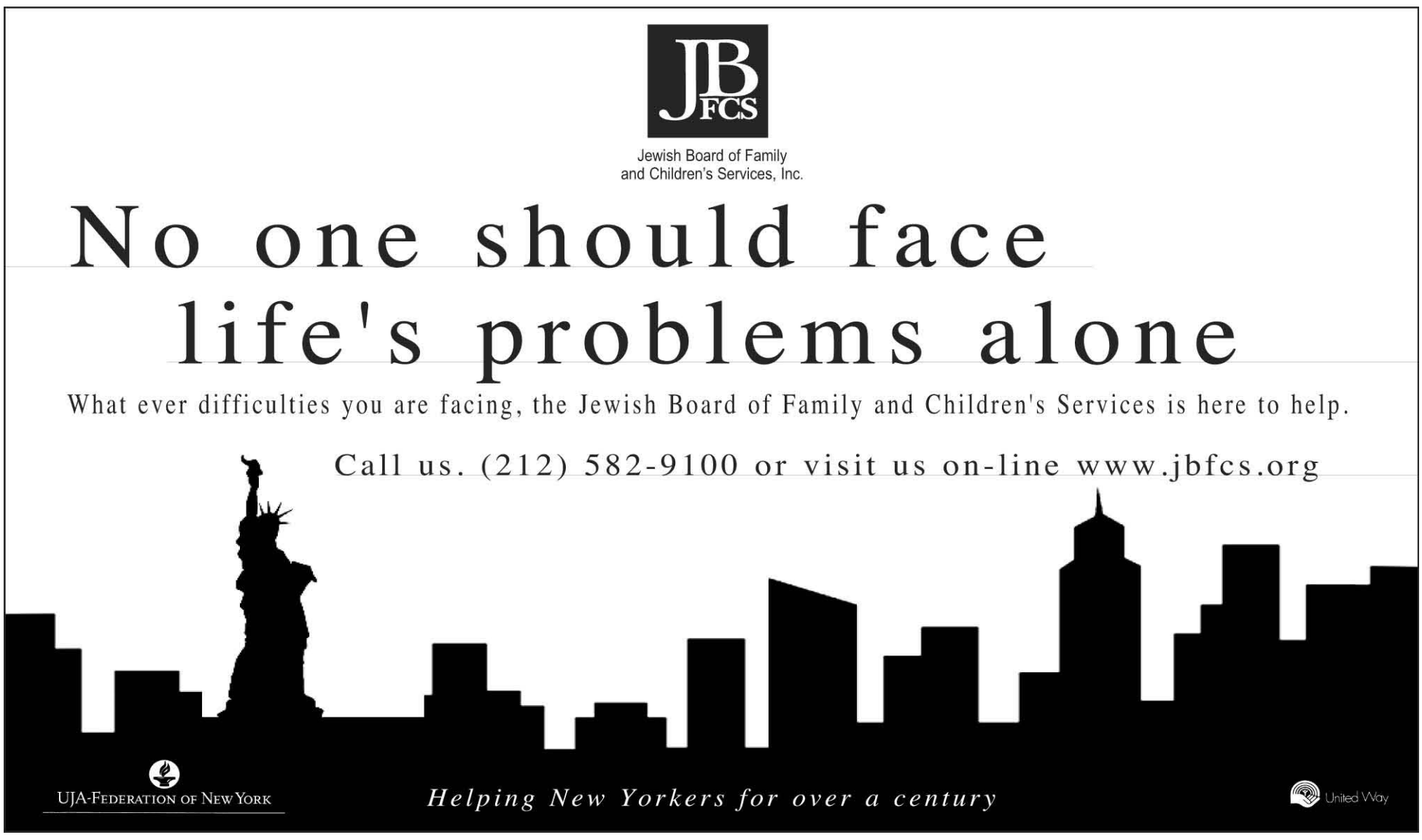
Treatment Approaches for Teens

JBFCS experts believe that effective treatment approaches to adolescent depression depends on the severity of the impairment and the duration of time of the condition. Treatment often combines psychotherapeutic intervention with medication. Groups are seen as an effective treatment modality for teens, a structure they are familiar with. YCL's summer program, "Teens on the Town" offers teens the chance to socialize and workers are able to monitor how the youths interact in groups.

To reinforce the tools for responding to teen problems, JBFCS frequently makes presentations to teachers, counselors and parent groups. They will address a specific topic schools have identified as important or they bring to the attention of schools issues they believe to be critical to teens.

Many teens referred to JBFCS are defiant, excessively truant and aggressive and are referred because of poor attendance at school or failing grades. Many struggle with attention deficit disorder or hyperactivity. More and more are identified as sad, withdrawn and depressed. In assessment session, clinicians may learn of suicide attempts or

see Challenges on page 40



Adolescent Depression: A Developmental, Multimodal and Biopsychosocial Perspective

By Abraham S. Bartell, M.D., MBA and Zvi S. Weisstuch, M.D.
Mount Sinai Medical Center

Adolescent depression is one of the most common illnesses seen by family physicians, pediatricians, and psychiatrists with a cumulative incidence of 25% during the teen years. The symptoms of depression can be expressed in a wide range of behaviors and often manifest differently in adolescents and adults. To understand adolescent depression one must first understand "adolescence." How do we define and understand or conceptualize adolescents. Adolescence is most simply defined chronologically; and although the age definition varies, the most commonly accepted range is 12 to 21 years plus or minus one year. To conceptualize adolescence, one must consider normal adolescent development. There are five major spheres of development in adolescents which need to be considered; these are 1) biological / physiologic 2) cognitive 3) emotional 4) social and 5) moral development.

Biological and physical development of an individual is influenced by that person's genetic endowment and includes physical growth in height and weight, neurologic development and endocrinologic (sexual) development.

Cognitive development in adolescents is complex but may be simply described by appreciating the transition from concrete to abstract thought process. Adolescents are now able to better abstract and are less concrete in the way they think. The adolescent is able to manipulate ideas and concepts and integrate new experiences to his armamentum in dealing with the world and those around him/her. They make great efforts to understand the world around them, understand themselves, and understand how the two integrate.

Emotional development manifests as emotions being more intensely displayed. This emotional development results in the emergence of more sophisticated and effective defense mechanisms.

Social development during adolescence is complex as well and reflects the impact of all the spheres of development. During adolescence sexuality and sexual interests, urges, curiosities, and impulses increase dramatically. The role and importance of peer influences increase substantially. The strive for independence and individual identity is a crucial element in the adolescent life. The challenges of social and emotional development result in the evolution of a new value system. Morality is developing exponentially during this time period and is greatly influenced by several factors including peers, parental teaching, family and cultural influences and social norms and ethics.

When this delicate and complicated developmental process is disrupted or developmental milestones are not appropriately achieved, arrest or intruded upon by major life stressors that psychopathology may present in the adolescents life. Depressive illness is an all too common result. The symptoms of depression can be expressed in a wide range of behaviors and often manifest differently in adolescents then adults. Compared with depressed adults, adolescents with depression are predictably atypical. They experience less melancholia and describe more anxiety, phobias, somatic complaints, irritability, and behavioral problems than depressed adults. Adolescents are more likely to act out their feelings with negative and risk-taking behaviors. These behaviors may include but are by no means limited to unprotected sex, substance use and/or experimentation, and thrill-seeking behavior such as speeding in a car.

To recognize concerning symptoms; accurately diagnose and treat depression in adolescents; the clinician must be aware of the adolescent's developmental issues. When depressive features are elicited or suspected, a multimodal/ biopsychosocial approach should be applied to further assess the individual and establish a treatment plan. Engagement is crucial to the evaluation process. The evaluation process should be discussed with the adolescent to form a therapeutic alliance and to anticipate and address any concerns regarding confidentiality. The multimodal approach consists of gathering as much data as possible about the adolescent's world and support systems. This approach can be viewed as a "bull's eye" with the adolescent in the center and the surrounding circles of the bull's eye representing their support systems. Each of the support systems should then be explored and close attention paid to the individual components. The process begins with the adolescent's immediate family comprising the inner most ring working outward identifying and examining each support system in the individual's life. An effort should be made to obtain the information from multiple reporters in each setting and/or system of the adolescent's life and multiple modalities of assessment may help in conducting a thorough and inclusive evaluation. The various modalities may include clinical interviews, structured interviews, self-report instruments and administered instruments.

see Perspective on page 52

Helping Teens Through Life Steps

By Brenda Taylor and Maria Esposito
Partnership With Children

With bright eyes and a warm smile, Keith holds the door for you and asks how you are today. While he appears to be a handsome and charming fifteen-year old, it might surprise you to learn that he has struggled with low self-esteem and has had a history of truancy, fighting, and criminal activity. When Keith and his family moved to New York from the West Indies, Keith felt different from the kids he met here and wanted desperately to fit in. His feelings of exclusion and frustration, however, ultimately led to misbehavior. His mother tried everything, ultimately calling upon outside assistance. Keith is now getting the help he needs through a community-based non-profit counseling agency called Partnership With Children (PWC). At PWC's Brooklyn offices, Keith meets weekly with a counselor and participates in a peer group. His school attendance has improved, he no longer fights and stays out all night, and in counseling, he is beginning to understand himself and appreciate his differences.

Keith is not unlike many other teens. The desire to fit in and at the same time develop one's own identity and independence is a hallmark feature of adolescence. This creates the "control versus autonomy" predicament for parents, leaving them feeling unappreciated and exasperated and teens feeling misunderstood and stifled. For better or worse, this family experience is normal. However, there are situations, such as Keith's, when additional help is needed to facilitate the child's development and passage to adulthood.

That is where PWC's Life Steps program comes in. Life Steps is a preventive counseling program for at-risk children and adolescents. It is staffed by bicultural masters-level social workers who assist clients with issues such as peer and family relationships, chronic illness, bereavement, alcohol and substance abuse, teen pregnancy, domestic violence, and the transition to work. Life Steps provides a place to explore values and goals, learn new skills, build new relationships, and have fun, all while utilizing individual strengths creatively.

While Life Steps' counselors see children of all ages, they have had the opportunity over the last 17 years to work intensively with teenagers and learn the various ways in which depression, as well as other disorders, can afflict them. A universal theme of adolescence is loss. As they begin to separate from their parents, teens experience a loss of childhood. The often self-imposed separation between them and their parents (to enable a closer affiliation with peers) creates a loss of connectedness that adolescents actually want and need. When you add the loss of a parent or other role model to this normative loss, the result can be traumatic. Their shame and embarrassment about wanting to stay connected may lead to difficulty for teenagers in expressing themselves positively. Boys, usually encouraged to separate from their mothers at earlier ages than girls, may attempt to deny their sad feelings (which some may equate with weakness) and to externalize a more socially-accepted emotion—anger.

Whether or not loss is the root of a teenager's depression, anger can be one of depression's loudest calling cards. While the generally understood symptoms of depression are physical, emotional, and/or psychological withdrawal from daily activities, it is becoming increasingly recognized that particularly in boys, aggression and hyperactivity are also signs of depression. Fighting at home and at school, failing in school, and rejecting household rules are some ways that depression masquerades as anger. Teenagers who act out in this way are often further isolated at a time when what they really want is connection and acceptance. Clearly, however, engaging a child who is experiencing this can be a challenge for parents.

Again, this is where Life Steps steps in. Counselors understand that while teens may not want—or be able—to talk with their parents, they need the support of a trusted adult. By facilitating the natural separation and individuation that takes place during adolescence, counselors assist teenagers in developing the independence they so desperately desire while also building the skills to identify and communicate their emotions. Individual counseling is enhanced by a teen's involvement in group activities at Life Steps. Group treatment allows the counselor to see first-hand how the adolescent relates to the outside

see Life Steps on page 50

Troubled Teens from page 33

shopping. The treatment model incorporates a developmental perspective that integrates an assessment of individual maturation level with specific environmental influence to ensure that the uniqueness of adolescent psychology is recognized. Once individuals are identified as requiring services, a team composed of psychiatrists, psychologists, social workers, obstetricians, midwives, nurses, nutritionists, internists, family physicians, perinatologists, and/or physicians-in-training develop a treatment plan. Care plans may include psychiatric medications, psycho-educational programming, time-limited supportive sessions, extensive psychotherapies, crisis management, and social work services.

Many program participants come from highly dysfunctional families, with poor parental role models, inconsistent nurturing, and limited opportunities to develop strong relationship skills. In order to build positive relationship experience, many participants attend therapy groups specifically designed to meet their needs. In group they can develop improved dynamics for interacting with peers and authority figures. All groups incorporate psycho-educational and experiential material to facilitate learning about and practicing successful methods for functioning well in pregnancy and motherhood, especially when they're coupled with anxiety, depression and other stresses.

Group therapy options include: a psychotherapy group for pregnant women ages 13 to 23 who suffer from psychiatric illness; a psycho-educational group for all pregnant teens and young mothers; a post-partum group to address the psychological aftermath of giving birth and coping with motherhood; and a psychotherapy group for new fathers. Social workers help resolve housing, financial and legal problems as well. When interventions that BIMC does not offer are required, such as visiting nurse home care, parent training, mother-child programs, and preventive care services, the team orchestrates appropriate referrals to community organizations with which the Primary Care Psychiatry Program has nurtured close ties.

In addition to emphasizing building positive relationships, the program provides a nurturing environment to meet the special needs of this often difficult to engage population: integration and continuity of care—all services are coordinated through the team and provided at one location; persistent follow-up to reduce missed visits; and certificates of recognition and other rewards for completing treatment.

Ongoing training of medical staff is viewed as a key component of the Primary Care Psychiatry Program in general and of its adolescent division in particular. Potential members of the adolescent team receive comprehensive training to improve the identification and treatment of common psychiatric disorders among adolescents. Particular emphasis is placed on learning to assess for a history of trauma and substance abuse while also recognizing and treating depression and anxiety during and after pregnancy. Medical staff is taught specific methods for addressing the challenging personality styles adolescent patients may offer. Care providers learn to avoid the common pitfalls of labeling such patients too hastily as anti-social or otherwise personality disordered and of failing to engage the vulnerable and needy person hiding beneath the too often alienating exterior.

The Primary Care Psychiatry Program and its adolescent division at BIMC works. The young women tell us repeatedly that in response to participating in the program their general functioning has improved, their happiness has increased, and their mothering roles come more easily. Of added benefit, their male partners grow closer and their family units feel more intact.

Case Study

Mariela is a 19-year-old Latina born and raised in New York City. This is her second pregnancy. Like all new Medicaid obstetrics patients at BIMC, Mariela meets with a social worker during her first visit. In that meeting, Mariela reports a history of episodic major depression. It appeared first in childhood and worsened during her first pregnancy. Following the birth of her son, who is now one year old, Mariela felt overwhelmed and presented at the BIMC emergency room complaining of suicidal thoughts. She was hospitalized for two weeks on an inpatient psychiatric unit. Following discharge, Mariela avoided outpatient follow-up and discontinued her medication.

Mariela and Juan, the father of both babies, met in high school and have been together for four years. While they would prefer to live together, due to financial limitations they live separately with their respective families. Both families are highly dysfunctional and fragmented and neither adolescent receives much emotional or financial support. Juan has managed to work steadily in a factory but has not been able to save much money. Mariela describes her relationship with him as good in the past but increasingly problematic due to his unwillingness to help out with the first baby and his growing inattention to her. She reports that he visits too infrequently and seems "changed". She hopes her current pregnancy will bring them closer together but it appears to be having the opposite effect.

During her session with the social worker, Mariela reports that her symptoms of depression have returned, including thoughts of suicide. She worries about caring properly for her young son as well as dealing with the pregnancy. To respond to the immediate crisis, the primary care psychiatrist is called and joins the interview. In consultation with her obstetrician, Mariela is placed on medication proven safe for use during pregnancy. Mariela is also referred to individual therapy with a psychotherapist and to an on-site psychotherapy group for psychologically challenged pregnant young women. To address the conflicts in her relationship with Juan, they meet several times with her social worker, who also helps Mariela access a complement of needed social services.

In the beginning, Mariela's participation in individual and group therapy is sporadic. To engage her further, she is outreached regularly and her medication compliance is closely monitored. Phone sessions are offered when attendance proves impossible. Arrangements to assist with baby and home care are pursued by the social worker to ensure additional support once the baby is born. Juan is encouraged to participate in the fathers' group to gain support and learn to perform better as a parent.

One month ago, Mariela gave birth to a healthy baby girl. She continues her medication, which has eased her depression and improved her parenting of her son and her newborn. She continues in individual therapy and just joined the post-partum group for new mothers. She is receiving extensive social services, including home visits by a preventive service counselor who attempts to educate her further on mothering and childcare. Her relationship with Juan is better as a result of his participation in the fathers' group as well as her improved mood. While Mariela is currently doing well, her treatment team monitors her to ensure that any downturn is addressed quickly and effectively. She smiles more these days.

For more information about these programs at Beth Israel Medical Center, please contact Dr. Stephan Quentzel, at (212) 844-8602.

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committee in formation

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Mental Health News is Now Seeking Articles & Display Ads For These Exciting Upcoming Issues:

Winter 2004 Issue: November 1st Deadline
The Crisis of Suicide in America

Spring 2004 Issue: April 1st Deadline
Eating Disorders: The Conflict Within

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Understanding and Treating Sleep Disorders

Testimony from page 10

Heed also the recommendation of the New Freedom Commission on Mental Health appointed by President Bush. The mental health service system must consider new ways to deliver care to children "in a place long overlooked, our Nation's schools." [Interim Report of President's New Freedom Commission on Mental Health, November 2002]. Legislation like H.R. 1170 – now part of the House bill to reauthorize IDEA (H.R. 1350)- undermine that tenet.

Decisions about appropriate medication for a child with a mental illness rests exclusively with parents and medical professionals—where partnership also is required. Medication is not the only option for families and should be considered in conjunction with a range of treatment options. NAMI hears from thousands of families across the country about their inability to get treatment and services for their child with a mental illness. That is the real crisis. NAMI asks that the Subcommittee support President Bush, the Surgeon General, and millions of American families in addressing this very real concern instead.

Center Lane from page 18

Although not a cure-all for teenagers with severe mental health diagnoses, the affects of the positive socialization services that Center Lane offers are often rapid and clearly visible. Most teens that come to Center Lane make friends, become more involved in social activities, and show signs of improved mood almost immediately.

For more information about Center Lane, please contact Sara Braun, Program Director at (914) 948-1042. For information about attending the Healing the Hurt conference, call Mary Jane Karger, Co-Chair of GLSEN (Gay, Lesbian, Straight Education Network) of the Hudson Valley at (914) 962-7888.

Challenges from page 37

incidents of self-mutilation. Often these youths have never told anyone else about these experiences or they may have told a parent but no further steps had been taken.

Arnold Markowitz, Director of Brooklyn Adolescent Services (BAP) and chair of the agency's Adolescent Services Leadership Group, believes that the best way to deal with adolescent depression is through "talking and doing". The "talking" includes individual and family therapy and the "doing" includes the use of groups, psychoeducational discussions and providing safe social activities. At the Brooklyn Rita J. and Stanley H. Kaplan Center, teens use a drop-in activities room to play pool or other games. The room is staffed by social workers and graduate students who are available for support. They offer summer programs as well as on-site programs at community centers. Medication management as well as drug and/or alcohol treatment are available at the Brooklyn center. Teens of all cultures participate in group discussions and recreational activities, which promotes greater tolerance among often conflicting groups.

Residential Treatment Services

Teens struggling with depression are a significant part of the population at JBFCS' residential treatment facilities in Westchester. Depression is part of a larger picture for residents at Linden Hill and Goldsmith Center. Residents there have complex situations with a range of diagnoses that include PTSD, bipolar disorder and psychotic disorder. Depression is addressed through therapy a wide range of psychotropic medications and with therapeutic interventions directly related to the precipitant of the depression. The depression might be related to a recent loss or to long-standing abandonment issues.

Much has been learned in recent years about adolescent depression, particularly since the events of September 11th, 2001. JBFCS will continue to launch new and innovative training, consultation and direct service efforts which may lead to new interventions and treatment approaches to effectively address the challenges of adolescent depression.

St. Vincent's Westchester *Connections Program* Fills Adolescent Day Treatment Gap

Staff Writer
Mental Health News

St. Vincent's Hospital Westchester in Harrison offers a short-term adolescent day treatment program that can serve both as an alternative to inpatient treatment and as a step-down program following an inpatient stay.

The Connections Program serves adolescents in a safe and structured environment. Program participants receive individual, group and family therapy from a multi-disciplinary treatment team, as well as tutoring from state-certified teachers. Children who attend the program suffer from a range of mental illnesses, including depression, oppositional disorders, and bipolar disorder.

"We adapt our groups to the needs of the adolescents in the program," said therapist Shirley Quinnell-Friedlander, CSW. Groups include psychotherapy, expressive therapy, diagnosis and medication education. The treatment team focuses on helping the adolescents understand the factors that trigger their symptoms and how to cope with them. Therapists work closely with families to help them to understand their child's illness and how to support their child's recovery.

"Identifying and maintaining a support system for every adolescent is an important part of preventing a rehospitalization," said Quinnell-Friedlander. Connections maintains close contact with the child's support circle. In addition to helping the student keep up with their class work, program staff work with teachers and counseling staff to make the adolescent's transition back to school as smooth as possible. Following their stay in Connections, a child will return to the care of his or her private therapist, or he or she may be referred for outpatient services at St. Vincent's or another agency. Connections staff also will provide advice to parents in seeking special education services at their child's home school if appropriate.

For information about Connections, please contact the St. Vincent's Westchester Evaluation and Referral Service at (914) 925-5320.

Filmmaker from page 18

To give a historical perspective the film takes us to the graveyard for the hospital with headstones dating to the late 1800s. (Headstones with no names, only numbers!) What emerges is a complex and vivid picture of this institution and the social structure that was so stultifying and an accounting of the lives of select Kings Park patients after their leaving the four walls of this state facility.

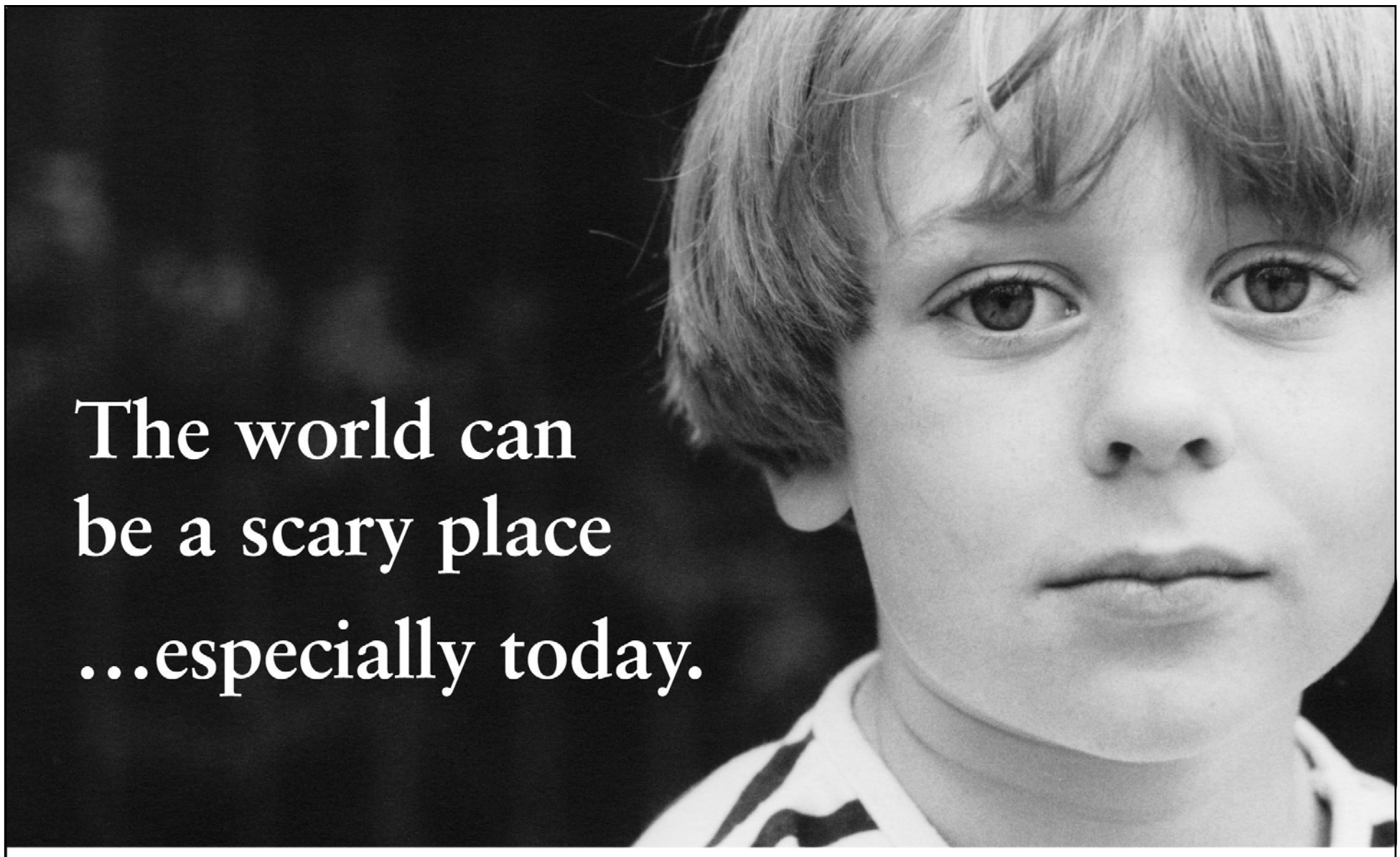
Lucy's summary is revealing: "My relief at learning of the institution's closing (in 1996), quickly gives way to outrage as I slowly unravel the shocking history of patient displacement and literal abandonment that has affected hundreds of thousands of people in need. What begins as a personal journey rapidly becomes a broader social inquiry into the realities of mental health care in America today."

With the help of co-producer Karen Eaton, consulting producers Deborah Hoffmann and Frances Reid, the enormous contributions in time and agony of interviewed former patients and staff, and a mosaic of funding contributors, Ms. Winer expects to complete production of this 90 minute film by the end of the year, with release of the final product sometime in 2004.

Anyone interested in the history of our flawed mental health system - consumers, families, mental health providers, elected officials, policy analysts and yes, tax payers - should plan to view "Kings Park". Its personal journey and social analysis, on film, make this project unique and highly compelling

A note to readers: Lucy is very interested in putting on film the stories of other patients and staff who were at Kings Park, especially during the 1960's and 70's. If you have a story to contribute, whether you wish to be filmed or not, Lucy Winer would like to hear from you. She can be reached at wildlight2@aol.com.

About the author: Alan Menikoff, began his career with South Beach Psychiatric Center, a facility of the NYS Office of Mental Health. For ten years he was Executive Director of a Westchester County psychiatric rehabilitation agency (Search for Change), founded a commercial psychiatric home care company (USBHC), and in November 2002 retired having completed 15 months as Deputy Director of The New York Work Exchange. His publications include a comprehensive review of the costs – direct and indirect - associated with schizophrenia, co-authored with Kenneth Terkelsen, MD.



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mha mental health association of new york city

MHA of NYC Programs Give Adolescents with Depression Another Chance at Success

Mental Health Association of New York City

Matty A.'s depression was diagnosed eight years ago, when she was 12 years old. "My brother had just died of AIDS and two other brothers had been killed in gang violence. I just started isolating. Beginning at 14 I didn't want to go to school anymore. I was afraid to leave my mother because I was afraid I'd lose her too. My parents didn't know what was wrong with me." By the time Matty turned 16 yrs., her depression was so pronounced she quit high school and refused to leave the house for two years. It seemed her life was over before it had even begun.

Depression in teenagers can be compounded by many "phase of life" complications. Adolescence is difficult enough as kids struggle with rapid-fire physical changes, peer pressure and schoolwork, all the while fighting to separate from their parents and define themselves as independent individuals. Gone undiagnosed and untreated, depression in adolescents can hinder the development of the important skills necessary to grow and mature, to go to school, and ultimately, to achieve the independence and sense of well-being they need to succeed as young adults.

In addition, the stigma associated with depression can prevent students, or their parents who may suspect there's a problem, from confronting the problem and seeking help. Even the teenagers themselves who might know there's something "wrong," can find it hard to reach out for help as they struggle to declare themselves separate from their parents and other authority figures. At its most serious, untreated depression can lead to hospitalization or worse, suicide.

The Mental Health Association of New York City operates C.O.P.E. (Community Outreach and Public Education), a program to screen for depression among high school students, enabling early detection, intervention and treatment. The MHA of NYC also maintains the Adolescent Skills Center in the Bronx, which gives adolescents who are not succeeding in high school a second chance to learn a vocation, develop social skills, and prepare for the high school equivalency exam (GED). These programs can give adolescents the tools they need to get their lives back on track.

Do Ask, Do Tell: C.O.P.E. and Early Detection of Depression

As with any progressive illness, early detection and treatment can help ward off more debilitating symptoms down the road. That's why The MHA of NYC's C.O.P.E. program focuses on early identification of depression. It can be difficult for parents and educators to tell the difference between "normal" teenage moodiness and depression. C.O.P.E. works to engage students, their parents, and their educators to make the distinction. They want to empower the caregivers to make decisions as to what is best for the teens.

C.O.P.E. uses interactive sessions, videos and screening tools to identify adolescents at risk for depression and suicidal behavior. Founded two years ago, C.O.P.E. program coordinators have visited high schools, parent meetings and after-school programs citywide, with the programs tailored to the individual needs of the groups. They educate their audiences about the symptoms of depression to help identify students at risk. For instance, extreme acting out with drugs or sex, or poor academic performance, can also be symptomatic of depression.

During the sessions we find that not only are participants willing to listen, many open up about their lives and experiences, or about people they know who might be depressed. The open discussion helps mitigate the stigma of feeling "different." After these sessions students often tell us, "We never get to talk about this stuff!"

The discussion sessions have enabled some students to alert us to their true emotional state. In several instances we have had students recount experiences that clearly put them in a high-risk category and they've sought help on the spot. The sessions also underscore the importance of peer support. Six months after a presentation at one school we heard of a boy who alerted his teacher of another student who was exhibiting clear symptoms of depression, which the boy recognized from the video we had shown earlier. They later learned that student had attempted suicide the previous year.

The screening tool offers a more in-depth view of the student's state of mind, and reminds us how prevalent adolescent depression is. For every hundred students, we will discover between three and seven who state that they have thought seriously about killing themselves in the past four weeks, and/or who say they have tried to kill themselves in the past year.

Many more students indicate that they are experiencing a cluster of other symptoms which indicate they are likely to be depressed. For those students in the highest-risk category, the school will contact the parents to help secure appropriate treatment. In one school, the screening tool identified a straight-A model student as a high risk for suicide, much to the shock of her teachers, parents and friends. After being treated in the hospital and receiving ongoing treatment, the principal reflected, "your program most likely saved the girl's life."

Adolescent Skills Center Offers an Alternate Route to Success

While an educational program like C.O.P.E. works within schools and communities to identify students at risk for depression, what about kids like Matty who have dropped out of the system? The MHA of NYC's Adolescent Skills Center works with young people, ages 16 through 21, whose ongoing struggles with mental illness have caused them to leave school.

Matty's experience with school is not unusual for teens with mental illness. "I was going from school to school, and I couldn't finish anywhere. I wasn't determined to do it; I went just because it was an escape from my parents. It wasn't until I reached 18 or 19 that I knew I wanted to do it for myself."

Located in the Bronx, the Center offers literacy classes, GED preparation and vocational training for up to 45 students. They attend classes between 12 and 18 months, from 9 to 5 Mondays through Fridays. Each class includes no more than 12 students.

Many of the adolescents who sign up for the Center face multiple stressors on a daily basis. Life in a tough neighborhood, often coupled with a challenging family situation, could wear anyone down over time. As a result, we find that most students need as much help acclimating to the structure of an academic environment as they do acquiring reading and writing skills.

As Matty recounts, "I was the type of kid who would wake up one day and want to go to school, and the next day I wouldn't want to go. So the director would call me to tell me to come to school. Staff members were really supportive and I found other kids were going through the same things I was going through."

Students are assessed not only on their academic work, but on how well they interact with teachers and classmates. In doing so we help students harness frustration and anger, and modify self-destructive behaviors they may have used in the past, to help them manage more successfully in the "real world." Our staff looks for progress helping the student to build self-esteem and to cope with their mental illness everyday.

Vocational training includes courses in computer literacy and computer repair, both valuable skills in today's workplace. We also offer training in professional skills – how to create a successful resume, and how to conduct a job search including reading want ads and using the Internet. Since its founding in 1999, nearly 200 students have been through the program, including Matty. Several have moved on to higher education, and to competitive work environments. In addition, the program offers paid placements within the business community, suited to the student's strengths. Recently WABC's News at Seven ran a segment on the Adolescent Skills Center, featuring several of our students and the changes the program has made in their lives.

Matty's experience provides an example for her peers, and an inspiration to the rest of us. In June, she and her family visited Washington DC to accept the Medal of Excellence, awarded by the National Mental Health Association. This honor is given to one student a year whose ongoing recovery and subsequent success serves as a role model for others to follow.

Today Matty is proud of her accomplishments. "I'm going to go to college in September, and I feel really good—I'm excited that I made it. I thought I'd never get there because of the depression. It showed me that good support would get you where you want to go. I'm surprised and happy to have the support I've had."

C.O.P.E. sessions are available to schools, and after-school and other community programs in the five New York boroughs. The Adolescent Skills Center is for students in the Bronx who have documented mental illnesses. If you would like more information on either of these programs, and how you, or someone you know, can take advantage of them, please contact the MHA of NYC at 212-614-6300.

Thanks to Rachelle Kammer, Director of the C.O.P.E. program, and to Anthony Diaz, Director of the Adolescent Skills Center, for their contributions to this article.

Mental Health News
Fairfield County Section
Danbury BRIDGEPORT Stamford Ridgefield Norwalk

Unique Partnership Creates Supportive Housing For Homeless Individuals With History of Mental Illness

Staff Writer
Mental Health News

Mutual Housing Association of South Western CT., Inc (MHA) and Laurel House, Inc. (LH) recently received a grant award of $454,000 from HUD to provide permanent, safe, affordable housing with comprehensive support services for homeless individuals disabled by serious mental illness. The grant will provide $345,000 in capital funds to purchase land and the rehabilitation of two landmark buildings in Stamford. The project will create four two-bedroom apartments and four one-bedroom and provide housing for twelve homeless individuals with histories of mental illness. The grant provides an additional $109,000 for support services.

Each unit will have a private bedroom and share the kitchen and living room. Case management and social support services will be provided or coordinated by Laurel House, Inc. in conjunction with other mainstream social, vocational, educational support services in the Stamford area. Support personnel will be based within the housing complex and will be tailored to the individual needs of each tenant. The focus of services will be to connect tenants with appropriate community resources and foster independence and self-sufficiency.

HUD funds will be used to leverage additional support from private and public sources, including the Stamford Community Development Block Grants and HOME Development funds, and an assortment of private foundations including the Fairfield County Foundation and the Melville Charitable Trust.

Highlights of Program Activity:

The program addresses a community need determined a priority by this community through the region's continuum of care analysis for permanent supported Housing for homeless individuals with a history of serious mental illness.

The program joins the resources of two non-profit organizations each with considerable experience in housing development and ongoing provision of support services.

This project would provide appropriate social and property management services in an integrated and coordinated program model.

This project would greatly enhance access by homeless individuals to existing social, vocational, educational resources with proven effectiveness.

The program addresses the problem of stable housing on several programmatic levels by providing logistical support and direct consumer involvement in a 'peer to peer" format that utilizes their unique capabilities for helping others while allowing them to develop their own leadership capacities in the process.

The program provides important consumer provided social support through the Warm Line and Double Recovery effort to a vulnerable population on "off-hours", i.e. evening, weekends and holidays, when most other support services are typically unavailable.

Because we use mainstream services, there are no direct costs to the individual, all services are provided as part of the program to which we refer the client. A personal lack of funds or lack of insurance will therefore not be an obstacle to the person receiving assistance, and we will take the client to the appropriate office to receive Medicaid our Medicare and we will stay with them until they are enrolled.

The proposed project will serve low-income individuals who are homeless and disabled by mental health disorders—in many cases chronically homeless and disabled—who may also be dually diagnosed. While not a specific eligibility requirement, it is expected that many of the adults served will be multi-diagnosed to include needs related to HIV/AIDS, physical disabilities, domestic violence histories, educational/job skill deficits, and other special needs.

Laurel House and Mutual Housing have concentrated their efforts on creating affordable housing because housing costs in lower Fairfield, and in particular the Stamford area, prohibit low-income individuals from full participation in the housing market. Exorbitant rental costs also make apartment maintenance a problem as well. In the Stamford area, a steady erosion of low-income housing stock has increased demand and placed rental costs, even with the benefit of Section Eight rental subsidies, beyond the reach of most disabled individuals.

In addition to affordability of housing, homeless individuals have various service needs that assist them with mental health and to develop daily living and interpersonal skills. Support must be comprehensive, integrated, flexible, individually determined and aimed at the development of appropriate skills and higher levels of self-reliance. Previous housing failures and deficits in coping skills put these individuals "at-risk" for repeated housing loss if necessary skills are not acquired or improved. The individuals assisted through this project will need to meet HUD criteria for homelessness, that is, a person sleeping in the street or a place not meant for human habitation or in an emergency shelter, transitional or supportive housing program (having originally come from the street or a shelter). And the person must also lack the resources and support networks needed to obtain housing. Outreach efforts to bring eligible candidates into the project will include community-wide announcement and referrals to the housing may come from any community agency or organization, from the individuals themselves, or other advocates. Eligibility will be determined through a review process involving Laurel House, Mutual Housing, consumers and other invested providers.

Partners in extending outreach to eligible candidates include the Pacific House Shelter, Salvation Army, Dubois Mental Health Centre – Crisis and Case management programs, Stamford Mental Health Centre, Stamford Housing Authority, Stamford Dept. of Social Services, Bureau of Rehabilitation Services, The Workplace, Jewish Family Services, Catholic Family Services, Mental Health Association, local public schools and other service centres where homeless individuals may be known. Laurel House (as a subcontractor to Mutual Housing Association) will collaborate Mutual Housing and other area shelters/transitional facilities to distribute a notice of housing availability to the Continuum at large.

This is the second supported housing project undertaken by Laurel House.

see Partnership on page 58

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Hall-Brooke Names New Unit Chief

Hall-Brooke
Behavioral Health Services

Karen Jean Hotchkiss, M.D., has joined Hall-Brooke Behavioral Health Center, 47 Long Lots Road, Westport, as Unit Chief, Child/Adolescent Ambulatory Service. .

"Dr. Hotchkiss brings a wide range of experience and a reputation as an outstanding clinician and teacher to our team," says Hall-Brooke Medical Director Thomas A. Smith, M.D.,
"She has developed psychiatric services for children and adolescents in her previous positions at the Sheppard Pratt Institute in Baltimore and the New York Presbyterian Hospital-Cornell Medical College in New York City."

Karen Hotchkiss, M.D.

Since 1999, Dr. Hotchkiss served as Unit Chief for the Adolescent Inpatient Service at the Westchester Division of New York Presbyterian Hospital. During this same period, she was Assistant Professor of Psychiatry at Weill Medical College of Cornell University.

Previously, she was Staff Adult and Child Psychiatrist at the William Beaumont Army Medical Center, El Paso, Texas, and Medical Director of the Children's Day Hospital of Sheppard Pratt Hospital, Baltimore, Md.

She served as Resident in Psychiatry at the University of Maryland's Institute of Psychiatry and Human Behavior, 1991-1993, and as Post Doctoral Research Fellow at the Johns Hopkins Hospital, Neonatology Department, 1990-1991. From 1989-1990, she was Resident in Pediatrics at Georgetown University Medical Center.

Dr. Hotchkiss has published two pediatric research papers relating to cerebral responses of newborns to maternal alcohol intoxication. She was Principal Investigator in a research project relating to post-traumatic symptoms in Roschach Diagnostic Tests.

She graduated Magna Cum Laude from Fordham University in 1983 and received her Medical Doctor degree from the University of Colorado in 1989. She was certified by the American Board of Psychiatry and Neurology in 1996.

A wholly owned subsidiary of St. Vincent's Health Services of Bridgeport, Connecticut, Hall-Brooke is affiliated with New York Presbyterian Healthcare System and with Columbia University's College of Physicians and Surgeons, Department of Psychiatry.

Sharp Diagnostic Tools Can Help Prevent Teen Suicide

Hall-Brooke
Behavioral Health Services

It's difficult to believe, but prior to the 1980s there was a prevailing disbelief in the existence of psychiatric illness among children and adolescents, says Dr. Karen Hotchkiss, Unit Chief, Child/Adolescent Ambulatory Service of Hall-Brooke Behavioral Health Services in Westport, Conn.

The good news, she reports, is that since the publication of the Third Edition of the "Diagnostic and Statistical Manual of Mental Disorders," which established operational criteria for child and adolescent mental illness, effective diagnostic instruments have been developed. Dr. Hotchkiss believes that the present state of refinement of diagnostic tools has led to an increase in awareness and diagnosis of adolescent depressive disorders. It is the result of better diagnosis and treatment of depressed youth that has led to a decrease in the percentage of attempted suicides among the teen population.

Diagnosis of adolescent mental illness will always remain a challenge, Dr. Hotchkiss notes, because as any parent knows, most teens have periods of irritable, moody, angry, and unpredictable behavior. Such adolescent turmoil is developmentally adaptive. So differentiating between this developmental phase and true psychiatric illness depends on severity and length of symptoms. Parents, school personnel and mental health professionals have to keep close watch and create a kind of scorecard, tallying up various aberrant behaviors, unusual physical symptoms, school problems, and negative personal environments, while noting the lengths of time involved.

Here is an inclusive list of indicators which can signal "danger," if persistent or recurring or appearing in multiples.

1. Distressing and impairing mood symptoms
   - Tearfulness, inappropriate anger reactions, or rages set off by minor provocations
   - Abnormal moodiness, depression, sadness, irritability which lasts more than a few days
   - Unexpected mood swings
2. School problems.
   - Academic underachievement
   - Poor school attendance
   - School failure
   - Decreasing levels of interests
   - Difficulty concentrating/ staying focused
   - Decreasing energy and motivation
   - Abandonment of hope of academic achievement or success
   - Refusal to attend school (Chronic truancy is often caused by clinical
   - depression.)
3. Family Conflict
   - Irritability leading to frequent conflictive interaction
   - Dangerous and unacceptable activities (In an effort to cope with sadness and depression, the adolescent may experiment with illicit substance abuse, engage in sexual activity, avoid school assignments and overinvest time with peers. These behaviors add to family conflict.)
4. Substance Abuse
   - Mood symptoms (These can occur before, along with, or after periods of substance abuse.)
   - Drug/alcohol use (Often this is an effort to alleviate growing sadness, and depression.)
5. Somatic symptoms

The Primary physician or school nurse may be the first to evaluate physical complaints which can signal depressive disorders.

   - Headache, chronic fatigue, gastro-intestinal problems
   - Muscular-skeletal aches and pains
   - Sleep and appetite disturbances
   - Failure to meet expected growth levels

6. Suicidal Crisis

It is not uncommon for the initial presentation bringing the adolescent into contact with mental health professionals to be a suicidal crisis.

   - Suicide ideation
   - Self-injurious behavior
   - Actual suicide attempt

The tragic incident of teen suicide is often shrouded in disbelief. "How could this happen," family and friends ask. "It happens, " Dr. Hotchkiss advises, "because adolescents often hide their symptoms and the adult world around them, either doesn't recognize the symptoms, or makes excuses for abnormal behavior.

"There should be greater emphasis on collateral sources of information. Parents, relatives, teachers, counselors, primary physicians, school nurses, all need to work as a team, watching an adolescent's behavior and monitoring his or her records," she explains.

A major depressive episode can occur at any age, with risk increasing each year. Peak incidence is in late adolescence. Over 20 percent of the population will have at least one depressive episode during their lifetimes. Children who experience pre-puberty depression have higher risks of recurrent episodes and may face additional problems with antisocial behavior and substance abuse.

Suicide among adolescents is a national concern, Dr. Hotchkiss warns. In 2000, 3877 young people took their own lives, making suicide among young adults ages 15 to 24 the third leading cause of their deaths. Appallingly, there were 295 deaths among those ages five to 14, she reports.

The Youth Risk Behavioral Surveillance Survey reports a high prevalence of suicidal behavior among the nation's high school students. In a survey of almost 16,000 students 14 to 17 years, 19.3 percent reported suicide ideation and 2.6 percent had made potentially lethal suicide attempts.

At the time of their deaths, 90 percent of teen suicides suffered from psychiatric illness, especially clinical depression or bipolar illness. Substance abuse can also contribute to suicidal feelings. Other risk factors include: previous suicide ideation, previous actual attempts, violent behaviors, ready access to weapons (*handguns)*, and a tendency for impulsive action.

Teens contemplating suicide, Dr. Hotchkiss explains, often feel hopeless, have poor self esteem and are highly critical of themselves. Suicide attempts sometimes follow recent stressful events, such as academic failure or punishment, a disrupted relationship, humiliation, such as bullying by peers for various reasons, including homosexuality.

In June 2001, Hall-Brooke Behavioral Health Services opened a new 58,000 square foot, residential style treatment center on its beautiful 24-acre main campus in Connecticut

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Hall-Brooke has provided comprehensive behavioral health and chemical dependency programs for 104 years.
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Commissioner Thomas A. Kirk Welcomed By Mental Health News Fairfield County Committee

Staff Writer
Mental Health News

Several members of the *Mental Health News* Fairfield County Committee met recently with Dr. Thomas A. Kirk, Commissioner of the Connecticut Department of Mental Health and Addiction Services based in the State Capitol of Hartford.

The informal breakfast meeting was hosted by Hall Brooke Hospital located in Westport, Connecticut. At the breakfast, members of the Fairfield County Committee were given an opportunity to introduce Commissioner Kirk to *Mental Health News* and its effort to bring the newspaper's mission of mental health education to Fairfield County.

In attendance to welcome Commissioner Kirk (pictured below) were Barry Kerner, MD, Chief of Adult Psychiatry at Silver Hill Hospital in New Canaan, Connecticut; Alexander J. Berardi, LCSW, Executive Director of KEYSTONE in Norwalk Connecticut; Andrea Kocsis, CSW, Executive Director of Human Development Services of Westchester in Mamaroneck, New York; Stephen P. Fahey, President & CEO of Hall-Brooke Behavioral Health Services; Thomas E. Smith, MD, Medical Director of Hall-Brooke Behavioral Health Services; David Brizer, MD, Chairman of the Norwalk Hospital Dept. of Psychiatry, and Chairman and Medical Editor of *Mental Health News's* Fairfield County Committee; James M. Pisciotta, ACSW, Chief Executive Officer of the Southwest Connecticut Mental Health System based in Bridgeport Connecticut; Charles Morgan, MD, Chairman of the Bridgeport Hospital Department of Psychiatry; and Alan D. Barry, PhD, Administrative Director of the Norwalk Hospital Dept of Psychiatry.

According to Fairfield County Chairman, David Brizer, MD: "We were delighted to have this opportunity to meet with Commissioner Kirk and to express our hope to expand our efforts in providing *Mental Health News* to more individuals and families affected by mental illness in Connecticut. We invited Commissioner Kirk to have a column in our Fairfield County section of the newspaper to bring the state's mental health issues and challenges directly to our readership."

The Commissioner responded to the meeting with equal enthusiasm and expressed his belief in the mission of the project and belief that Mental Health News will help provide direction and hope to many in the state. His column is planned for the upcoming Winter issue.

Barry Kerner, MD, Alex Berardi, Andrea Kocsis, Dr. Thomas Kirk, Stephen Fahey, Thomas Smith, MD, David Brizer, MD, Jim Pisciotta, Charles Morgan, MD, and Dr. Alan Barry

Andrea Kocsis and David Brizer, MD

James Pisciotta and Charles Morgan, MD

Keystone House Awarded Three-Year CARF Accreditation

Staff Writer
Mental Health News

A milestone in Keystone House's 30-year history was reached this past April when the agency was awarded a three-year accreditation from CARF. CARF, the Rehabilitation Accreditation Commission, is an international nonprofit accrediting body whose mission is to promote the quality, value and optimal outcomes of services provided by an organization.

"Keystone's CARF Accreditation is the culmination of many years of agency development. It was heartening to see the staff pull together and spend considerable time addressing the many last minute details before the survey to achieve the ultimate outcome from CARF--a three-year accreditation," said Alex Berardi, Keystone's Executive Director. Berardi has been with Keystone for 12 years and guided the staff and agency through the arduous preparation.

Keystone House, a rehabilitation service provider for adults with severe and persistent mental illness and other disabilities, is located in Norwalk, Connecticut and serves over 250 clients in Fairfield County. Keystone House is well-known on the local and state levels for its efforts to decrease homelessness and place individuals with disabilities into jobs. Keystone services promote individual choice and satisfaction as well as independent living and community integration.

Serving mid-Fairfield County, Keystone has extensive collaborations and partnerships throughout the state of Connecticut. "Community stakeholders and clients can be assured when they see the Keystone House name, that we are an accredited organization, have gone through a detailed evaluation, and are committed to quality and accountability in every area," said Kara Shomberger, Keystone's Development Officer.

Preparing for the accreditation survey was a lengthly process that spanned approximately two years. The written policies and meeting minutes of the agency were just one aspect of the accreditation process. The CARF survey team also examined Keystone House's programs, its administrative practices, ethics, outcomes management, and client and stakeholder satisfaction.

Thais Gordon, Program Director of Keystone Employment Options, commented that there were a lot of challenges. "My main challenge, though, was making sure that much of what we were doing, and had been doing was put in writing, which was often a painstaking process. But the upside of all this work was that we put ourselves through a true self-assessment within the agency and really evaluated ourselves. The clients also gave us feedback and were involved throughout the whole process," said Gordon, who has been with agency for 12 years.

What are the growing organization's goals now having gone through a CARF survey, a notable feat? Keystone House has made maintaining their accreditation a strategic goal for themselves and will continue looking for ways to fine-tune their services to ensure continuous quality improvement. Most importantly, Keystone staff will continue serving individuals with psychiatric disabilities in hopes of giving them a better quality of life.

"The most important aspect of all of this, however, are the comments that Keystone House stakeholders made to the CARF surveyors including clients, staff, employers and family members. We were told in the exit conference and the report from CARF that we are to be commended for the positive stakeholder satisfaction with Keystone House. To me, this is what the accreditation was all about, validating the hard work that the staff at Keystone do every day," Berardi concluded.

Cloudy Issue from page 13

in his or her struggle not to use substances is to keep the conversation going—be aware of what is going on in your adolescent's life. I always tell parents to ask their adolescents questions (e.g., "Where are you going?" "What time will you be home?" "I want the phone number of your friend's house where the party is being held so I can talk with their parents." etc.). Your adolescent may resent these questions, but if they become the rule rather than the exception, they will quickly grow used to them, especially if they are asked with love and respect. It is always important, regardless of your adolescent's reaction, to let them know how much you love them and that you do understand the difficulties that they are experiencing as they develop into men and women. This may be seen as a "Leave it to Beaver" approach, but the reality is that it works. Don't let your adolescent's initial reaction to your firm but fair parenting skills deter you—deep down, your adolescent will respect what you are doing regardless of the "show" they may put on.

Harris B. Stratyner, Ph.D., CASAC, is an Assistant Professor of Psychiatry in Psychology, Weill Medical College of Cornell University and Director of Addiction Recovery Services of "The Retreat at Westchester," on the campus of New York-Presbyterian Hospital in White Plains, New York.

Norwalk Hospital News

Staff Writer
Mental Health News

Norwalk Hospital Social Worker Receives Prestigious Award

Carolyn A. Taylor, MSW, LCSW, of Norwalk, a certified clinical social worker in the Norwalk Hospital Department of Psychiatry, is the recipient of the prestigious Public Service Award from the Office of the Secretary of the State in Connecticut.

In presenting the award, Susan Bysiewicz, Secretary of the State, said, “As a dedicated volunteer who has served your community, you are an example of what makes our towns and cities work. Your commitment to your community and your willingness to serve your fellow citizens is what makes Connecticut such a wonderful place to live.”

Taylor is a therapist in the Department of Psychiatry at Norwalk Hospital as well as the Sono Behavioral Health Center in South Norwalk, affiliated with the hospital. She facilitates group therapy programs at the hospital including a new outpatient women’s group. In addition to her responsibilities in assisting and counseling patients with depression, anxiety and personality disorders, she is very involved in community service work. She is an active member of the Department of Children and Families Regional Advisory Council. She is an advocate for her patients and is admired by her co-workers for her dedication and commitment to the community.

Prior to joining Norwalk Hospital in 1999, she was Director of the Intensive Family Preservation Program and Clinical Director of Hall Neighborhood House in Bridgeport. She has extensive experience as a social worker and case manager, having also held previous positions at St. Vincent’s Hospital in Bridgeport and Montefiore Medical Center in the Bronx, New York.

Taylor holds a Bachelor of Science Degree in Allied Health Administration from SUNY, New York, and a Masters in Social Work Degree from New York University. She holds a certificate from Columbia University for providing field instruction and also has earned a certificate for providing pre-and post-HIV/AIDS counseling.

Silvermine Guild Arts Center Gallery Presents Art to Norwalk Hospital

Norwalk, CT, June 8, 2003, The Norwalk Hospital Department of Psychiatry has a new artistic touch. Thanks to the generosity of the Silvermine Guild Arts Center Galleries in New Canaan, a collection of original and beautifully unique artwork is now on display, including paintings from Mayo Sorgman, a renowned local artist. The collection can be viewed along the corridors of the first floor in the Community Pavilion. The collection is on permanent loan to the department.

"We are most appreciative to be the recipient of these creative works that will be enjoyed by our patients, visitors and staff," said David A. Brizer, MD, Chairman of the Department of Psychiatry at Norwalk Hospital.

The art of Mayo Sorgman, a native of Stamford, is represented in museums and private collections throughout the country. He was the recipient of the prestigious Emily Lowe Award in New York and is listed in "Who's Who in American Art" and "Who's Who in American Literature." For many years, he was the Director of Art for the Stamford Public Schools and is past-director of the Stamford Art Association. His paintings have been described as poetic, reflecting the passions of the expressionist movement.

The Silvermine Guild Arts Center Galleries, making this possible, was incorporated as a non-profit organization in 1922 to provide a formalized support of art, which "speaks to, for and through us." Their objective is "to cultivate, promote and encourage growth through the arts, to showcase and serve artists and to foster arts education and appreciation opportunities for the greater community."

"We are delighted to be able to share the artwork which brightens the space at Norwalk Hospital," said Helen Klisser During, Gallery Director of Silvermine. As a unique and special offering, Norwalk Hospital makes art and music therapeutic programs available for patients. Creative arts have been proven to help promote healing by providing an outlet to express feelings, thoughts and ideas. In addition, expression through art can help promote self-awareness and alleviate stress. "It means a great deal to us to be able to enrich the lives of others through expressive art," said Cynthia Clair, Executive Director of the Silvermine Guild Arts Center Galleries. "This wonderful collection brings a fresh new atmosphere to the entire department," said Dr. Brizer.

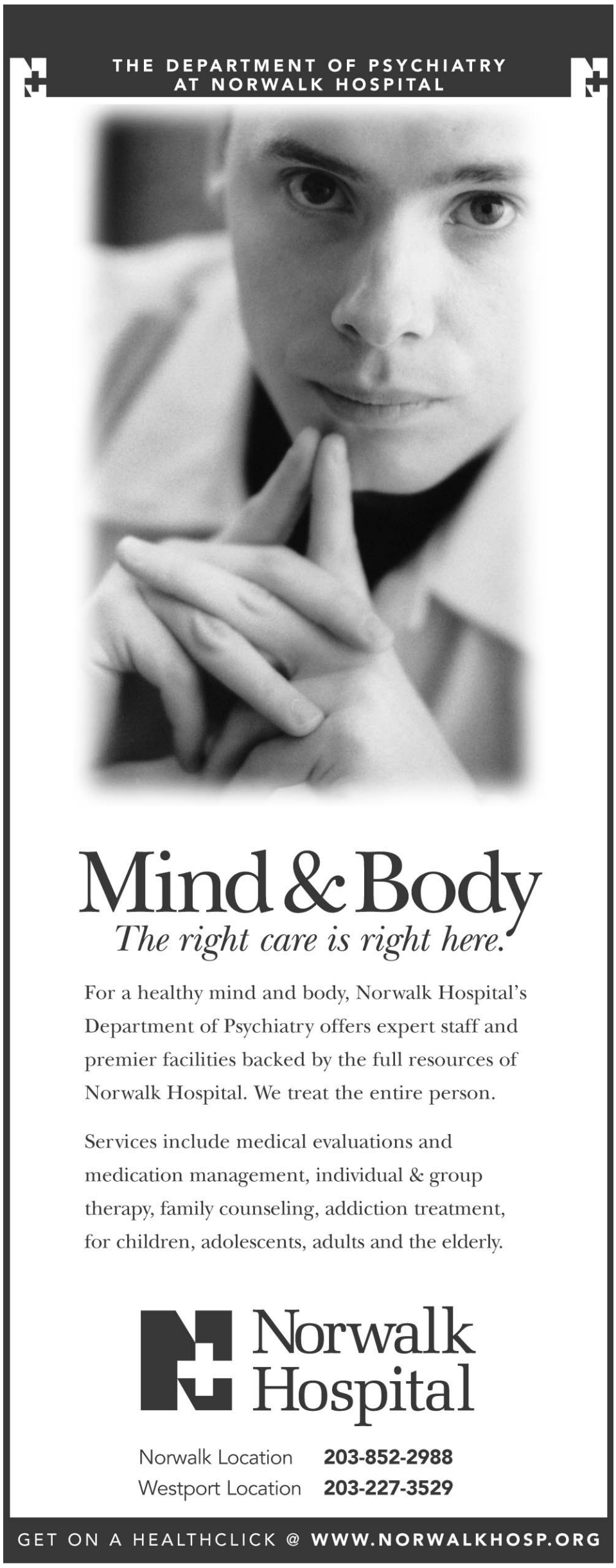
The Westport Clinic Offers Adolescent Young Men’s Group

The Westport Clinic, which is affiliated with Norwalk Hospital, offers an “Adolescent Young Men’s Therapy Group” on Wednesdays from 4 - 5 p.m.

This program is for male high school students between the ages of 14 to 18 to discuss topics of problem solving, relationships, family conflict, self-esteem, substance abuse, peer pressure and future plans.

The facilitator is Jeffrey A. Tauscher, LCSW, ACSW, a psychotherapist experienced in working with adolescents and their families. Mr. Tauscher provides psychotherapy, addiction counseling, critical incident and stress debriefing groups.

The Westport Clinic is located at 319 Post Road East in Westport. For more information, call (203) 227-3529.



Silver Hill Hospital Names New President and Medical Director

Staff Writer
Mental Health News

Sigurd H. Ackerman, M.D. has been named President and Medical Director of Silver Hill Hospital in New Canaan, Connecticut. In announcing the appointment, Steve Stillerman, Board Chairman of the nationally recognized psychiatric hospital, noted Dr. Ackerman's distinguished career in the practice of psychiatry. "Dr. Ackerman brings to the Silver Hill community, to staff, patients and families, the breadth and depth of 25 years of outstanding leadership in clinical care, teaching, research and program development," Mr. Stillerman said. Dr. Ackerman replaces Dr. Richard Frances who led the hospital as Medical Director and President for the past six years. Dr. Frances remains on the medical staff as Senior Medical Consultant and Director of Public and Professional Education.

Formerly Chief Executive Officer and President of St. Luke's-Roosevelt Hospital Center in New York City, Dr. Ackerman also served as Chairman of the hospital's Department of Psychiatry. He is a Professor of Clinical Psychiatry, Columbia University College of Physicians & Surgeons and has held academic titles in psychiatry at Cornell University Medical College and Albert Einstein College of Medicine.

In discussing his new position, Dr. Ackerman stressed the hospital's strengths and areas that he would like to develop. "Silver Hill," he said, "is known for outstanding treatment of substance abuse and other psychiatric disorders and substance use disorders which very frequently—more than half the time—occur together and are called dual disorders. This puts the Hospital in the unusual in unique position of having the expertise to treat a very broad spectrum of dually diagnosed patients. We see an increasing need for this treatment in the medical community, and we are going to emphasize it more and more.

"Secondly, for all disorders, from schizophrenia to substance dependence, we plan to grow towards a focus on keeping patients out of the hospital, not just treating those who need hospitalization. Relapse prevention is a major and most effective part of substance abuse treatment. Providing a more comprehensive and extensive role in relapse prevention for other psychiatric disorders may encompass expanded work with clinicians, families and community groups, added residences and more outpatient services to help patients stay well." We also want to extend the scope of our work in helping patients and their families with the process of recovering from an episode of illness. Upon discharge from the hospital, many patients continue to need help with the steps necessary to regain a full life. To achieve this, we plan to offer more transitional support to patients, their families and their therapists in the community."

Richard J. Frances, M.D. greets Sigurd H. Ackerman, M.D. newly named President and Medical Director of Silver Hill Hospital

Dr. Ackerman concluded, "I'm very excited about being here. Throughout its 72-year history Silver Hill has been, and still is, on the cutting edge of psychiatric care. The physical setting is extraordinarily phenomenally beautiful, and that counts itself is helpful to the recovery or our patients. The setting itself promotes recovery. The experienced staff is very dedicated and conscious of their responsibilities towards patients and families. The Board of Directors is an active, involved group, truly committed to the betterment of the Hospital. All of this together makes for a first-rate facility."

An honors graduate of Harvard College, Dr. Ackerman received his medical degree from Tufts University School of Medicine. He trained in psychiatry at Montefiore Medical Center, Albert Einstein College of Medicine, where for 10 years his full-time research on the effects of early maternal separation was federally funded by National Institutes of Mental Health (NIMH) Research Scientist Development Awards Type II, and a National Institutes of Health (NIH) research project awards. Before joining St. Luke's-Roosevelt Hospital as Executive Vice President and Medical Director, Dr. Ackerman led a clinical research unit for affective disorders and was the Associate Director for Clinical Affairs and Research at the Eating Disorders Institute of New York Hospital, Cornell University Medical Center, Westchester Division.

Dr. Ackerman is a fellow of the American Psychiatric Association and a member of numerous other scientific societies. A reviewer for professional journals, he has published widely on his specific research topics and clinical practice interests which include psychopharmacology, depression, eating disorders, sleep disorders and the treatment of dual diagnosiis.

Dr. Ackerman and his wife Cecelia McCarton, MD, a developmental pediatrician, have five children and reside in Stamford, Connecticut.

Established in 1931, Silver Hill Hospital is a private, not-for-profit facility with a full range of mental health programs, including inpatient, partial hospital, intensive outpatient and transitional care.

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Robert Cancro, MD, Chairman, Department of Psychiatry, New York University Medical Center
Developing Insights into the Understanding and Management of Schizophrenia

Kenneth L. Davis, MD, President and CEO, Mount Sinai Medical Center
Oligodendrocytes in Schizophrenia

John A. Talbott, MD, Professor of Psychiatry, University of Maryland School of Medicine
The Chronic Mentally Ill: Problems, Promises and Perspectives: Past, Present and Future

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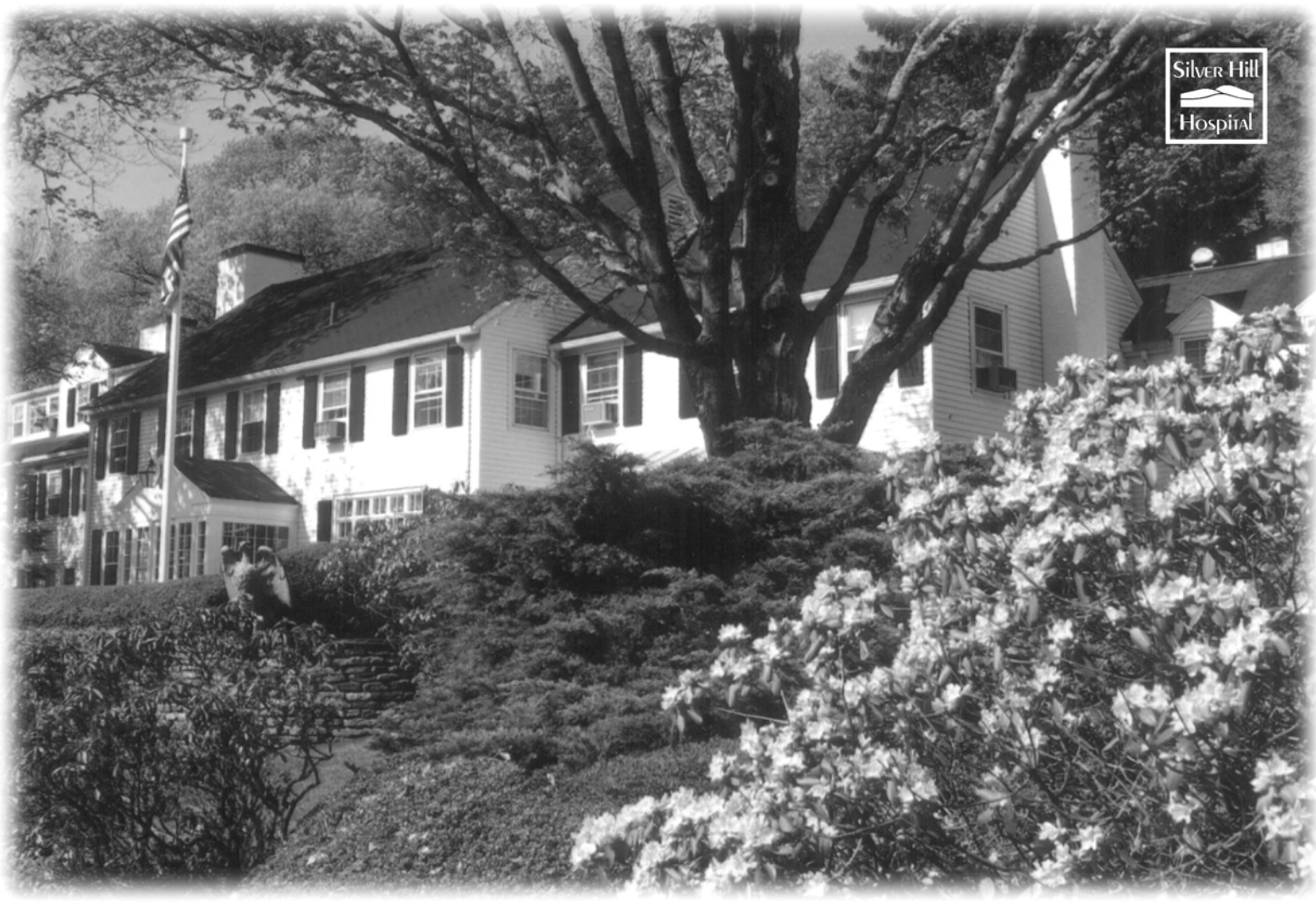

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Treating Adolescents Who Suffer From Depression

By Darren J. McGregor, LMFT, DAPA
The New Learning Therapy Center

This article is on recognizing and treating depression in adolescents with suggestions how caregivers can help. In brief, recognizing depression during this time is difficult because such behaviors are often part of the natural growth process. Depressive features become of clinical concern when negative emotions and behaviors are more intense and longer in duration. Please note that any indication or suspicion of suicide is always to be taken seriously and professional help is strongly suggested. Additional attention is to be paid if suicidal ideation and past attempts are part of the family history and/or the media has recently publicized a teen suicide. Behaviors that traditionally indicate suicidal intentions are disengaging from previously valued activities, giving away prize possessions, ending friendships, and increasing isolation.

Adolescent Development

To better understand depression in adolescents, an understanding of the developmental process is helpful. Development can begin as early as age ten or eleven and end sometime in the early twenties. It may be better defined as a maturational process with puberty marking its onset and ending in adulthood. During this time, complex and rapid changes occur in physical, emotional and psychosocial development that many adults commonly refer to as "growing pains." Keep in mind that these pains are physically and emotionally real. Adolescents feel an array of pains and pangs during growth spurts, weight gains and losses, and hormonal changes. Adolescent development is often compared to the growth rate seen during infancy.

In addition to internal changes, there are numerous external factors that influence feelings and behaviors. First, the rate of change among peers varies at a time when identifying with a particular group is of great importance to them. Adjusting to this change may result in depression. Both boys and girls are at risk of having a poor self-image. Being teased about accelerated or delayed development of sex characteristics coupled with low self-esteem may produce symptoms in need of clinical attention. Second, how caregivers react to their "adult in training" significantly impacts teenage behavior. Self-confidence and self-esteem plummet whenever the focus of conflict revolves around the adolescent. Finally, and most challenging to control, are changes in acceptable behaviors as set by society. The general public, greatly influenced by the media, often misconstrues acceptable behavior. Exaggerated attitudes, dress, and interactions designed for entertainment are adopted as "normal" behavior. Adolescents observe behaviors of family, friends and others for clues on how to model their own behavior. This fluid pattern of acceptable behavior makes it difficult to determine what is normal.

Assessment

Clinicians generally refer to the Diagnostic and Statistical Manual of Mental Disorders, (DSM) for assessment purposes. The latest edition, DSM-IV-TR defines an adult depressive episode as feeling depressed and/or sad nearly every day, for most of the day, for a period of no less than two weeks. Additional symptoms necessary to meet the criteria include losing interest in pleasurable activities, fatigue, feeling worthless, poor concentration, and recurrent thoughts of death including suicidal ideation, among others. A key factor of depression is outlined in criterion "C" noting, "the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (1994). Two modifications are made for children and adolescents: a report of irritable mood and a failure to meet expected weight gains are sufficient to indicate depression.

More frequently diagnosed disorders for adolescents include Attention Deficit, Oppositional Defiant, substance abuse, anorexia, bulimia nervosa, dysthymia, and adjustment disorders. Other disorders contributing to feelings of depression include learning disabilities, low self-esteem, and bereavement. The mental health practitioner will be able to differentiate between a major depressive episode and depression as a symptom of any aforementioned disorders.

Warning signs for caregivers to look for include dramatic departures from positive behaviors, failing grades, involvement in criminal activity, and illicit substance use.

Treatment

Individual, family, and group therapies are standard treatment methods for most mental health disorders. Other methods, such as, "survival camps" need careful screening for treatment methods and the ratio of licensed clinical staff members and non-professionals. Personally, I have found group therapy and medication to be most effective.

Medication therapy, managed by a psychiatrist, and group therapy affects both internal and external change. Individual therapy may require several sessions simply to gain the trust of the patient assuring him or her that you are not merely an agent of his or her caregivers. In family therapy, the initial work for the therapist is to educate the family about their role in perpetuating the problem. Many caregivers present their teenager as the problem and disown any contributing factors. I have known several families to terminate treatment soon after the caregivers were confronted with having to change.

It is certainly not my intention to diminish either treatment method. I have successfully treated adolescents in both individual and family therapy settings and strongly recommend family therapy after, or in conjunction with, group therapy. The benefit of both therapies is the opportunity to bond with the adolescent. The therapist/adolescent relationship strengthens during group process and allows him or her to trust the therapist and the treatment method in family sessions.

The patient often views group therapy as a non-threatening environment. It allows the adolescent the opportunity to be both observer and participant among peers who share similar issues. According to the American Group Psychotherapy Association in New York (www.agpa.org, 2003), "group therapy creates more change than any other therapy used in treating adolescents."

The primary purpose of group work is to provide a forum for [members] to support each other in pro-social behaviors, to confront maladaptive behavior patterns, and to mobilize the power of the peer group in a productive manner. Peers are expected to both give and receive feedback from the other team members.

Caregivers

Adolescents cope with developmental changes by displaying wide and rapidly changing mood swings. Understandably difficult to tolerate at times, caregivers need to understand and support their child(ren) during this experience. Listening, staying involved, and giving praise (even when it appears unwanted) is your primary treatment plan. What you can expect from your child are physical changes that appear to occur overnight, bouts of irritation, sadness, and confusion, as well as sleeping all the time, a need to be right, and a push for autonomy. To adults, it often appears as a rapid, short-lived, intense outburst with little justification and without intervention. Remember it is of clinical concern when the teenager's "moodiness" is more intense and lasts longer than two weeks.

What do you do if you believe your child is depressed? Do not hesitate to talk with your child's teachers, counselors, coach, etc. Keep in mind that depression is a treatable disorder and not a sign of weakness or laziness. In addition to psychotherapy, an appointment with the pediatrician is recommended to rule out medical causes for the symptoms. Hypothyroidism, pregnancy, among others may produce symptoms of depression. In addition, your child should be evaluated for substance abuse, especially if there has been a past issue with drug use and/or a family history of use. Alcohol and marijuana are known contributing factors to depressive symptoms. An evaluation with a psychiatrist is indicated if the symptoms continue to cause significant distress.

Life Steps from page 50

world. Countless situations arise during group sessions that require socialization skills, conflict resolution and anger management skills and leadership development. One of Life Steps' most successful group programs has been Adventure-Based Counseling (ABC). Recognizing that play has transformative power, ABC challenges teens to go outside their comfort zones where growth can occur. ABC has brought inner-city youth to the mountains that lie just outside New York City and as far as Colorado—to places where they can build community, camaraderie, and trust among each other.

Life Steps also counsels families, because the child is part of a unit—a system in which each member affects the others. Fostering open communication, counselors help members to relate more positively to one another, more clearly state their expectations of each other, and build on their family strengths. Another component of parent support is empowering parents to assert themselves with both their children (through limit-setting) and with professionals. Advocating for their children with educational and health professionals can seem overwhelming. Life Steps assists parents in building comfort during these interactions through role play and talk therapy.

These are some of the ways that a program such as Life Steps can be a timely and relevant resource to families and adolescents. Whether you think your child may be depressed, experiencing another type of mood or mental disorder, or having a hard time for other reasons, it is wise to consider professional help. In choosing a counselor, while parents should have confidence in the professional's abilities, it is just as important for your child to make a connection with that person. It is also helpful to recognize that change takes time and requires patience. The staff of Life Steps also suggests that parents stay engaged and connected, practice positive reinforcement, redefine your parental role, if necessary, to exercise appropriate authority, and use rewards and consequences to provide the structure kids want and need. Above all, remember that if your attempts to improve a situation are not achieving desired results, it may be time to seek professional help.

For more information about Life Steps, contact Brenda Taylor at (718) 875-9030. To learn more about Parnership With Children, please visit them at www.partnershipwithchildrennyc.org

Gene from page 9

Based on clues from studies in mice, monkeys and functional brain imaging in humans, the researchers hypothesized that the short variant predisposed for depression via a "gene-by-environment interaction." They charted study participants' stressful life events—employment, financial, housing, health and relationship woes—from ages 21-26. These included debt problems, homelessness, a disabling injury, and being an abuse victim. Thirty percent had none, 25 percent one, 20 percent two, 11 percent three, and 15 percent four or more such stressful life experiences. When evaluated at age 26, 17 percent of the participants had a diagnosis of major depression in the past year and three percent had either attempted or thought about suicide.

Although carriers of the short variant who experienced four or more life stresses represented only 10 percent of the study participants, they accounted for nearly one quarter of the 133 cases of depression. Among those with four or more life stresses, 33 percent with either one or two copies of the short variant — and 43 percent of those with two copies of the short variant — developed depression, compared to 17 percent of those with two copies of the long variant.

The stressful life events led to onset of new depression among people with one or two copies of the short gene variant who didn't have depression before the events happened. The events failed to predict a diagnosis of new depression among those with two copies of the long variant. Among those who had experienced multiple stressful events, 11 percent with the short variant thought about or attempted suicide, compared to 4 percent with two copies of the long variant. These self-reports were corroborated by reports from participants' loved ones.

The researchers suggest that effects of genes in complex disorders like psychiatric illnesses are most likely to be uncovered when such life stresses are measured, since a gene's effects may only be expressed, or turned on, in people exposed to the requisite environmental risks.

Among people who had inherited two copies of the stress-sensitive short version of the serotonin transporter gene, 43 percent developed depression following four stressful life events in their early twenties, compared to 17 percent among people with two copies of the stress-protective long version. About 17 percent of the 847 subjects carried two copies of the short version, 31 percent two copies of the long version, and 51 percent one copy of each version.

Buy-in from page 10

residence, family care home, or Residential Care Center for Adults, the application is processed through the OMH Patients Resources Office.

As part of the Department of Health's outreach efforts related to the new program, fifteen agencies are actively providing training and education to individuals with disabilities, about New York's Medicaid Buy-in Program for the Working Disabled. Of those 15 agencies, four are providing extensive outreach to individuals with psychiatric disabilities. In a personal conversation, Harvey Rosenthal, Executive Director of NYAPRS, told me that the NYAPRS Training Collective has already conducted 20 training sessions, and plans to offer over a hundred more such trainings this year. Further, the Mental Health Empowerment Project will be featuring special trainings on the Buy-in this fall at each of its regional conferences.

Individuals with specific questions, or who need advocacy services specific to the Medicaid Buy-in program can contact any of the four providers listed below:

- New York Association of Psychiatric Rehabilitation Services, 1 Columbia Place, Albany NY 12207, (518) 436-0008
- Mental Health Empowerment Project, 261 Central Avenue, Albany NY 12206, (518) 434-1393, or toll free (800) 643-7462
- Hands Across Long Island, P.O. Box 1179, Central Islip, NY 11722, (631) 234-1925
- People, Inc., P.O. Box 5010, Poughkeepsie, NY 12602, (845) 452-2728

John Allen, Director of OMH Director of Recipient Affairs, is also available to assist anyone who would like more information about the program.

The new Medicaid Buy-in program dovetails well with other OMH initiatives currently underway. For example, Assertive Community Treatment, of ACT, is being implemented Statewide, and is being used as a platform for the delivery of comprehensive and flexible treatment, support and rehabilitation services. Treatment plans are individualized to address the needs and goals of the recipient, and the new Buy-in program may be an appropriate step in helping a person to achieve his or her vocational objectives.

People with mental illness have the same life goals as anyone else, and rewarding and satisfying work experiences can be an important part of a satisfying, fulfilling life. New York's new Medicaid Buy-in program is an important addition to the network of programs and services designed to support people with psychiatric disabilities as they work toward recovery.

Sharon Carpinello has been named Acting Commissioner of the Office of Mental Health. She has more than 25 years of healthcare and research experience and has been with OMH since 1989, most recently as Executive Deputy Commissioner.

Kudos from page 9

Americans living with mental illnesses. For more information, www.nami.org.

The National Association of State Mental Health Program Directors (NASMHPD) serves the interests of the directors and commissioners of 55 state and territorial government mental health agencies. NASMHPD and the state agencies it represents seek to create effective, culturally-sensitive services that promote recovery and active participation in community life for those they serve. For more information, visit www.nasmhpd.org.

The National Mental Health Association is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. NMHA works to improve the mental health of all Americans through advocacy, education, research and service. For more information, visit www.nmha.org.

Other Campaign for Mental Health Reform partners made the following statements in response to the release of the Commission's report.

"The American Psychiatric Association (APA) commends the President and the Commission for their strong efforts to improve our nation's mental health delivery system. APA urges President Bush and Congress to provide real solutions to fix the current fragmented mental health delivery system, pass mental health parity legislation, and provide adequate funding in the public health system," said Marcia K. Goin, M.D., APA President. (703) 907-7300

"The Commission's final report constitutes a major step on the road to recovery for our nation's mental health system," stated Norman Anderson, Ph.D., chief executive officer of the American Psychological Association. "The challenge now before us is to develop and finance a continuum of culturally appropriate mental health and family support services, ranging from prevention to acute and chronic care, across the lifespan." (202) 336-5500

"The 1999 Surgeon General's Report on Mental Health described the science underlying the identification, assessment, and treatment of mental disorders, including the disorders of childhood. 'The 20,000 family members of CHADD (Children and Adults with Attention-Deficit Hyperactivity Disorder) hopes that the President's Commission Report will result in financing and management strategies which delivers the science to all individuals with mental disorders and their families," according to CHADD CEO, E. Clarke Ross (301) 306-7070

"Bipolar disorder is an illness significantly predisposed to substance or alcohol abuse. DBSA commends the Commission for recognizing the seriousness of the under diagnosis of mental illness and co-occurring disorders," said Lydia Lewis, president of the Depression and Bipolar Support Alliance. "The lack of accurate diagnosis in our mental health system is a gaping hole that must be filled." (312) 642-0049

"The Federation of Families for Children's Mental Health remains committed to insuring children with mental health needs and their families can count on immediate access to quality services and supports that are community based. It is our desire that the President's New Freedom Commission's report reflect the current status of children's mental health. We look for a commitment from this administration to take action and support policy changes with necessary increased funding in order to change the way this nation serves its children with mental health needs and their families," said Barbara Huff, Executive Director, Federation of Families for Children's Mental Health. (703) 684-7710

"The report of the President's New Freedom Commission on Mental Health takes a major step forward by first recognizing the shambles of our current system and, second, by emphasizing the importance of building a mental health system based upon the recovery of every person with a mental illness," stated IAPSRS President Anita Pernell-Arnold. (410) 789-7054

"The National Association of County Behavioral Health Directors joins other national mental health organizations in commending the Commission's just released report and intends to work with all to ensure that the report spurs action to improve services for people with mental illnesses." Thomas E. Bryant, MD, JD, executive director, NACBHD, 202-234-7543

"With the timing and release of the final report, we are confident that the President is dedicated to crowning his Administration's significant list of accomplishments with the priority of mental health services to all." said Charles G. Ray, president and CEO, National Council for Community Behavioral Healthcare. (301) 984-6200

"The Commission report offers a great opportunity for consumers to continue to lead on in infusing the light of recovery, hope, self-determination, love, and empowerment into the mental health system," said Daniel Fisher, MD, PhD, executive director of the National Empowerment Center. (978) 685-1518

"As someone who has been diagnosed with a mental illness, I think it's about time the serious problems we have in getting decent services are recognized at this level. I congratulate the President's Commission on its excellent work," said Joseph A. Rogers, executive director, National Mental Health Consumers' Self-Help Clearinghouse. (215) 751-1810

"We applaud the Commission's call to improve and expand mental health care, enabling many to overcome their pain and choose life," said Jerry Weyrauch, founder, Suicide Prevention Action Network USA. (202) 294-8132

"It appears the President's New Freedom Commission has taken into account the Surgeon General's Report and emerging research by acknowledging opportunities to implement and support consumer-operated programs, such as drop-in centers, peer specialist training, outreach, businesses, employment, housing, and crisis services, etc. Consumers, staff, and the mental health system all benefit through meaningful work, successful role-modeling, and a potentially more sensitive service system," said Larry Belcher, CEO of WVMHCA CONTAC. (304) 345-7312

Helping Parents from page 11

out of the home. Adolescents may demonstrate more high risk behavior, such as substance abuse, which worsens depression, and suicidal behavior, which is even more likely in the presence of drug intoxication with intense emotions and impaired judgment. And because children are dependant on adults, and are emotionally vulnerable to instability in their caretakers, especially if it is persistent, or if it is neglectful or abusive, children's depression will reflect the family's difficulties.

Somewhat arbitrarily, but also to make the point about persistent depression being "true" depression, as opposed to normal mood reactions and upsets, current criteria for childhood depression require at least two weeks of a minimum number of symptoms, and demonstrated interference in daily activities and usual functioning. Usually, by the time children are brought for treatment, however, more time has gone by, often months, sometimes because people have tried to manage it on their own, or not clearly recognized it, or not considered that help from outside the family was appropriate or available to them. Sometimes, what seemed a normal depressive reaction, say, the loss of a parent to death or a parent leaving the home, will continue past a reasonable time and not resolve, and then families will seek outside help. Sadly, only a minority of children and adolescents with clinical depression actually do get professional help.

Hopefully, you have not given up by this point in the article, because there is hope. Early recognition and treatment can make a significant, even profound difference, in outcome for a child or adolescent with depression. We now have tools to do this, even if not enough children are brought for treatment, or there are not yet enough clinicians to treat them. New psychotherapy techniques can be very effective, including more traditional psychodynamic psychotherapy, and newer approaches that are variations of what is called cognitive behavioral treatment, such as Interpersonal Therapy or Dialectical Behavior Therapy, which actively engage patients in developing skills in day-to-day problem-solving that directly address maladaptive coping in thinking, feeling, and behavior. In particular, treatment of children should also involve working with their parents, even their siblings. Helping parents help their children is often a key part of successful treatment.

When the impact of depression is severe or life-threatening, antidepressant medication will usually be necessary, along with psychotherapy. Although a variety of different antidepressants can help with adult depression, and some of these may be helpful for childhood depression, there is only one class of antidepressants, the Specific Serotonin Re-Uptake Inhibitors (SSRI), that has shown consistent effectiveness with a minimum of side effects for childhood depression. Six of the SSRIs are often used in the U.S., including fluoxetine (Prozac), citalopram (Celexa), escitalopram (Lexapro), fluvoxamine (Luvox), sertraline (Zoloft), and paroxetine (Paxil). Athough not all are approved by the FDA for childhood depression, they all work, though not everyone has the same response on different SSRIs or the same type or degree of side effects, when they occur, which they sometimes can. Some of the more common side effects, which do not typically occur and are usually mild when they do occur, and often fade as people adjust to the medication, include jitteriness, agitation, decreased libido, difficulty sleeping, increase in impulsivity, GI upset, and fatigue. Recent concerns expressed in journals and the media about paroxetine not being effective for childhood depression and causing increased risk for suicidal behavior in children has not been confirmed, as the data to support this concern requires additional validation. Nevertheless, caution should be exercised in using any antidepressant, and alternatives to paroxetine are good ones to consider until more information is available.

When other psychiatric disorders are present with depression, other antidepressants may be appropriate, or medications for different purposes can be appropriate to use in conjunction with antidepressants. Sometimes, in situations where severe depression does not respond to antidepressant or adjunctive medication therapy, electroconvulsive therapy (ECT) is appropriate. Certain substances that have been reported helpful in adult depression, such as St. Johns Wort and SamE (S-adenosyl methionine), may be helpful for childhood depression, but supportive data is lacking for children, and they should not be first choice as antidepressants.

Childhood depression usually responds to therapy, in some or a great degree, and there is a period of months, usually, when therapy is continued. Psychotherapy can be tapered over time, perhaps stopped, or done as needed, while medication usually should be continued longer, usually months beyond the intensive psychotherapy phase, often through a school year, to ensure consolidation, sometimes longer. While having a depression puts a child at increased risk for another episode, it is not a given; and strengths within a child and within the family, timely opportunities, other supports through school and friends, and experiences of success and growth, can contribute to minimizing that risk.

Flemming Graae, M.D., is the Chief of Child and Adolescent Psychiatry at Westchester Medical Center, and is an Associate Professor of Psychiatry and Pediatrics at New York Medical College Behavioral Health Center in Valhalla, New York. In addition to his clinical, research and teaching responsibilities, Dr. Graae has been responsible for the development and Medical Directorship of many new innovative and successful ambulatory programs at Weill Medical College of Cornell University - New York Presbyterian Hospital, including: attention deficit disorders, obsessive-compulsive and anxiety disorders service and adolescent and family programs. In his first year at Westchester Medical Center, Dr. Graae has begun to develop new programs .

Breaking the Silence from page 33

the Silence about Mental Illness. Almost $2,000 in contributions were made to the "Breaking the Silence" education project through the drive. It will be followed this fall by free distribution of lessons plans to all schools (grades 4-12)with a Friendly's within the boundaries of their school district. This unique business/non-profit partnership was spearheaded by Joe Vitrano, owner of the Long Island Friendly's franchise, and is believed to be the first of its kind for mental illness education.

This year the BTS Education Project has also pioneered introducing future educators to "Breaking the Silence". Lorraine Kaplan, who heads our Education and Training Committee, has spoken with great success to future health teachers and educators at local colleges including Adelphi University, Molloy College and Dowling College. The enthusiastic reception our educational message has received encourages us to believe that educating about mental illness is truly an idea whose time has come. We invite you to start a "Breaking the Silence" project in your own community. NAMI-Westchester has sponsored an ongoing BTS education project since 2000. Education Director (title?), Jean Schneider, says (quote from Jean). Do it independently or partner with providers and agencies in your community. Locally BTS has partnered successfully both with the Mental Health Association of Nassau County and North Shore/Long Island Jewish Hospital's Mental Health School Alliance in bringing BTS to the schools along with teacher and staff training. "Breaking the Silence" is available for upper elementary, middle school and high school, and costs $12.50 for each grade level or $35 for all three, plus postage and handling. Copies can be ordered through NAMI Queens/Nassau, (516) 326-0797 or btlessonplans@aol.com, or at our website www.btslessonplans.org

Breaking the Silence in Westchester County: *News*

Since November 2000 when Nami-Westchester hired Jean Schneider M.S.W. as Director of Educational Outreach to promote the Breaking the Silence program, all school districts in Westchester County have been contacted via letters to district superintendents and high school and middle school principals. Health educators were reached by phone and personal meetings were arranged in which the BTS leson plan packets were discussed as a way to teach students the facts about mental illness as part of the health education curriculum.

In July, 2001,Mr. Steven Friedman, who was then Commissioner of the Department of Community Mental Health personally wrote to all Westchester school superintendents recommending that the Breaking the Silence lesson plans be used every school.

Teacher response has been extremely positive.I would like to share comments written by an experienced health education teacher in the Edgemont school district:" Breaking the Silence teaching program increases students overall awareness of mental illness.First of all,mental illness is out there and there are so may people suffering from various types of mental illness. The BTS lesson plans dispel the myths often propagated by television, the media and old wives tales, increasing fears that kids have about mental illness without having much accurate information. The program increases their comfort level in discussing mental illness and teaches that there are many effective treatments available. We have a really bright student population and they have had an opportunity to understand some of the symptoms of mental illness and with increased familiarity become more comfortable with this very important issue."

Perspective from page 38

Once the information is gathered the clinician must then decide how to utilize those involved in the adolescent's world to further help and offer appropriate support to the adolescent during the depressive episode and afterwards as well to maintain remission. Essentially a well-executed multimodal assessment leads to a multimodal intervention. The interventions that should be considered include individual, group, and family therapies, a school based intervention and, when necessary, psychotropic medication. The decision of what or how much to include in the treatment plan will likely vary and depends on the severity of the symptoms and the resulting degree of impairment or dysfunction. The treatment recommendations need to be determined on a case-by-case basis.

Depression jeopardizes adolescents in many ways. Adolescents that experience depression are at a higher risk for decreased school performance, impaired relationships, and adulthood depression and are more vulnerable to suicide. It is imperative for all clinicians that work with adolescents to screen for and diagnose depression appropriately. A developmentally sensitive, biopsychosocial approach should be implemented with regard to both evaluation and treatment in order maximize its efficacy and to assure that adolescents reach their full potential. Early and aggressive intervention will improve response and long-term prognosis and likely have significant lifelong impact.

Abraham S. Bartell, MD, MBA is an Assistant Professor of Psychiatry & Pediatrics at the Mount Sinai School of Medicine and the Director of Clinical Services for the Division of Child and Adolescent Psychiatry and the Mount Sinai Medical Center.

Dr Zvi S. Weisstuch is a Clinical Instructor of Psychiatry & Pediatrics at the Mount Sinai School of Medicine and an Attending Psychiatrist in the inpatient Child & Adolescent unit at the Mount Sinai Medical Center

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The Guidance Center is a health and human services organization that provides services to individuals with disabilities.. Artworks is a Guidance Center vocational program.

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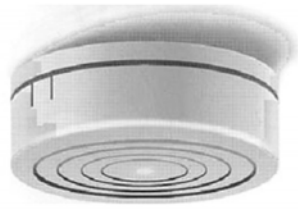

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Alternative from page 11

adolescents who are depressed enough to be suicidal. They are as follows:

- ***Lack of concern about personal welfare*** including experimentation with medication, accepting dares from friends, reckless driving, and self mutilation (carving intials, etc. into the skin);
- ***Changes in social patterns*** including radical changes in cooperation at home, changes in long-term friendships, dropping out of activities, becoming argumentative at school and at work, "hanging out" with a group of kids who are involved in illegal or immoral activities;
- ***Decline in school achievement*** resulting from preoccupation with suicidal thoughts as a result of depression, failure to do any homework, etc.
- ***Difficulty in concentrating*** resulting in less and less ability to focus on logical problem solving and reasoning, and, as confusion escalates, more and more fixation on suicide as being the only viable alternative;
- ***Altered eating and sleeping patterns*** – any dramatic change in eating more or eating less, or sleeping more or sleeping less, offers strong evidence that something may be wrong and needs to be addressed;
- ***Attempts to put personal affairs in order or to make amends*** (occurring when the adolescent has made the final decision on a suicide plan) is recognized by an adolescent beginning to apologize for hurtful actions, reestablishing old friendships, and/or giving away prized possessions;
- ***Use or abuse of alcohol or drugs*** resulting in decreased ability to cope, lessening of impulse control, and decreased ability to communicate accurately;
- ***Unusual interest in how others are feeling*** resulting in inordinate interest in the pain of others which tends to mask their own pain;
- ***Preoccupation with death and violence themes*** manifested by obsessive interest in reading books or poetry about death, violence or suicide, writing stories about death, dying and loss, drawing or sketching destructive or violent pictures, watching movies that portray self-destruction or violence towards others;
- ***Sudden improvement after a period of depression*** appearing to indicate resolution of the problem, but actually many times indicative of a concrete plan for suicide resulting in a feigned happiness and contentment because the decision is made, and will be carried out in the near future; and
- ***Sudden or increased promiscuity*** resulting in increased sexual activity to lessen feelings of isolation and refocus attention away from suicidal ideation.

Many adolescents will not be able to talk openly about their problems or give definite verbal hints that they are considering suicide. But there are always verbal cues which can be a window to self-destructive intentions. Comments can range from a direct statement such as "I'm going to kill myself", to more subtle statements such as "I'm tired of all this, I just want it to end," or "She'll be sorry for the way she has treated me," or "You won't have to worry about me anymore…" etc. The most important thing any adult can do when an adolescent says something that could be interpreted in a number of different ways, is to ask what the person means. Never assume that things are okay, and never minimize the feelings expressed. Often an adolescent who is not particularly communicative or expressive, will say something in hopes that someone will pick it up and provide assistance.

There are two main avenues in treatment: psychotherapy and medication. Sometimes both may be required concurrently. For mild depression in teenagers, supportive psychotherapy with active listening and advice and encouragement and referral to community agencies for alcohol and substance abuse is indicated. Formal family therapy may also be required to deal with specific problems and issues. For more serious or longer term depression, medication is indicated and may well be life-saving. It is important that the medication be given for at least four to six weeks, and that dosages be monitored carefully for best results.

It is widely believed that 90% of all adolescents suffering from depression, who successfully complete suicide, gave some kind of cues to people around them before their attempt. If we each become attuned to listen carefully to teenagers, and to pay attention to the hints they drop, as well as to any changes in behavior, we may well save a life. One of these lives is depicted below in her own words.

Kim's Story

Adolescent suicide is a really sad thing to hear about. Having a precious life taken from you is traumatic. My name is Kimberly, and I have had to deal with adolescent suicide from two different starting points. Here is my story.

I was 14 years old and in the 8th grade when my brother of 16 committed suicide. He was a bright kid with a lot of potential. Clinton knew so much about everything, and was learning the fine line of Chinese. There were no signs before it happened. Keeping to himself was normal, so it didn't phase me or my parents. On April 2, 2000, my brother decided he was going to take his life and shot himself in the head with one of our father's guns. He thought it to be a way out – a permanent solution to a temporary problem. Too bad it was not a solution.

For a long time, I made myself believe that I had dealt with the pain, but I hadn't. Two years later, when I was 16 years old, I made my first suicide attempt. I couldn't deal with living without my brother anymore. I'd like to share a personal poem that was written two months before I became a victim of suicide.

These are my innermost feelings that I didn't even acknowledge. I ended up at a psychiatric hospital for a week and a half.

Suicide does not solve anything. I have had to go through a lot because of my attempt. Nothing is too bad that you have to take your life. A quote that someone once told me was: "Everything's okay in the end. If it's not okay, it's not the end." Stay strong and don't ever give up on yourself or other people. If you need someone to talk to, find someone you can trust. Don't be afraid to open up. Do something you enjoy doing until your mind is off of suicidal thoughts.

If your friend is contemplating suicide and you know about it, do something to help.

Don't stay quiet. Let someone know. You could save someone's life.

NIMH from page 34

- Feelings of worthlessness or inappropriate guilt
- Difficulty concentrating
- Recurrent thoughts of death or suicide

Five or more of these symptoms must persist for 2 or more weeks before a diagnosis of major depression is indicated.

Signs That May Be Associated with Depression in Children and Adolescents

- Frequent vague, non-specific physical complaints such as headaches, muscle aches, stomachaches or tiredness
- Frequent absences from school or poor performance in school
- Talk of or efforts to run away from home
- Outbursts of shouting, complaining, unexplained irritability, or crying
- Being bored
- Lack of interest in playing with friends
- Alcohol or substance abuse
- Social isolation, poor communication
- Fear of death
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Reckless behavior
- Difficulty with relationships

While the recovery rate from a single episode of major depression in children and adolescents is quite high, episodes are likely to recur. In addition, youth with dysthymic disorder are at risk for developing major depression. Prompt identification and treatment of depression can reduce its duration and severity and associated functional impairment.

Screening

There are several tools that are useful for screening children and adolescents for possible depression. They include the Children's Depression Inventory (CDI) for ages 7 to 17; and, for adolescents, the Beck Depression Inventory (BDI) and the Center for Epidemiologic Studies Depression (CES-D) Scale. When a youngster screens positive on any of these instruments, a comprehensive diagnostic evaluation by a mental health professional is warranted. The evaluation should include interviews with the youth, parents, and when possible, other informants such as teachers and social services personnel.

Risk Factors

In childhood, boys and girls appear to be at equal risk for depressive disorders; but during adolescence, girls are twice as likely as boys to develop depression. Children who develop major depression are more likely to have a family history of the disorder, often a parent who experienced depression at an early age, than patients with adolescent- or adult-onset depression. Adolescents with depression are also likely to have a family history of depression, though the correlation is not as high as it is for children.

Other risk factors include:

- Stress
- Cigarette smoking
- A loss of a parent or loved one
- Break-up of a romantic relationship
- Attentional, conduct or learning disorders
- Chronic illnesses, such as diabetes
- Abuse or neglect
- Other trauma, including natural disasters

Treatment

Treatment for depressive disorders in children and adolescents often involves short-term psychotherapy, medication, or the combination, and targeted interventions involving the home or school environment. There remains, however, a pressing need for additional research on the effectiveness of psychosocial and pharmacological treatments for depression in youth. While data from adults indicate the need for maintenance treatment after episode recovery in order to prevent recurrences, the value of such treatment in children and adolescents has yet to be determined through research.

Psychotherapy. Recent research shows that certain types of short-term psychotherapy, particularly cognitive-behavioral therapy (CBT), can help relieve depression in children and adolescents. CBT is based on the premise that people with depression have cognitive distortions in their views of themselves, the world, and the future. CBT, designed to be a time-limited therapy, focuses on changing these distortions. An NIMH-supported study that compared different types of psychotherapy for major depression in adolescents found that CBT led to remission in nearly 65 percent of cases, a higher rate than either supportive therapy or family therapy. CBT also resulted in a more rapid treatment response.

Another specific psychotherapy, interpersonal therapy (IPT), focuses on working through disturbed personal relationships that may contribute to depression. IPT has not been well investigated in youth with depression; however, one controlled study found that IPT led to greater improvement than clinical contact alone.

Continuing psychotherapy for several months after remission of symptoms may help patients and families consolidate the skills learned during the acute phase of depression, cope with the after-effects of the depression, effectively address environmental stressors, and understand how the young person's thoughts and behaviors could contribute to a relapse.

Medication. Research clearly demonstrates that antidepressant medications, especially when combined with psychotherapy, can be very effective treatments for depressive disorders in adults. Using medication to treat mental illness in children and adolescents, however, has caused controversy. Many doctors have been understandably reluctant to treat young people with psychotropic medications because, until fairly recently, little evidence was available about the safety and efficacy of these drugs in youth.

see NIMH on page 55

Researcher Wins NIH Award...*without even applying*

Nathan Kline Institute
For Psychiatric Research

Daniel C. Javitt, M.D., Ph.D., a research psychiatrist at the Nathan Kline Institute for Psychiatric Research (NKI), usually works diligently over the course of many months to piece together an application for the highly competitive federal grant funds that help support his pioneering work. Dr. Javitt is one of a relatively small number of young researchers who have devoted their careers to unraveling the mysteries of schizophrenia. But like the recipients of the better-known McArthur "genius" awards, Dr. Javitt received an unexpected surprise one morning.

Dr. Javitt, 45, learned recently that he was selected as one of 64 new recipients of MERIT (Method to Extend Research in Time) awards made though the National Institute of Mental Health. He is the only researcher to receive a MERIT award in the area of clinical neuroscience this year and is among a group of only five individuals nationally to receive an award in the area of psychiatry (the only one in New York State).

MERIT awardees are selected on the basis of outstanding individual achievement and unsolicited recognition by scientific peers, but the selection of the NKI researcher also reaffirms the Nation Kline Institute as one of the nation's premier institutions for state-of-the-art psychiatric research for individuals affected by neurobiological brain disorders.

Based on his competence and productivity in research, this unusual award will provide long-term support to Dr. Javitt to continue and extend his prior efforts to study the neurobiological bases of behavioral disorders. One of the special blessings the award confers is that it will allow the scientist to devote more time to his work rather than to the tedious process of writing new grant applications.

Much of Dr. Javitt's work has focused on examining how glutamate imbalances, acting on brain NMDA receptors, are involved in schizophrenia. The NKI psychiatrist's publication reporting this finding was the second most cited paper in the area of schizophrenia during the decade of the 90's and has been named a citation classic. Javitt is also studying the effects of glycine and D-serine as treatments for the negative symptoms of schizophrenia.

"These are the first treatments that show promise of addressing the 'negative symptoms' of schizophrenia, which may include lack of motivation, blunted emotions, and the inability to experience pleasure," comments Robert Cancro, M.D., Director of NKI. "Finding ways to address these negative symptoms is as important as treating the psychotic features of the illness. Negative symptoms can have a profound affect on an individual's ability to interact with others, become and remain gainfully employed, and live independently in the community."

Dr. Javitt is Director of the NKI Program in Cognitive Neuroscience and Schizophrenia, and a professor of psychiatry at the New York University School of Medicine. He currently receives funding for his work from the National Institute of Mental Health, the National Institute on Drug Abuse, the New York State Office of Mental Health, the Burroughs Wellcome Fund, and the Stanley Research and Ritter Foundations. He has previously received Young and Independent Investigator Awards from the National Alliance for Research on Schizophrenia and Depression.

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In the last few years, however, researchers have been able to conduct randomized, placebo-controlled studies with children and adolescents. Some of the newer antidepressant medications, specifically the selective serotonin reuptake inhibitors (SSRIs), have been shown to be safe and efficacious for the short-term treatment of severe and persistent depression in young people, although large scale studies in clinical populations are still needed. So far, there are two controlled studies showing efficacy of fluoxetine and paroxetine, respectively. It is important to note that available studies do not support the efficacy of tricyclic antidepressants (TCAs) for depression in youth.

Medication as a first-line course of treatment should be considered for children and adolescents with severe symptoms that would prevent effective psychotherapy, those who are unable to undergo psychotherapy, those with psychosis, and those with chronic or recurrent episodes. Following remission of symptoms, continuation treatment with medication and/or psychotherapy for at least several months may be recommended by the psychiatrist, given the high risk of relapse and recurrence of depression. Discontinuation of medications, as appropriate, should be done gradually over 6 weeks or longer.

NIMH has initiated a large-scale, controlled clinical trial at 10 sites across the U.S. to compare the long-term effectiveness of fluoxetine, CBT, and the combination of these interventions for treatment of depression in adolescents. More information about this trial, called the Treatment of Adolescents with Depression Study (TADS), and others can be found through the Clinical Trials page of the NIMH web site at http://www.nimh.nih.gov/studies/index.cfm.

Talking With Parents

It is very important for parents to understand their child's depression and the treatments that may be prescribed. Physicians can help by talking with parents about their questions or concerns, reinforcing that depression in youth is not uncommon, and reassuring them that appropriate treatment with psychotherapy, medication, or the combination can lead to improved functioning at school, with peers, and at home with family. In addition, referring the youth and family to a mental health professional and to the information resources listed at the back of this publication can help to enhance recovery.

Other Types of Depression
in Children and Adolescents

Bipolar Disorder

Although rare in young children, bipolar disorder—also known as manic-depressive illness—can appear in both children and adolescents. Bipolar disorder, which involves unusual shifts in mood, energy, and functioning, may begin with either manic, depressive, or mixed manic and depressive symptoms. It is more likely to affect the children of parents who have the disorder. Twenty to 40 percent of adolescents with major depression develop bipolar disorder within 5 years after depression onset.

Existing evidence indicates that bipolar disorder beginning in childhood or early adolescence may be a different, possibly more severe form of the illness than older adolescent- and adult-onset bipolar disorder. When the illness begins before or soon after puberty, it is often characterized by a continuous, rapid-cycling, irritable, and mixed symptom state that may co-occur with disruptive behavior disorders, particularly attention deficit hyperactivity disorder (ADHD) or conduct disorder (CD), or may have features of these disorders as initial symptoms. In contrast, later adolescent- or adult-onset bipolar disorder tends to begin suddenly, often with a classic manic episode, and to have a more episodic pattern with relatively stable periods between episodes. There is also less co-occurring ADHD or CD among those with later onset illness.

Bipolar Disorder: Manic Symptoms

- Severe changes in mood—either extremely irritable or overly silly and elated
- Overly-inflated self-esteem; grandiosity
- Increased energy
- Decreased need for sleep—able to go with very little or no sleep for days without tiring
- Increased talking—talks too much, too fast; changes topics too quickly; cannot be interrupted
- Distractibility—attention moves constantly from one thing to the next
- Hypersexuality—increased sexual thoughts, feelings, or behaviors; use of explicit sexual language
- Increased goal-directed activity or physical agitation
- Disregard of risk—excessive involvement in risky behaviors or activities

A child or adolescent who appears to be depressed and exhibits ADHD-like symptoms that are very severe, with excessive temper outbursts and mood changes, should be evaluated by a psychiatrist or psychologist with experience in bipolar disorder, particularly if there is a family history of the illness. This evaluation is especially important since psychostimulant medications, often prescribed for ADHD, may worsen manic

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Passages from page 36

At our program we assess each youngster to determine his/her ability “to learn” and institute a cognitive remediation program tailored to the youngster’s needs. Success in learning improves with improved cognition. Concentration, following directions, completing tasks and staying focused on the outcome improves along with self-confidence and self-esteem.

Abuse and Neglect. Other factors affecting the teens’ emotional stability are: a high incidence of substance abuse, physical and sexual abuse, teens living in single parent households with little supervision, and a high percentage living in adoptive or kinship arrangements, often due to the death of a parent or because they have been physically abandoned. Of the participants enrolled in “PASSAGES,” 82% were exposed at some point in their lives to the trauma of violence or sexual abuse, 35% live with a caretaker other than a parent, and 18% have experienced the loss of a parent due to AIDS, violence or substance abuse.

These problems can contribute to social alienation. Teens in an effort to get needed attention and acknowledgement may get involved in gangs or engage in promiscuous sexual behavior. The “PASSAGES” program helps them to see that counselors and peers are interested in their issues, listen to them when they need to talk, and that together they can solve problems. Participation in the program allows them to focus on emotional intimacy and bonding. “PASSAGES” and support from the Counseling Center helps our participants reduce their contacts with destructive peers in the community. They begin to see the value of setting goals for the future and eventually they start to explore career options. **Rehabilitation combined with treatment works, and hope replaces depression and despair.**

SEVERE DEPRESSION

WITH IRRATIONAL THOUGHTS

Physicians at the Weill Medical College of Cornell University are investigating treatments for patients who have severe depression with irrational thoughts. If you, or someone close to you, are suffering from these symptoms and would be interested in learning more about our research, please telephone

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- *The Housing Services Program*, available to low and moderate income individuals and families in Post Chester through the Neighborhood Preservation Company, includes tenant assistance, eviction prevention, home ownership counseling, landlord-tenant mediation and housing court assistance.
- *Hope House* is a place where persons recovering from mental illness can find the support and resources they need to pursue their vocational and educational goals. Located in Port Chester, the Clubhouse is open 365 days a year and draws members from throughout the region.

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symptoms. There is also limited evidence suggesting that some of the symptoms of ADHD may be a forerunner of full-blown mania.

The essential treatment for bipolar disorder in adults involves the use of appropriate doses of mood stabilizing medications, typically lithium and/or valproate, which are often very effective for controlling mania and preventing recurrences of manic and depressive episodes. Treatment of children and adolescents diagnosed with bipolar disorder is based mainly on experience with adults, since as yet there is very limited data on the safety and efficacy of mood stabilizing medications in youth. Researchers currently are evaluating both pharmacological and psychosocial interventions for bipolar disorder in young people.

Bipolar Disorder: A Warning About Antidepressants and Psychostimulants

Using antidepressant medication to treat depression in a person who has bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer, such as lithium or valproate. In addition, using psychostimulant medications to treat ADHD or ADHD-like symptoms in a child or adolescent with bipolar disorder may worsen manic symptoms. While it can be hard to determine which young patients will become manic, there is a greater likelihood among children and adolescents who have a family history of bipolar disorder. If manic symptoms develop or markedly worsen during antidepressant or stimulant use, a child psychiatrist should be consulted, and treatment for bipolar disorder should be considered. Physicians should be aware of the signs and symptoms of mania so that they can educate families on how to recognize these and report them immediately.

Valproate Use

According to studies conducted in Finland in patients with epilepsy, valproate may increase testosterone levels in teenage girls and produce polycystic ovary syndrome in women who began taking the medication before age 20.39 Increased testosterone can lead to polycystic ovary syndrome with irregular or absent menses, obesity, and abnormal growth of hair. Therefore, young female patients prescribed valproate should be monitored carefully.

Dysthymic disorder (or dysthymia)

This less severe yet typically more chronic form of depression is diagnosed when depressed mood persists for at least one year in children or adolescents and is accompanied by at least two other symptoms of major depression. Dysthymia is associated with an increased risk for developing major depressive disorder, bipolar disorder, and substance abuse. Treatment of dysthmia may prevent the deterioration to more severe illness. If dysthymia is suspected in a young patient, referral to a mental health specialist is indicated for a comprehensive diagnostic evaluation and appropriate treatment.

This Article: Depression in Children and Adolescents - A Fact Sheet for Physicians is by The National Institute of Mental Health Publication No. 00-4744, September 2000, for a list of references can be found at their website, www.nimh.nih.gov

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fluoxetine (Prozac) and paroxetine (Paxil). Except for lower initial doses, the administration of SSRIs in adolescents is similar to that for adult patients with a recommended duration of at least four weeks. In the absence of adolescent relapse studies and considering the adult literature, teens with two or three episodes of major depression are recommended to receive maintenance treatment for at least 1 – 3 years. Teenagers with a diagnosis of both depression and anxiety can be acutely agitated, requiring an anti-anxiety medication, such as diazepam (Valium) or alprazolam (Xanax), rather than waiting the several weeks needed for an SSRI to relieve symptoms.

There is a pressing need for additional research on the effectiveness of psychosocial and pharmacological treatments for depression in youth. Under the FDA Modernization Act (1997), manufacturers of selected medications already approved for use in adults, but also prescribed to youths, will need to provide studies in the pediatric population. Because of these regulations, several trials of other SSRIs and norepinephrine serotonin reuptake inhibitors (NSRIs) are ongoing. Recruitment of subjects for clinical trials and the lack of an adequate research infrastructure limit the pace of new research in this area. Both industry-sponsored and federally funded research has been hampered by recruitment difficulties. This is not because of a lack of adolescents with depression, rather it may reflect differences in access to care, with many patients being treated by primary care physicians or not at all.

This article is an excerpt from "Adolescent Depressive Disorders," originally published in the NARSAD Research Newsletter, *Vol. 13, Issue 3, Fall 2001.*

NARSAD FACT SHEET

Depressive Symptoms in Adolescence

- Vague, non-specific physical complaints such as headaches, muscle aches, stomach aches or tiredness
- Absences from school or poor performance in school
- Talk of, or efforts to run away from home
- Outbursts of shouting, complaining, unexplained irritability or crying
- Being bored
- Lack of interest in playing with friends
- Alcohol or substance abuse
- Social isolation, poor communication
- Fear of death
- Extreme sensitivity to rejection or failure
- Increased irritability, anger or hostility
- Reckless behavior
- Difficulty with relationships

Adolescent Depressive Disorders are Common and Potentially Fatal

- Major depression affects approximately 4 - 8 percent of adolescents.
- Within 5 years of the onset of major depression, 70 percent of depressed youths will experience a recurrence.
- Depression in young people often co-occurs with other mental disorders, most often anxiety, disruptive behavior or substance-abuse disorders.
- Longitudinal follow-up studies estimate that 20 - 25 percent of depressed adolescents will develop a substance-abuse disorder.
- As many as 5 - 10 percent of adolescents will complete suicide within 15 years of their initial episode of major depression.
- Although adolescent depression is twice as common in girls as boys, in post-puberty (ages 15-19), the male suicide rate is 5 times that of the female rate.

Common Characteristics Among Adolescents Who Commit Suicide

- Pessimism about the future, manifested as hopelessness
- Poor self-efficacy (helplessness)
- Poor self-esteem, expressed as worthlessness
- Recklessness
- Impulsivity

Manic Symptoms in Adolescence

- Severe changes in mood – either extremely irritable or overly silly and elated
- Overly-inflated self-esteem; grandiosity
- Increased energy
- Decreased need for sleep – able to go with very little or no sleep for days without tiring
- Increased talking – talks too much, too fast; changes topics too quickly; cannot be interrupted
- Distractibility – attention moves constantly from one thing to the next
- Hypersexuality – increased sexual thoughts, feelings or behaviors; use of explicit sexual language
- Increased goal-directed activity or physical agitation
- Disregard of risk – excessive involvement in risky behaviors or activities

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Partnership from page 43

The first was initiated in 2000, shortly after Laurel House completed the construction of its new clubhouse facility in Stamford, when Laurel House completed construction on six new housing units with bond funds from the state of Connecticut and private funding through the Housing Development Fund of South Western Connecticut. The units provided support services to fifteen homeless individuals with service dollars provided by the Dept. of Mental Health and Addiction Services' PILOTS program, United Way and the Fairfield County Foundation. The new HUD project will increase the number of individuals served through Laurel House supported housing to fifty six people overall, almost all of whom have been homeless at some point in their past.

Laurel House has been providing comprehensive support services, including emergency shelter, food and support services to homeless and at-risk individuals and families since 1984. The organization operates a variety of "Wrap Around" support services such as a Food Cooperative, Financial services for banking needs, a Thrift Store for furniture and household goods, an evening Drop-in type Social Program, an evening Warm line and a double Recovery Program that assists people who are dually diagnosed with mental illness and substance abuse to attend AA and NA meeting during evening and weekend hours. Since 1984, Laurel House has provided mobile outreach services to individuals in the community who require continuing support to maintain their housing. This program was developed from years of experience with members who were at risk of hospitalisation or behaviours that would jeopardize their housing stability.

The Mutual Housing Association of South-western CT (MHA) is a nationally recognized housing developer founded in 1990 with offices in Bridgeport and Stamford CT. The mission of the MHA is to develop, finance, own, lease and manage safe, quality permanently affordable housing for low income and moderate-income households throughout Fairfield County. MHA seeks to create a continuum of housing opportunities for all sectors of the community and serve as an ongoing producer of affordable housing throughout the South-western region to meet present and future housing needs.

MHA has extensive experience developing affordable housing throughout Fairfield County and is an active participant in the Connecticut Coalition To End Homelessness and the Partnership for Stronger Communities. MHA has coordinated its activities with state and local housing authorities and since its founding MHA has become a regional organization throughout Fairfield County with existing housing and new developments underway that represents over $38 million of investment in neighbourhood revitalization

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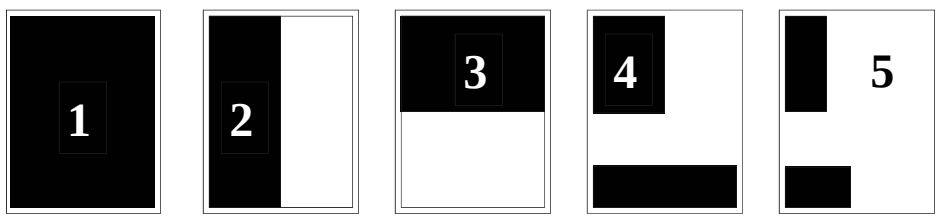

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