MENTAL HEALTH NEWS™

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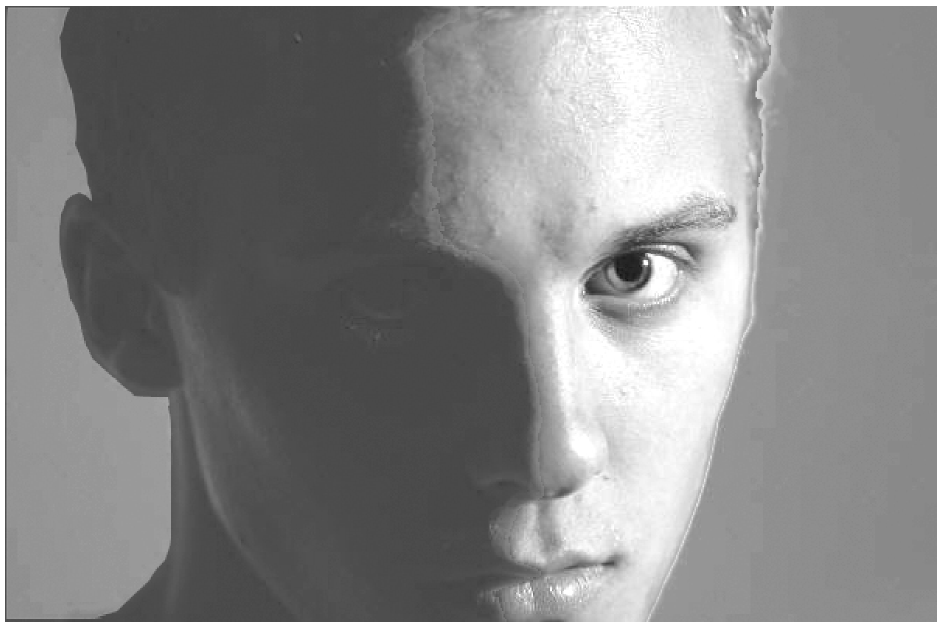
Understanding and Treating Schizophrenia

National Institute of
Mental Health, NIMH



Schizophrenia is a chronic, severe, and disabling brain disease. Approximately 1 percent of the population develops schizophrenia during their lifetime—more than 2 million Americans suffer from the illness in a given year. Although schizophrenia affects men and women with equal frequency, the disorder often appears earlier in men, usually in the late teens or early twenties, than in women, who are generally affected in the twenties to early thirties. People with schizophrenia often suffer terrifying symptoms such as hearing internal voices not heard by others, or believing that other people are reading their minds, controlling their thoughts, or plotting to harm them. These symptoms may leave them fearful and withdrawn. Their speech and behavior can be so disorganized that they may be incomprehensible or frightening to others. Available treatments can relieve many symptoms, but most people with schizophrenia continue to suffer some symptoms throughout their lives; it has been estimated that no more than one in five individuals recovers completely.

This is a time of hope for people with schizophrenia and their families. Research is gradually leading to new and safer medications and unraveling the complex causes of the disease. Scientists are using many approaches from the study of molecular genetics to the study of populations to learn about schizophrenia. Methods of imaging the brain's structure and function hold the promise of new insights into the disorder.

Schizophrenia as an Illness

Schizophrenia is found all over the world. The severity of the symptoms and long-lasting, chronic pattern of schizophrenia often cause a high degree of disability. Medications and other treatments for schizophrenia, when used regularly and as prescribed, can help reduce and control the distressing symptoms of the illness. However, some people are not greatly helped by available treatments or may prematurely discontinue treatment because of unpleasant side effects or other reasons. Even when treatment is effective, persisting consequences of the illness—lost opportunities, stigma, residual symptoms, and medication side effects—may be very troubling.

The first signs of schizophrenia often appear as confusing, or even shocking, changes in behavior. Coping with the symptoms of schizophrenia can be especially difficult for family members who

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A New Context for the Treatment of Schizophrenia

By Stuart Forman, MD
Medical Director
Capitol Region Mental Health Center
Hartford, Connecticut

I have spent the last 23 years mainly working with people who carry the diagnosis of Schizophrenia. Only during the past year have I heard the term "recovery" routinely mentioned. These days, however, one is hearing it more often. It appeared repeatedly in the report of the New Freedom Task Force appointed by President Bush to redefine mental health services in our country. Implementation of the Recovery Model is a major strategic goal of Connecticut's Department of Mental Health and Addiction Services. Is something new really going on here, or are we simply playing with semantics?

One way to understand the recovery paradigm is to contrast it with more traditional "medical model" views of severe and prolonged psychiatric illnesses. In the traditional view of chronic illness, schizophrenia is understood to be a brain disorder in the same sense that diabetes is considered a disorder of the pancreas. Patients diagnosed with diabetes are told that they will need to measure their blood sugars, watch their diets, and probably take some sort of medication for the rest of their lives. Similarly, people with schizophrenia have often been told that they "have a chronic illness" and will always need to take medication. The idea regarding both schizophrenia and diabetes is that one can treat the symptoms (i.e., high blood sugar for diabetes and psychosis for schizophrenia), but that in some sense, the disease persists even in the absence of symptoms.

For years, the idea of making mental health more "medical" has been appealing to many. Perhaps, if we could somehow become more "scientific," we would discover more effective and efficient treatments. Some of our notoriously labor-intensive treatments might be dropped in favor of medications and other less costly interventions. If properly understood as organ malfunctions, psychiatric illnesses might attract less stigma. Maybe insurance companies would then cover psychiatric illnesses as fully as they do medical problems.

Perhaps, on the other hand, brains are different enough from pancreases that the analogy doesn't really work too well. At this moment in time, a person whose pancreas has stopped making insulin is likely to need insulin injections on a permanent basis. Let's now contrast this with a person experiencing some sort of psychotic symptom. Someone experiencing auditory hallucinations, for example, might be able to learn to ignore the hallucinations, or at least to distinguish them from other stimuli. Might this have the effect of reducing (or even eliminating) the need for medication? The fact that psychiatric symptoms overlap with conscious thinking renders them quite different from bodily functions (e.g., insulin production) that tend to operate apart from things that are under our control. (This is not to disparage, of course, the critical "lifestyle" changes that can make an enormous difference in diabetes; it is merely to suggest that the processes of thinking and producing insulin are probably more different than they are similar.)

The Recovery Model reminds us that psychiatric illnesses have a way of depriving people of their hopes and dreams. In the broadest sense, our goals as mental health providers should be to help people recapture these treasured aspects of their lives. We professionals need to remember, of course, that we are technical consultants with relatively modest contributions to make to the recovery efforts of the people with whom we work. What we have to offer is "treatment." We are, after all, experts in using medications to reduce certain "symptoms." We know how to teach certain skills, and how to help people understand psychological patterns in

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Our office hours are from 9-5 (M-F) at (914) 948-6699
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Ira H. Minot, CSW, Executive Director
Mental Health News Education, Inc.

From The Publisher

The Hope For People With Serious Mental Illness

By Ira H. Minot, CSW, Founder and Publisher, Mental Health News

I am truly proud of everyone who helped us put together this issue of *Mental Health News* which is dedicated to the understanding and treatment of schizophrenia. Thanks to our volunteer network of clinicians, provider organizations, consumers, advocates and public policy analysts, we are fortunate to provide you with many inspiring and informative articles. They run the gamut from life-saving treatment programs, individual triumphs over adversity, calls for action on the legislative front, and the hope that research gains will improve the lives of people with serious mental illness.

Our cover story by the National Institute of Mental Health (NIMH) gives us a comprehensive look at the many clinical and treatment aspects of schizophrenia. I am eternally grateful to the NIMH, whose website always helps us provide our readers with concise and up-to-date reviews of the full range of mental illnesses. I encourage you to visit their website, www.nimh.nih.gov.

Our second cover page article is by Stuart Foreman, MD. Dr. Foreman provides us with a fresh and inspiring look at how mental health providers in the State of Connecticut are establishing and implementing ‘recovery’ principles as a major strategy. Their hope is to be able to demonstrate that by listening to and involving the client in providing treatment services, they will increase their effectiveness in helping people with mental illness regain valued aspects of their lives. I was inspired and filled with feelings of hope for the clients who will be impacted by Connecticut’s initiative, because of memories of my own recovery from a ten-year battle with severe depression. After years of repetitive outpatient attempts to get well, it was attending a neighborhood (peer-run ‘recovery’ oriented) drop-in center that helped me reclaim the lost elements of my own inner strengths as a person—not just as a patient. This, put me on the road to recovery and led me to create the publication you are now reading.

Isn’t it amazing what people with mental illness can achieve, if given the right care, respect and opportunity?

Providing *hope* for people with mental illness is one of the cornerstones of *Mental Health News*. This theme continues to weave a heartfelt and compelling fabric in this issues four personal account stories.

Susan Weinreich, an award-winning artist, gives us a close-up look into her childhood and her oncoming decent into schizophrenia in: *Reflections on a Childhood Before the Onset of Schizophrenia (page 5).* Susan, who today has reclaimed her life, explains her transformation from darkness into a brighter light as the spirit within all living things: “to move beyond our limitations—to build a fire underneath ourselves and to finally acknowledge and give honor to the individual unique strength in each of us to survive, endure and excel.”

Ira H. Minot, CSW

Mindy Appel, ACSW, LCSW, tells the story of a young man’s decent into schizophrenia in: *Trapped in A Fugue: Jimmy’s Story (page 12).* Her compelling description of Jimmy, his parents and younger sister, details the pain, despair and feelings of guilt, that many families endure when a loved one is gripped by a serious mental illness. Ms. Appel offers a hopeful message amidst the tragic story of Jimmy in saying: “It is essential that there be more parent and family education concerning treatment and medications available in such cases. Only in destigmatizing those with mental illness can we hope to get them the treatment they need and cut down on the denial and ignorance of the true nature of mental illness. Jimmy’s life was a testament to the need for that process – may his legacy be in increasing the awareness of others in similar situations before it is too late.”

Denise Kreitzman, of The Mental Health Association of Nassau County tells the story of Orlando and his battle with schizophrenia in: *Reclaiming a Life: Orlando’s Story (page 27).* In it, she describes Orlando’s ordeal, the help and support he received from the MHA and his inspiring path to recovery. In his own words, Orlando shares his personal feelings in saying: “Recovery is a combination of things. Getting better happens when you utilize the system to your advantage…to the best of your capabilities. That means compliance with meds, therapy and the internal drive to want to recover. I had to hit rock bottom before I came around and saw things realistically again. When that happened I wanted the stability, I wanted to be at my best. Once you start to get your old feelings back…feelings of wellness, you don't want any other conscious state. You want to be alert, vibrant and as far away from an altered state as possible. Most importantly, knowing that there's hope - that I could get better - kept me striving.”

In his own words, L.A., a young man who sustained Traumatic Brain Injury (TBI) and has the additional burden of a mental illness, gives us his feelings about his recovery process in: *The Story of L.A., A Client at Connecticut Valley Hospital (page 36).* With TBI, L.A. has difficulty doing simple tasks, He credits his own determination, his spiritual beliefs and the caring staff at his facility for keeping him going towards success. He says: “I’ve learned to love myself more and hate myself less. I’ve been doing really well now. I stay real busy by working at separate things. I like feeling like this inside—happy and content! Plus I don’t feel so stupid anymore. I take that bad attention off myself and put it on things I know I can do and I do them...I have a lot more friends now including staff who will take some time to talk to me when I need it. They tell me “good job L.A., Keep it up!” I plan not to let them down or myself.”

I wanted to single out these personal accounts for their courage, hope and inspiration. However not all stories have happy endings—reminding us of the importance of providing mental health education to you and to communities near and far. It reminds us that proper treatment, family involvement, and recovery options must be provided to help people with mental illness. We must also remember that people need respect and an opportunity to call on their own inner strengths when they find themselves seeing the light at the end of the tunnel.

During my own battle with serious depression, I reached a pivotal time when I knew I was ready to leap ahead toward recovery. For me, it came several months after a specialized course of treatment had finally succeeded in lifting the dark curtain of my depression. I will never forget my frustration and chagrin with the program director of the outpatient program I had been attending, who would not take my enthusiasm for recovery seriously. When I insisted I be put on a faster track to recovery she said, “why don’t we talk about this in Group.” I will also never forget a staff member at the same program who understood my frustration at being turned a deaf ear. She took me aside behind closed doors that very day and told me, “there is a peer-run drop in center in the community that I think can help you.” I went, it helped, and the rest is history.

If I had more room I would tell you about all the other wonderful articles in this issue, but will leave that to you.

As the fall season comes our way and beckons forth another new year, it is my hope that we continue to fight for more adequate funding for mental health services, increased funding for groundbreaking research which is unlocking the mysteries of brain disorders, and for all of us to become more vigilant stewards for the elimination of stigma towards people with mental illness.

Have a wonderful fall season !!

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your participation is welcomed

Winter 2006 Issue
“The Many Faces of Anxiety Disorders”
Deadline: November 1, 2005

Spring 2006 Issue
“Managing Mental Health Crises”
Deadline: February 1, 2006

Summer 2006 Issue
“Understanding Autism Spectrum Disorders”
Deadline: May 1, 2006

Reflections on a Childhood Before the Onset of Schizophrenia

By Susan Weinreich

With the delighted mind of an inquisitive child growing up amongst the dense embrace of an enigmatic nature, I began my life. I studied the earth's floor, overturning rocks and examining birds with their locked wings as they lay in silence in the steamy decay of leaves that padded the woods outside my home. Having flown unaware into the large plate glass windows of our contemporary house, the birds struck with a force and fell stunned, to the ground. Some recovered and in time, flew off. Others did not. Numerous streams and marshy terrain surrounded the neighborhood in which I lived. Crouching for hours, my knees damp and stained, I relished the deep draw and ornery scent of skunk cabbage nearby. Those were the times I would lose myself in the endless flow of water, navigating pebbles, leaves and twigs to redirect the rush of foam and frogs. Creation lived in the woods. In its simple sophistication and in it's rigorous brutality. Both held equal fascination.

Following these explorations of nature were the quiet, concentrated and solitary years I spent in the damp, unfinished basement of my family home working with clay. There I abandoned myself to making art under the earth, in the dark place, while the other children played outdoors, smoked cigarettes and drank in the light of the sun. They practiced their sexual innuendoes, grew tall and went to the prom.

Everyday after school and on weekends, I went down to my basement studio. My drive to create engulfed me, intrigued by the seductivity and sensuosity of this fundamental earthy substance. "As clay is to the hand of the potter, thus, is man to the hand of God". I discovered this passage in the high holiday prayer book during Rosh Hashanah, the Jewish New Year. Keeping a time sheet on the basement wall, I logged in daily and recorded the hours I spent at work. Eventually I would surface, leaving a trail of muddy wet clothes and dusty footprints on the polished black slate floor, above.

At times I would fixate on the kilns and large walk-in gas furnaces that would bring my clay vessels to a place of stability, inevitably, my mind would shift to the gas chambers of World War II. I imagined the fingernail scratches on the firebrick from inside the kiln as I loaded my earthenware for transformation to its hardened state.

Retreating deeper and deeper into my work with a mind that had not been challenged by any external discipline, I managed to avoid communicating my troublesome thoughts. I avoided any form of social development. Whatever the degree of instruction I received from my parents, was negligible. Despite my excessive desire and driven instinct to be creative from a young age, I was haunted by a dark cloud which cast a shadow over my internal world. I contemplated death and identified strongly with significant figures from Shakespearean tragedies.

Susan Weinreich

Anything I learned about life, I learned, not from parents, family, friends, teachers, but from the execution of my work. From the design of the natural world. I learned about risk-taking, chance, problem solving and the things that brought breath to a painting as well as the things that destroyed it. My silence and detachment with others led to countless fantasy and isolation. Yet, my tendency towards introspection gave me the ability in later years, to develop tremendous insight. I had difficulty forming and maintaining friendships. The two adults in the house, my mother and my father drew consistently and emotionally absent, though I had a profound feeling of closeness and attachment towards my father, an architect by profession, who supported and nurtured my interest in art. One brother retreated into his intellect, the other, perhaps the strongest, ventured out of the family domain. All of us in our own illusive cocoons, spinning independently, without any real communication with each other of any kind.

The basement was a virtual landscape of skirting field mice, spiders, bugs and musty dark corners. I had a great fear of the basement. Whether my fear stemmed from a common apprehension or a questionable crime scene of childhood trauma, I will never know. Nonetheless, I forced myself daily down the green linoleum steps that served as a mote between the world above and my world below. Each time I went down to release the intense passion that I felt through my art, I had to battle the dragon waiting. One afternoon when I ventured into a section of the basement I clearly kept my distance from, I found my father's paint box. It was sitting on a work bench in the far corner of the cellar. Most of the tubes were old and dry but the strong infusion of oil remained and I drew them to my nostrils. I managed to open a tube and with the smear of an index finger I placed a dab of oil and pigment behind each ear. I failed every subject in school except art and English. I even failed gym. Biology fascinated me, especially dissection, reproduction and osmosis.

In the fall of 1973 I entered my freshman year at The Rhode Island School of Design. Unprepared emotionally, my isolation continued and I succumbed rather steadily into a deep descent with extreme psychological deterioration. The intensity and confusion of my sexual drive served to exacerbate an already accelerating disease process. With the analytic spin of the Freudian psychiatrist treating me, I continued to unravel with great force. My mind eventually shattered and disseminated into a thousand isolated multiple fragments, a splintering of substance into ether. Mirrors, when placed facing each other, receded into an endless reverberation of boundary-less sensory and psychological reality.

Many years have passed in what has felt like a lifetime. In me, a new soul was born and a new breath was given. From the dryness and desolation, I evolved, and built a new life. A gift so profound, there are no words. Yet I found myself searching for the meaning in all of the lives of all of the people I had met, young and old, including my own, during my journey through illness and recovery. For all of the years of suffering and torment, I could not help but ask *why*?

Janice was a brilliant young poet whom I had met during my hospitalizations. She fought her demons as I had and struggled incessantly. I wanted so much to make sense of what was lost and I wondered what had become of her. I had hoped that despite her illness, her soul had continued to flourish. I also had hoped that some of her poetry, which she read to me night after night from my hospital bedside, was contained in the suitcase that she left with me for safe keeping. Her suitcase had been locked for twenty years and had rested untouched in the basement of my childhood home in Connecticut. As the years passed, I grew impatient. My need for answers swelled within my now fully functioning heart and mind, until one day, hammer in hand, I made the familiar descent down the green linoleum stairs. That afternoon, in the summer of 1999, I broke into Janice's suitcase. I was looking for her poetry, her life, her art, for meaning. What I found that day shocked me. I found a suitcase filled with empty aluminum pie tins and a

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SUSAN WEINREICH

"The Kiss"

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Providing a Second Chance For People with Schizophrenia

By Andrew Bloch, MSW, Program Coordinator and Adam Savitz, MD, Unit Chief, Second Chance Program NewYork-Presbyterian Hospital Westchester Division

Andrew Bloch, MSW and Adam Savitz, MD

Despite advances in psychopharmacology, many individuals with schizophrenia remain too impaired to be discharged from the state hospitals. One response to this problem in New York State was the establishment of a unique partnership among a private hospital, the New York Presbyterian Hospital-Westchester Division (NYPH-WD), the New York State Office of Mental Health (OMH), and four community residence providers in New York City. The goal of this partnership was to develop an alternative treatment model for those "untreatable" patients who had been in state hospitals for more than three years, or who had otherwise been unable to establish any substantial tenure in the community. Such patients would be placed in what was called the Second Chance Program, a specialized 30-bed inpatient unit at NYPH-WD. The program was initially conceived and developed by Rami Kaminski, MD who is the Director of the Family Liaison Bureau at OMH, Ken Terkelsen, MD who was the director of the day treatment program at the time at NYPH-WD, and Michael Friedman, MSW who was doing program development at NYPH-WD.

The program opened its doors in the winter of 1998. Patients are identified by the staff at the state hospitals as potential candidates for Second Chance. All prospective patients are then interviewed for clinical appropriateness, to make sure they understand the nature of the program, that they and their families have had all of their questions answered, and that they are willing to participate voluntarily in the program.

In the Fall of 1999 Steve Silverstein, PhD came to NYPH-WD from the University of Rochester to become the Program Director of Second Chance. His primary mission at the time was to introduce a comprehensive behavioral treatment program that has long been known to be effective in treating the severe and persistently mentally ill (SPMI) population. Recognizing that behavioral problems as well as symptoms can be major impediments to many patients' ability to live successfully in the community, behavioral interventions to address behavior excesses (e.g., aggression) and deficits (e.g., social isolation) were implemented at the milieu, group, and individual treatment levels. A point system based on comprehensive observational ratings of both socially inappropriate and appropriate behavior is used for determining on-ward and off-ward privileges. Patients receive daily ratings, and feedback, for appearance and grooming, room cleanliness, behaviors during mealtimes, and preparation for sleep. These specific behaviors were targeted because we knew that the community residences placed a high premium on these skills, as well as that consumers with these skills have longer community tenures than those without them.

The program also uses a token economy, which can be thought of as a prosthetic environment for people with severe cognitive deficits. Patients earn tokens for meeting specific behavioral targets: such targets may be for the behaviors noted above or for aspects of group therapy, including arriving on time, participating and staying for the entire session. These are skills that are important for the patients to have as they re-enter the community and participate in day treatment or pre-vocational programs. Tokens provide immediate reinforcement for positive, prosocial behaviors and provide a daily sense of success and mastery for even the most impaired individuals. As a patient's behavior begins to approach community standards the external reinforcers (tokens) are used less, and social and internal controls are relied on more.

Adam Savitz, MD, has been the Unit Chief since July 2001 and has been dedicated to the social learning program as well as to overseeing the psychopharmacology for the patients. The general philosophy is to not over-sedate the patients with medication, for two very important reasons. First, over-sedation simply masks problem behaviors and symptoms which need to be addressed more actively in treatment; and second, the emphasis of Second Chance is to help the patients learn essential skills needed to live in the community, and it is very difficult to learn when over-sedated on medication.

The Second Chance Program model has proven to be quite effective for treating patients who were considered unlikely to be discharged from state hospitals. We have discharged over 250 individuals since the program's inception and have been able to successfully transition 80% into the community, and 80% of these individuals are out in the community at any given time. Increasingly over the past 1-2 years, we have been working with individuals who would otherwise have been transferred to a state facility for intermediate level of care, and the social learning and token economy has been effective in preventing state hospital transfer for many of these individuals. We have demonstrated that when intensive behavioral treatment is combined with appropriate pharmacology, the number of patients deemed to have treatment refractory psychosis is far lower than when medication alone or medication plus traditional milieu approaches are used.

At the program's inception, forethought was given to the need for available community residence beds where the patients could be placed once they were ready for re-integration into the community. OMH used reinvestment monies at the time to provide the program with 30 supported housing beds dedicated to Second Chance patients being discharged who needed the support and structure provided by a community residence. This was a vital component of the program as many of our patients have comorbid medical problems such as diabetes and high blood pressure, serious substance abuse histories, as well as histories of involvement with the criminal justice system that make them very difficult to place in the community. We obtained a commitment from four well-established housing providers in New York City to prioritize the Second Chance Program patients. It was decided at the time to concentrate the 30 beds among fewer housing providers to promote closer and more intensive working relationships between the inpatient setting and housing providers taking the patients, and this proved to be a good decision. We also wanted to use housing providers that were close to where the patients had family and/or other community supports. To date, almost all of the 30 dedicated beds have been filled with individuals who have graduated from Second Chance. The housing providers have done an excellent job supporting the patients in the community and continuing to teach the community living skill in vivo that were reinforced in the inpatient setting. We are currently discharging the patients through the SPOA system, mostly in New York City, competing with other hospitals for limited openings in the community residences.

Initially there were regularly scheduled meetings with OMH, NYPH-WD and the housing providers to discuss the newly developing working relationships and to facilitate a better understanding of the special needs and perspectives of the partners. There was genuine excitement and enthusiasm amongst the partners embarking on this new relationship, and a trust that developed as we worked together in the service of providing the best transition for the patients whom had been institutionalized for many years. Andrew Bloch has been the liaison between Second Chance, OMH and the housing providers since the program opened its doors, and having one contact as the "point person" has facilitated the smooth transition of patients from one level of care to another. Housing providers find working with Second Chance advantageous from several perspectives. They know that the patients being referred have been through a comprehensive rehabilitation program that maximizes the acquisition of community living skills. They also know that the patients have been stabilized on a medication regimen that best addresses their psychotic and affective symptoms while minimizing troubling side effects. The housing agency gets "credit" toward their requirement for taking state hospital patients when they take a Second Chance patient. The agencies work closely with Second Chance to have someone readmitted to the hospital for stabilization if that should be required. This provides a supportive safety net for the housing agencies when working individuals with such challenging difficulties.

Establishing these partnerships between the inpatient setting and the housing providers has clearly been beneficial to the consumers of these services. On occasion a clinician from Second Chance has been asked to consult with a particular residence to strategize together on how to use some of the behavioral interventions at the residence as they attempt to address troublesome behaviors effectively. Unfortunately, limited resources of time and personnel do not allow for this potentially very useful service to occur often. It would greatly benefit the consumers if there could be even greater coordination of the treatments being used across treatment settings, from inpatient, to residential and day treatment programs. It remains a curious phenomenon that while some of the best

see Second Chance on page 16

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MENTAL HEALTH NEWSDESK

NKI Center for Dementia Research Awarded $9.1 Million To Examine The Root Causes of Alzheimer's Disease

Staff Writer
Mental Health News

The National Institute on Aging (NIA) of the National Institutes of Health (NIH) recently announced the award of a $9.1 million program project grant to Ralph Nixon, PhD, MD, director of the Center for Dementia Research at the Nathan Kline Institute for Psychiatric Research (NKI) in Orangeburg, New York.

The grant will allow Dr. Nixon and his team to continue their pioneering work analyzing brain cells of individuals at the earliest stages of Alzheimer's disease---even before memory problems surface---to identify the biological factors that trigger plaque-like aggregates of a peptide called amyloid-beta (Aβ) and other pathology associated with memory impairment.

Ralph Nixon, PhD, MD

Many scientists believe that Alzheimer's disease may be caused by over-accumulation of Aβ, a toxic form of protein that is normally present in healthy cells. Unfortunately, the factors underlying the abnormal rises in brain Aβ levels have long remained a mystery. Prior work by Dr. Nixon's laboratory identified abnormalities of small vesicular components of the cell, called endosomes, which are one of the first telltale signs of the disease. They found that these endosomes are potent Aβ factories, which become overactivated in Alzheimer's disease. In addition, endosomes perform many roles that are crucial for brain cell survival and for communication between brain cells during memory formation. Impairment of these endosomes in Alzheimer's, therefore, has further consequences in promoting symptoms of the disease that are currently being explored.

The NIA grant program is designed to support broad-based, multidisciplinary, long-term research. The program involves a large team of investigators at NKI (Efrat Levy, PhD, Stephen D. Ginsberg, PhD, Paul M. Mathews, MD, PhD) and collaborators at McLean Hospital (Ann M. Cataldo, PhD) in Boston and Albert Einstein College of Medicine (Ana Maria Cuervo, MD, PhD) in the Bronx.

With the new award, Dr. Nixon and his team will develop and characterize new laboratory models to complement human tissue studies on Alzheimer's disease. Using sophisticated genomic and proteomic analytical techniques, they will be able to simultaneously examine thousands of genes and proteins at the level of even a single brain cell or a fraction of isolated brain endosomes to understand how they function or malfunction. They will also investigate how genetic, dietary and pharmacological factors affect the functions of the endosome system in brain cells and influence the development of the disease.

An estimated 4.5 million Americans suffer from Alzheimer's disease, according to the Alzheimer's Association. Increasing age is the greatest risk factor for the disease, which is estimated to affect one out of 10 individuals over the age of 65 and half of those over 85 years of age.

"This new avenue of research promises to increase our understanding of the root causes and risk factors for Alzheimer's disease and to improved therapies to prevent and forestall the devastating deterioration associated with the disorder," says Jerome Levine, M.D., interim director of NKI.

"The team led by Dr. Nixon has already made substantial progress toward a better understanding of Alzheimer's disease pathobiology, and we look forward to even further progress with this next cycle of grants," says Dr. Stephen Snyder, program director in the NIA Dementias of Aging Branch. "Beyond Alzheimer's disease, the group's work may also yield new insights into similar neurodegenerative diseases, especially the so-called proteinopathies, work that we hope will help to identify novel therapeutic targets."

Dr. Nixon is also a professor and vice-chair of the Department of Psychiatry and professor of cell biology at New York University School of Medicine. He has published nearly 200 scientific papers and is a member of the editorial board of numerous scientific journals. He is the recipient of numerous awards, including the MERIT Award and the Leadership and Excellence in Alzheimer Research (LEAD) Award from NIH, the Academic Career Leadership Award from the NIA, the Temple Foundation Discovery Award and the Zenith Award from the Alzheimer's Association, and the Focused Giving Research Award from Johnson and Johnson Corporation. □

American Medical Association Students See Need for Mental Health Education

Albert Einstein Medical School Students Gather Support at National AMA Conference

By NAMI
Queens/Nassau, New York

Erin Callahan, a second year medical student at Albert Einstein Medical College, in Bronx, N.Y., a NAMI Queens/Nassau (National Alliance for the Mentally Ill) volunteer, presented a resolution titled, "An Initiative to Encourage Mental Health Education in Public Schools" to the medical student's section of the national American Medical Association (AMA) conference which was held this past June. Initially written by medical students Erin Callahan, Robyn Gartner and Katherine Scott, it was approved by the Albert Einstein Medical College division of the AMA student section last fall. The resolution was amended to include SUNY Buffalo medical student, Lauren Scott's resolution titled, "Reducing Stigma and Increasing Detection of Mental Illness." The amended resolution that passed as policy reads, "Resolved, that our AMA work with mental health organizations to encourage patients to discuss mental health concerns with their physicians; and be it further Resolved, that our AMA work with the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for elementary through high school students."

The resolution will be forwarded to the AMA at its 2006 annual meeting and presented to the House of Delegates of the Physicians Section. If adopted as policy, specific funding and lobbyist resources may be designated to promote the adoption of mental health education programs in public schools nationwide.

"Growing up, one of my best friends suffered from bipolar disorder. I watched as her illness caused her to live in shame and secrecy. Knowing *she* was not her illness and feeling frustrated by my inability to really help her, I vowed to play a part in combating the stigma associated with mental illness and finding a way to help others. This prompted my decision to become a psychiatrist where I came across a NAMI program called "Breaking the Silence" (BTS). BTS are user-friendly teaching modules for grades 4-12 designed to separate fact from fiction; combat the stigma of mental illness and promote early treatment.

Janet Susin
"Breaking The Silence"
NAMI
Queens/Nassau, New York

"We feel it is imperative that mental illness be taught alongside other important health topics. Just as students learn about cancer, diabetes and AIDS they need to know about diseases of the brain. The fact that these medical students took on the task of approaching the AMA to back mental illness education speaks volumes for the need for mental illness awareness among our young people," states Janet Susin, BTS Co-Author, Project Director & NAMI Queens/Nassau Co-President.

NAMI is a nationwide, grassroots, self help, support and advocacy organization of people with mental illness and their families and friends. For further information on this resolution, BTS and NAMI contact NAMI Queens/Nassau at 516 -326-0797, E-mail btslessonplans@aol.com or visit www.btslessonplans.org. □

MENTAL HEALTH NEWSDESK

New York State Office of Mental Health Implementing Medication Management Initiatives

By Sharon E. Carpinello, RN, PhD
Commissioner, New York State
Office of Mental Health

The New York State Office of Mental Health (OMH) is continuing to advance its transformation to a system of recovery-based care through a multi-year, multi-layered approach that improves outcomes for adults and children with psychiatric disabilities through the use of proven, effective treatments. OMH has been making marked progress in the area of medication management: the Pharmacy Service and Clinical Knowledge Enhancement System, or PSYCKES, is having a positive impact at State-operated psychiatric centers and on the individuals served by them; and building on the success of PSYCKES, OMH has also recently started to implement other new pharmacotherapy initiatives designed to improve outcomes for New Yorkers with mental illness.

Sharon E. Carpinello, RN, PhD

PSYCKES

PSYCKES is a state of the art, web-based tool designed to support the decision making and information needs of physicians. It improves the quality and safety of medication prescribing practices by incorporating evidence-based medicine into day to day practice. Implementation was completed within the past year and PSYCKES is now being used in all State-operated psychiatric facilities.

PSYCKES pulls together information from multiple sources, and gives clinicians real-time access to previously unavailable information about an individual's treatment history. It displays data on admissions and locations of service, length of service, diagnoses, types of medications received, adequacy of the doses prescribed, and duration and efficacy of medication trials. It also includes access to clinical guideline-based quality indicators, and fiscal indicators.

The program was initially developed as a way to improve clinician access to patient medical information and relevant clinical practice guidelines, but its use has improved care in other ways as well. PSYCKES has proven itself to be an effective clinical tool that supports recovery by helping individuals obtain and maintain functional levels that enable them to live successfully in community settings. For example, by displaying an individual's treatment history, PSYCKES allows for past use of medications to be examined, and provides information about medications that were effective in helping an individual, as well as about medications that were not helpful.

PSYCKES was developed by an innovative team of critical thinkers from Creedmoor Psychiatric Center and OMH's Central Office. The PSYCKES team received the 2004 Workforce Champions Award from the Governor's Office of Employee Relations, and PSYCKES was recently selected as a recipient of the Council of State Governments' prestigious 2005 Innovations Award, being cited as one of the best new and creative approaches to address an issue facing the State.

By improving clinician access to patient medical information and relevant clinical practice guidelines, we can increase quality of care, improve patient outcomes, and can better enable recovery from schizophrenia and other psychiatric disabilities. PSYCKES builds on previous clinical algorithms by providing clinicians with an individual's treatment history, dosing and outcomes in one integrated decision support tool. To the best of our knowledge, it is the first example of an integrated, guideline-driven, clinical and fiscal decision support system for psychiatry.

Reducing the Use of Polypharmacy

Another new initiative will simplify dosing requirements, and go far to improve outcomes and quality of life for individuals with serious mental illness. It is part of a national trend to support medication compliance by making it easier for people to adhere to and maintain their medication regimen.

The new initiative, "Rational Pharmacotherapy Quality Improvement" (RPQI), is examining current practice concerning use of multiple antipsychotic medications. There is insufficient evidence in the medical literature of any potential benefits of concurrent administration of three or more antipsychotic medications, to justify the

see Initiatives on page 16

New York State Passes Landmark Legislation Designed To Address The Mental Health Needs Of The Elderly

By Jane Linker

With the passage of The Geriatric Mental Health Act (A.4742/S.7672), New York State has taken a leadership position in addressing the need mental health needs of its elderly citizens. The Act, which passed both houses of the legislature last summer, is expected to be signed by Governor Pataki in the fall. It is the first legislation of its kind, according to mental health advocates.

The Act had strong bi-partisan support in both houses of the New York State Legislature. In the Senate, leadership was provided by Nicholas Spano, Senior Assistant Majority Leader, Thomas Morahan, Chair of the Mental Health Committee and Martin Golden, Chair of the Aging Committee. In the Assembly, Peter Rivera, Chair of the Mental Health Committee and Steven Engelbright, Chair of he Aging Committee took the leadership role

With the population of older adults with mental disorders in the United States expected to jump from 7 million to 14 million over the next twenty-five years, mental health advocates have been warning that existing services are woefully inadequate to meet the anticipated demand as the Baby Boom becomes the Elder Boom. Already, experts say, the elderly with mental illness are a severely underserved population. They point to statistics that estimate that of the 2-3 million American seniors with depression, only 20% are receiving treatment from mental health professionals.

The Geriatric Mental Health Act, which had the strong support of over 110 nonprofit advocacy and service organizations, outlines what New York State must begin to do in order to be ready to provide adequate mental health care for its growing elderly population. It provides for the development of innovative, model mental health programs for older adults that will enable them to remain in the community as they receive treatment and ongoing services. The Act also creates an inter-agency planning council that will ensure cohesive action among state agencies that work with seniors.

"The Act lays the groundwork for future programs and improvements for a segment of the population that has all too often been ignored and underserved," said Michael Friedman, chairman of the Geriatric Mental Health Alliance of New York, an advocacy group with over 750 individual and organizational members that was instrumental in initiating the legislation. "It will stimulate needed innovation and establish a planning process that will bring together key state agencies to develop integrated approaches of responding to the health and mental health needs of aging New Yorkers."

"It has long been said that those that fail to plan are planning to fail. The Geriatric Mental Health Act engages New York in a planning process that will help us begin to better prepare to address the growing mental health needs of our ever-growing elder population," said Assemblyman Peter M. Rivera, the Bill's lead sponsor in the Assembly.

"We know that untreated mental conditions can lead to disability, exacerbate symptoms of other illnesses, lead to premature death, and may result in suicide. In fact, the rate of suicide among elderly men is the highest of all age groups. This is vital legislation, and its passage means that we will be able to begin to meet the mental health challenges

see Legislation on page 16

Schizophrenia: A Day Treatment Perspective

By Matthew Romanelli, MD
Phelps Memorial Hospital Center
Behavioral Health Department
Continuing Day Treatment Program

A young woman named J.* was an outgoing teenager, an honors student in junior high school with a circle of good friends. She lived at home with her parents and sister, and her hobbies included sports and reading. Her family began to notice that J. was becoming more and more isolated, avoided spending time with her friends, and stopped participating in school activities like her soccer team, which she had once enjoyed. She was less attentive to her appearance, and her mother had to remind her repeatedly to shower and comb her hair. J's grades deteriorated and she was in danger of failing at least two of her classes. Her parents were concerned about possible drug use, but J. didn't appear to have access to illicit substances. She hardly left the house and didn't even receive phone calls at home. She appeared increasingly preoccupied, anxious and disorganized. One night, she became very agitated and struck a family member. She accused the family of trying to hurt her, her thoughts seemed disconnected from each other, and she reported hearing voices. Her family called 911.

J. was brought to a local emergency room where she was evaluated. Her blood tests were unremarkable, and a urine toxicology test indicated that drugs were not involved. She was started on medication while in the hospital, her symptoms improved, and she was discharged to outpatient mental health care. Over the next several years, J. was hospitalized on three other occasions, usually for hearing voices (auditory hallucinations) and becoming agitated. Often, symptoms returned because she tried to stop her medication. Ultimately, she was diagnosed with schizophrenia. She remained on medication, which was monitored in regularly scheduled outpatient visits. Although she did not complete high school due to her illness, J. was able to obtain her GED. She participated in a day treatment program, which she attended several days a week, and where she received education about her illness, attended therapy groups with people who had similar illnesses, and worked with a psychiatrist to adjust her medication. Having found an effective medication that she was able to tolerate, she attended a job training program, worked with an employment counselor, and began her first part-time job, using her day program to assist her in adjusting to the stresses and challenges of employment.


Matthew Romanelli, MD

Schizophrenia likely represents a group of brain disorders that may leave varying amounts of residual impairment. Symptoms typically begin before age 25, and occur in about 1% of the population. (This appears to be true across cultures.) Symptoms include disorders of thinking, such as false beliefs (delusions), hearing voices or seeing things (auditory or visual hallucinations), thought disorganization, changes in muscle tone or movement (catatonia) or loss of normal nonverbal behaviors (such as loss of facial expressiveness or tone of voice.) Often, there is a decline or change in behavior prior to the onset of clear symptoms, called a prodromal phase, which may include withdrawal from social, personal or occupational functioning; anxiety; physical complaints; and unusual behavior, speech or ideas. Persons with schizophrenia frequently have difficulty attaining their potential in interpersonal relationships, occupation and other areas of achievement due to their illness.

Although the exact cause of schizophrenia is unknown, there is evidence for both genetic and environmental risk factors. Individuals with relatives who have schizophrenia are more likely to have the disease themselves. The closer an affected relative is, the higher the risk. The identical twin of a person with schizophrenia carries the highest risk (even if the twins are raised separately by adoptive parents), but that risk is still well under 100%. (An identical twin of a person with schizophrenia is more than five times as likely to have the disease as a non-identical twin.) Environmental factors also may increase the risk of developing schizophrenia. More people with schizophrenia are born in winter months. Minor neurological deficits may include alterations of some reflexes, changes in rapid eye movements and blinking, impaired perception of emotion (such as interpreting facial expression and tone of voice), impaired left-right discrimination, and inability to carry out certain tasks (apraxias).

Schizophrenia takes an enormous toll on individuals and their families. The onset of illness, commonly in early adulthood, can effectively delay or block important developmental milestones. Individuals may have difficulty building adult relationships or meeting academic or occupational goals. Patients of all ages may experience a profound sense of loss with the realization that peers have progressed while their own achievement is slowed or stalled. Depression is a common co-occurring disorder and also requires treatment. Families experience emotional (and often financial) stress in attempting to assist an affected family member, and all are impacted by the social stigmatization that frequently accompanies mental illness. Individuals or families may themselves hold stigmatizing attitudes (e.g., that mental illness is a character defect or personal weakness rather than a medical illness.) Such attitudes may prevent earlier recognition and appropriate treatment, discourage continuation of successful treatment, and limit valuable social support.

Schizophrenia for most individuals is a chronic illness: about two thirds with a good medication response for three to five years relapse off medication within a year and a half. Medication is only part of the treatment picture. Individuals benefit from understanding their illness and the risks and benefits of medication, finding support from others with similar symptoms, learning to recognize skill deficits, and working in a structured way to improve their overall functioning. Psychosocial treatments, therefore, have a proven role along with effective medication in managing the symptoms of schizophrenia.

Day treatment is an intermediate level of care that lies between more intensive inpatient (overnight hospitalized) care level, which tends to be short term (weeks); and less intensive outpatient clinic care, which may be weekly or monthly for clients who are able to effectively manage symptoms with less oversight. In day treatment, clients typically attend a structured program several days a week but continue to live in their homes. (Many clients with chronic illnesses such as schizophrenia benefit from the additional structure of a group home, adult home, or community residence.) The treatment in day treatment includes group therapy, education groups (such as coping skills, physical health management, assertiveness and self-esteem), individual counseling, and medication management.

Clients benefit from spending time with others with the same illness, and build competence and self-esteem by learning from good examples as well as serving as role models for others. The sense of community that is built among clients reduces stigmatization and can assist in building a more positive personal and social identity. Patients often arrive at a very different understanding of their symptoms when they observe others struggling with similar difficulties. Some individual need assistance in learning basic social and interpersonal habits (such as appropriate eye contact, speech and body language), and day treatment provides a safe environment to practice and perfect these communication skills. The day treatment environment can act as a microcosm for the larger world outside of treatment, as clients address issues including stigmatization, anger, and jealousy, as well as positive experiences such as developing friendships, working as a team, and contributing as a recognized member of a community. (Community meetings are a standard feature of day treatment as well as other outpatient and inpatient settings.) Clients utilize the support offered within the program to develop and meet their potential. Many clients in day treatment participate additionally in outside services including case management, self-help groups, vocational counseling and volunteer jobs. Clients who successfully move toward their goals inspire staff and other clients alike.

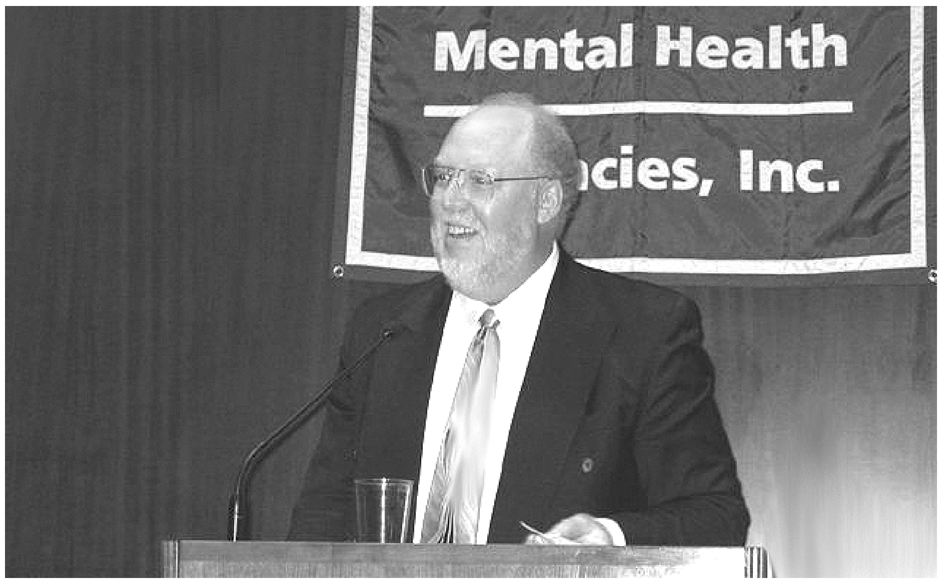
It's been my privilege to work in the Continuing Day Treatment Program for the last two and a half years, part of the Phelps Memorial Hospital Center's continuum of care. For further information about our program, please contact Toby Greene, ACSW, at 914-923-5700. □

Mental Health News Founder Receives Media Award

Staff Writer
Mental Health News

This June, Mental Health News Founder and Publisher, Ira H. Minot, was presented with The 2005 Media Award given by The Coalition of Voluntary Mental Health Agencies, Inc. The Coalition which was founded in 1972 is the umbrella advocacy organization of New York's mental health community, representing over 100 non-profit community based mental health agencies that serve more than 300,000 clients in the five boroughs of New York City and its environs.

Presenting the award to Mr. Minot were Phillip A. Saperia, Executive Director of The Coalition, Dr. Peter C. Campanelli, President and CEO of The Institute for Community Living and current President of The Coalition Board of Directors, and Dr. Alan B. Siskind, Executive Vice President and CEO of The Jewish Board of Family and Children's Services, Past President of The Coalition Board of Directors and current Chairman of the Board of Mental Health News .



Mental Health News Founder and Publisher Ira H. Minot Receives The Coalition of Voluntary Mental Health Agencies 2005 Media Award

The following, are Dr. Siskind's remarks in making the presentation which tell of Mr. Minot's heroic struggle that led him to start *Mental Health News*:

According to James McGregor Burns, "great leadership arises out of great conflict". Surely, Ira, you embody the resilience of the human spirit. You have passed through the difficulty and pain of mental illness and not only recovered your own life, but you have realized a vision that would help others learn from your experiences and help them focus on the silver linings in their own dark clouds.

You were an early mental health worker, directing your energies to fundraising and public relations for health and human service organizations. You were always involved in a career of helping others. But debilitating depression that did not respond to medication stopped you in your career and family tracks.

But persistence and strength on your part and the diligence of your caregivers helped to lift the dark cloud that had settled on you. Today you are energetically publishing *Mental Health News*, looking for new entrepreneurial horizons and raising money to take your message to as wide an audience as possible.

As you have said so simply, yet eloquently; "When I was out there struggling to overcome my illness, I had three

see Media Award on page 18

Spitzer Receives APA Award

Staff Writer
Mental Health News

On June 15, 2005, Dr. Barry B. Perlman, Director of Psychiatry at Saint Joseph's Medical Center and President of the New York State Psychiatric Association, presented the Jacob K. Javits Public Service Award to New York State Attorney General Eliot Spitzer. Dr. Perlman cited Attorney General Spitzer's action against GlaxoSmithKline and others for concealing data relevant to prescribing antidepressants for children. This action will help ensure that pharmaceutical companies are more open with their clinical findings. "Once fully realized, this movement towards transparency, we believe, will greatly improve the care provided by psychiatrists and other physicians for their patients," said Dr. Perlman.

The Jacob K. Javits Public Service Award was established by the American Psychiatric Association ("APA") in 1986 to honor the legacy of a U.S. Senator from New York, Jacob K. Javits. Senator Javits served as Senator for 24 years and spearheaded many reforms that advanced the care of the mentally ill and those who battle substance abuse issues. These issues have been advanced by numerous other Public Service Award recipients including U.S. Senator Pete Domenici, Senator Paul Wellstone, State Senator Nicholas Spano, Senator Harry Reid, and Connecticut Attorney General Richard Blumenthal. It is the Committee on Government Relations of the APA that bestows the award.

Attorney General Spitzer and Barry B. Perlman, MD

As Director of the Department of Psychiatry at Saint Joseph's Medical Center since 1981, Dr. Perlman oversees a comprehensive program of mental health services, including inpatient and outpatient care, continuing day treatment, community support and substance abuse treatment.

The New York State Psychiatric Association is an organization representing 4,500 psychiatrists in New York State on professional issues, as well as advocacy on behalf of persons with mental illness. The NYSPA is the state affiliate of the American Psychiatric Association.

Saint Joseph's Medical Center, a full-service, 194-bed hospital, is located at 127 South Broadway in Yonkers. □

Platz New Residential Head

Staff Writer
Mental Health News

Joyce A. Platz, a member for 17 years of Senior Management at Hall-Brooke Behavioral Health Services, has been named to the organization's new position of Executive Director, Community Residential Services Division. Hall-Brooke is located at 47 Long Lots Road, Westport.

The Division includes the highly lauded Homestead Residential Program which provides permanent housing and supportive services to adults and single parent families with behavioral health disorders in 16 locations throughout Bridgeport, Norwalk, Fairfield and Westport. The US Department of Housing and Urban Development (HUD) and the Connecticut Department of Mental Health and Addiction Services funds the program.

Ms. Platz played a key role in the development, implementation and administration of Hall-Brooke's award winning residential programs for almost two decades. In her new role as Executive Director, Ms. Platz will oversee, develop and expand these programs, and will implement a recent $750,000 award from the Department of Housing and Urban Development (HUD) to develop 12 units of supportive housing. The grant also calls for development of collaborative relationships with other agencies for expansion of supportive housing opportunities in Fairfield County, and for expansion of Hall-Brooke's community residential programs through development of additional housing and supportive services for all age groups.

Joyce A. Platz

"I am excited about the opportunity to develop and expand our services to provide additional residential opportunities for adults, as well as for children and adolescents, and possibly to include community services ,such as educational and vocational programs," says Ms. Platz.

"Hall-Brooke's successful residential programs demonstrate that persons with behavioral health disorders can live independently in the community provided they have the necessary support. Our goal is to continue meeting the needs of communities we serve and to further our mission by expanding housing opportunities and supportive services for persons with behavioral health disorders,

see Platz on page 38

Trapped in A Fugue: Jimmy's Story

By Mindy Appel, ACSW, LCSW

He was the first-born male in a loving Jewish family. He came into the world destined for greatness and surrounded with love. He fulfilled every family prophecy and expectation throughout school, and became class valedictorian. He graduated with honors, scored a nearly perfect score on the SAT test, and was accepted by every college to which he applied, except Princeton. He never got over the fact that Princeton had turned him down. This first major rejection (as he saw it) started him on a downward spiral which would end, ultimately, with his death at age 40, alone, in a hotel room, absent friends, absent family, and beset with the psychiatric demons that had threatened him for years.

Jimmy was not accepting of failure or falling short. From an early age, his desire to be perfect led him to obsessive compulsive behaviors ranging from uncompromising perfectionism to obsession with washing his hands in a deliberate manner throughout the day. Always suspicious of family and friends, the predromal signs before psychotic episodes began to appear early in life. He was socially awkward from an early age, and exhibited unusual behaviors which further isolated him from his peers. But nothing in his upbringing could account for his descent into the abyss of schizophrenia. His sister was born when he was five, and they forged a partnership together as best friends and mutual protectors, which nothing could sway. But in the final analysis, all of the love and encouragement of his mother, father, sister, and extended family could not compensate for the inner turmoil he faced daily.

As a young man, his bar mitzvah at age 13 placed him again in the family spotlight. Even at the tender age of 8, his sister saw his desperate need for approval and tried to take care of his emotional well-being as much as she could. He, in turn, became her defender and protector from what he perceived to be dangerous and over-bearing parents. Seeing her brother (whom she truly adored), go through the torment he frequently experienced, and shared only with her, she determined (while still in grade school) that she would devote her life to helping people who were struggling emotionally.

Jimmy's family, throughout these years of inner struggle, was in complete denial as to the reality of the situation and the depth of Jimmy's needs. They felt responsible for his psychosis, and as they were unable to accept that responsibility, it became easier and easier to deny its existence or to accept that a son of theirs could be mentally ill. Living day to day consumed them, and dwelling on things they could not "fix" was counterproductive and even destructive to their son's emerging psyche. So life went on, with each day resulting in more being swept under the family rug. Meanwhile, Jimmy was exhibiting more and more symptoms: disorganized speech and behavior, decompensation, regression, and psychosis. His lack of trust made friendships difficult due to his inability to attach to others.

Jimmy left for college, and once he arrived there, he found himself among 2500 other valedictorians from across the country. He discovered, to his chagrin, that his innate intelligence was not adequate for the cut-throat academic competition at that level. He was a loner, and preferred his own company to social gatherings in which he never participated. Lonely and alone, and experiencing less than A's for the first time, he plodded through college doggedly, barely keeping his head above water. He was consistent in denying that his increasingly isolative and antisocial behavior and periods of losing contact with reality were symptomatic of deeper problems. His trips home reflected his altered state of reality and he affirmed again and again that everything was fine, and that he was happy making grades at the top of his class. Part of Jimmy's illness during college was an extreme level of narcissism and grandiosity which led to cocky and arrogant behavior. The incongruence of his life versus his perception of that life was drawing him further and further away from reality.

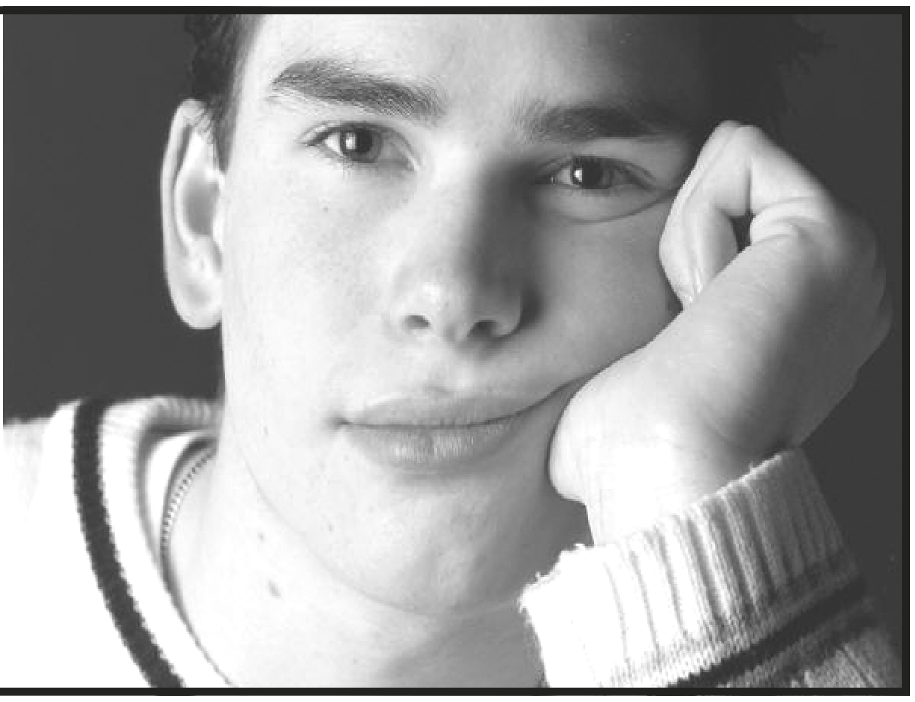
When the truth finally surfaced and he was about to flunk out of college, he was sent to the local Mental Heath Center and it was suggested that he take some time off from school and graduate a semester late. Entering into psychiatric care at that time resulted in the first confirmation by Jimmy and by his family that perhaps his problems were more serious than time, love and support could correct. His first treatment with anti-psychotic medications (Haldol, Prolixin, and Cogentin) began at that time. Jimmy was inconsistent in the administration of these medications because he disliked the detached emotional feelings and felt that he was not living life to its fullest in the zombie-like, drug-induced calm. His conscious decision to eschew medical advice and deal with his psychosis head on would eventually spell disaster.

Upon graduating from college, Jimmy applied to a number of law schools, and was accepted at only one which was located in the mid-west. He moved out to Iowa, and although he made frequent phone calls and sent many letters back home as to his outstanding progress there (he reported all A's, and an invitation to the Dean's house to be honored, etc.,) his ruse was uncovered when the school sent his grades home and he had all D's and F's. Shortly thereafter, his mental state deteriorated and he arrived home one day with only the clothes on his back, no food, no money, and in a disoriented state of mind. Realizing that the situation was critical, he was hospitalized (one of many times) and released shortly after with the recommendation for medication management and follow-up therapy.

As the years passed, Jimmy never held a meaningful job commensurate with his intelligence and became more and more a social anomaly. His beloved sister followed in his footsteps to another college in upstate New York, from which she graduated about the time he was returning home from Iowa. She continued her education in graduate school in New Orleans, and established residency there, earning a masters degree in social work and becoming a board certified social worker. She worked in both private practice and at a series of hospitals, and was on the job on July 24, 1992, when the call came in from home that Jimmy was dead.

She rushed home to New York to comfort her grieving parents, and tried to make some sense of what had happened. The coroner's report indicated that Jimmy had died of asphyxiation. There was no indication of foul play. A bright light was extinguished on that summer day almost 15 years ago, and all of those left behind are filled with questions and no answers. A man of infinite promise became trapped in a disturbed state of schizophrenia.

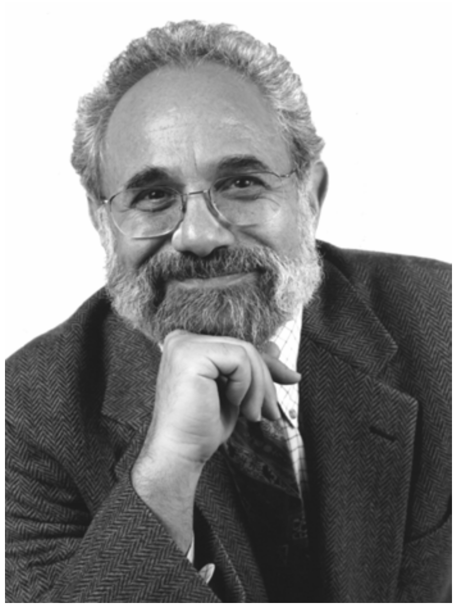
The story of Jimmy's journey is told in order to help someone else who might recognize themselves or a family member in this description. In this way, Jimmy will always live on to help others even though he could not help himself. His mother felt a tremendous sense of guilt because she thought she had done something wrong and was not a good enough parent. It is essential that there be more parent and family education concerning treatment and medications available in such cases. Only in destigmatizing those with mental illness can we hope to get them the treatment they need and cut down on the denial and ignorance of the true nature of mental illness. Jimmy's life was a testament to the need for that process – may his legacy be in increasing the awareness of others in similar situations before it is too late. □



POINT OF VIEW

Baby Boomers With Schizophrenia And Other Long-term Psychiatric Disbilities: Prepare Now

By Michael B. Friedman, LMSW



Michael B. Friedman

William, who just turned 75, has suffered from schizophrenia since his early 20s. He was a patient in a state hospital for many years. During deinstitutionalization, he moved to a single room occupancy hotel (SRO) and would have become homeless when SROs were converted to luxury housing if his parents had not been able to take him in. When they died ten years ago, he was fortunate enough to get a supported housing unit with a visiting case manager. As he has aged, he has become increasingly obese. Now he has diabetes, arthritis, and the beginnings of dementia. Living independently and participating in a day program have both become difficult for him. His case manager has been unable to arrange good medical care or to find housing with more supports in the community. He has begun to consider referring him to an adult home or a nursing home.

As the population of the United States ages over the next 25 years, so will the population of people with schizophrenia and other serious, long-term psychiatric disabilities. Unfortunately, the mental health system is not adequately prepared to serve these older adults; and, as a result, many will end up losing their independence and being shifted from mental health services in the community to adult homes and nursing homes that will not provide adequate care for them.

The recent passage of the Geriatric Mental Health Act provides a great opportunity for New York State to develop interagency plans and innovative program models that will meet the needs of people with severe psychiatric disabilities as they age.

As part of this undertaking, the mental health system—working collaboratively with the health and aging systems—must confront several key challenges.

> *Loss of family caregivers:* Over time, more and more parents of adults with serious mental illness will become disabled and die. The mental health system is not adequately prepared to take over the care giving roles that parents have played.

> *Problems with Physical Health:* As people with long-term psychiatric disabilities age, new needs emerge—especially needs that have to do with physical health problems. They are prone to obesity, hypertension, diabetes, heart disease, and pulmonary disorders. And people with long-term psychiatric disabilities are no less likely than other older adults to develop dementia. This limits their ability to manage activities of daily living.

> *Low Life Expectancy:* People with long-term psychiatric disabilities live approximately 10 years less than the general population. This appears to be the result of poor health exacerbated by inadequate health care as well as high suicide and accident rates.

> *Developmental Changes:* People with long-term psychiatric disabilities experience important developmental changes. Like all older people, their expectations of themselves change, they experience saddening losses of friends and family, and they must come to terms with their own mortality.

To meet these challenges, New York State needs an innovative system of care to:

1. *Focus on life expectancy:* Helping people with long-term psychiatric disabilities to live long enough to become elderly and to remain healthy as they age should become a key goal of the mental health system.

2. *Integrate health and mental health:* People with long-term psychiatric disabilities would have improved access to quality health care and enjoy improved health, if health and mental health care were integrated. This includes linking primary health care and mental health services, developing home health services designed for people who have both physical and mental health problems, and helping people with long-term psychiatric disabilities die with dignity, close to those they care about.

3. *Expand and redesign housing services:* A large percentage of adults with serious mental illnesses live with their families. When their families can no longer provide care, they will need alternative housing, preferably in the community.

And housing for older adults with psychiatric disabilities needs to be constructed with an eye to the physical problems that are increasingly common with age. For example, housing will need to be accessible to people with physical disabilities and designed to prevent injuries from household accidents—particularly falls. In addition housing-related support staff will need to be better prepared to handle co-occurring mental and physical disorders and to manage multiple medications.

4. *Adapt the Community Support Program:* Since the early failures of deinstitutionalization, the mental health system has been devising supports to help people to remain in the community including case management, rehabilitation, assertive community treatment, family support, peer advocacy, etc. All of these services have been designed with middle-aged adults in mind. They will need some modification to meet the unique needs of older adults. For example, much of psychiatric rehabilitation focuses on employment; many older adults will prefer “retirement.” And rehabilitation’s emphasis on access to the mainstream should probably be broadened to include linkages to senior centers and other services for older adults.

5. *Provide more mobile treatment:* Currently the mental health system is largely designed on the assumption that people with mental illnesses can go to clinics, day treatment programs, or private practitioners’ offices for treatment. But as people age, going to treatment settings becomes increasingly difficult. Providers often need to go to consumers in the home, rather than waiting for them to come to the office.

6. *Improve care in institutional settings:* With higher quality, more mobile, and more integrated mental health and health services, it should be possible to help more and more older adults with serious mental illnesses to live in the community. But there will undoubtedly continue to be a need for congregate care facilities. We know, however, that the quality of care in adult homes and nursing homes is generally inadequate for people with serious mental illnesses. Improvements in institutional care are critical.

7. *Enhance family support:* For those families who survive and remain healthy long enough to continue to care for family members with long-term psychiatric disabilities, family support will become increasingly important. As well as respite and access to support in times of crisis, this undoubtedly should include the adaptation of psycho-educational approaches that currently are designed for families with young and middle-aged adults so that they can be used with families with older adults with psychiatric disabilities.

It is particularly important to reach out to families who have cared for family members with psychiatric disabilities virtually without help from the mental health system. These families tend to be poorly informed about mental illness, treatment and rehabilitation, and where to go for services. Outreach to senior centers, settlement houses, and social service programs in naturally occurring retirement communities (NORCs) should be organized so as to engage this hidden population.

We should also develop appropriate supports for people with psychiatric disabilities who try to take care of their parents when they become disabled. With support and education, some of them can probably play this role effectively.

8. *Provide public education:* Older adults with psychiatric disabilities are affected by two stigmas—the negative perception of people with mental illnesses and ageism, the perception that aging results in a hopeless decline that makes recovery meaningless. Public education is needed to counter these inaccurate stereotypes.

9. *Develop an adequate workforce:* There is a vast shortage of people with the clinical and cultural competence to serve older adults with long-term psychiatric disabilities. This includes psychiatrists and other mental health professionals. It also includes physicians, nurses, and home health workers. To address this shortage we need more training, better education in professional schools, and incentives to entice people to enter professions serving older adults with mental illnesses.

It is also important to develop new roles using paraprofessionals and volunteers—especially peers. Peer advocates, bridgers, etc. play important roles in the community mental health system. With

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The NARSAD Report

The National Alliance for Research on Schizophrenia and Depression

Schizophrenia Research: NARSAD Supports the Search for Risk Factors & New Treatments

By Constance E. Lieber, President NARSAD

Constance E. Lieber

Prevention and treatment. The approach medical science takes to illness centers on these two fundamental principles – preventing susceptible individuals from becoming ill, and providing the most effective treatments with the fewest side-effects for those who are sick. Schizophrenia, among the most devastating of brain and behavior disorders, often strikes adolescents and young adults. Research scientists funded by NARSAD are studying the problem of schizophrenia from the perspectives of prevention and treatment. Scientists are seeking to better understand early risk factors for the disorder and find clues in the brain that may indicate susceptibility to it. Many researchers are studying possible new treatments for schizophrenia and novel drug therapies. The dedicated efforts of these scientists continue to advance our understanding of the human brain and lay the groundwork for breakthroughs to come.

Identifying Early Risk Factors

Understanding Childhood Brain Abnormalities

Identifying brain abnormalities in children who are at high risk for schizophrenia may offer one of the best ways to develop targeted, early intervention programs. Kristin R. Laurens, Ph.D., Institute of Psychiatry, Kings College London (NARSAD 2005 Young Investigator) is conducting a study aimed at advancing knowledge in this area. She plans to study the brain structure and function of 11 year-old children who are at an increased risk for developing schizophrenia by virtue of a family history of the disorder. Previous research suggests that many children who go on to develop schizophrenia are anxious and socially withdrawn, and may also show evidence of cognitive impairments, developmental delays, and abnormalities in motor and language function. Other children who later develop schizophrenia have conduct and behavioral problems that persist into adulthood.

Dr. Laurens' team will use magnetic resonance imaging (MRI) techniques to study both the structure of the children's brains and their brain function – how the children use their brains while performing tasks involving memory and motor control. The study will compare the brain structure and function of those children who are primarily socially withdrawn and anxious, with those who have conduct disorder. Significantly, the study will also examine whether children's brain function is related to genes that have been implicated in schizophrenia. The findings of the study will contribute to understanding how and why schizophrenia develops, and will inform the design of specialized treatment programs aimed at preventing schizophrenia in high-risk children.

Genetics: A family study of the genes associated with psychosis

Elvira Bramon, M.D., Institute of Psychiatry, King's College London (NARSAD 2005 Young Investigator), is leading a study aimed at better understanding genetic susceptibility to psychosis. Prior research has shown that psychotic disorders – such as schizophrenia and bipolar illness – run in families and are strongly influenced by genetic factors. However, only recently have the first susceptibility genes (Neuregulin and Dysbindin) been identified. There is no single gene for psychosis. Rather, there are a number of genes that have been implicated, each one of which adds to an individual's vulnerability to developing psychosis.

Dr. Bramon's team has set out to study families with members who suffer from schizophrenia, bipolar disorder and other forms of psychosis. Three-hundred individuals in seventy families – one third of them affected by psychosis – volunteered to participate. They donated DNA samples and underwent an assessment of brain function. By testing brain function and measuring symptoms and diagnosis, the team hopes to clarify how Neuregulin and Dysbindin impact on psychosis. Dr. Bramon also hopes to help identify some of the other elusive genes that confer risk for psychosis. Recognizing new susceptibility genes for psychosis may help to more rapidly advance the understanding and treatment of psychotic disorders.

Prenatal Risk Factors

A research team led by Alan S. Brown, M.D., New York State Psychiatric Institute (NARSAD 2004 Independent Investigator) is studying prenatal risk factors for schizophrenia. Other research suggests that schizophrenia may be partly caused by a disturbance of brain development, and that environmental factors may foster this abnormality. Specifically, Dr. Brown's team is studying the schizophrenia risks that prenatal stress and vitamin A deficiency may pose to a developing fetus. Dr. Brown will utilize a unique resource for the study – blood samples that have been in storage for decades. From 1959 through 1967 a group of pregnant women participated in a study, and the prenatal blood samples taken from them have been frozen since that time. Dr. Brown has conducted previous follow-up schizophrenia studies of the children that resulted from these pregnancies, and is now looking to identify additional, specific pre-natal risk factors. The findings from his work could help point the way toward schizophrenia prevention, and help us better understand the biological events that contribute to the development of the illness.

Understanding Susceptibility

Substance Use in Schizophrenia Patients

With schizophrenia patients twice as likely as healthy individuals to smoke marijuana, Lynn L. Johnson, Pharm.D., University of Colorado Health Sciences Center, (NARSAD 2005 Young Investigator) seeks to better understand the reasons that make marijuana use so attractive to this population. One reason often suggested is that many schizophrenia patients use marijuana in an effort to relieve some of the disorder's troubling symptoms. These may include auditory or visual hallucinations (hearing voices or seeing things that are not present), delusions, or the depression and anxiety that these symptoms bring on.

When healthy people are under the influence of marijuana they are less able to recall words, experience reduced reaction time, are distractible, and may be inappropriately uninhibited. However, marijuana (cannabis) may affect people with schizophrenia differently. Receptors for cannabis are concentrated in the brain, and maladjustment of this receptor system may be linked to schizophrenia's disordered thought patterns. Dr. Johnson's research is examining whether – for schizophrenia patients – symptoms, learning, memory, inhibition and distractibility are improved or made worse by heavy marijuana use.

Another NARSAD researcher investigating substance use is D. Darlene H. Brunzell, Ph.D., Connecticut Mental Health Center (NARSAD 2005 Young Investigator). Schizophrenia patients are up to three times as likely as the general population to smoke cigarettes. As with marijuana, many scientists believe the cigarette smoking is an attempt to "self-medicate," using nicotine to help relieve schizophrenia's symptoms. Dr. Brunzell believes that better understanding the brain's nicotine receptors may shed new light on an individual's susceptibility to the disorder.

New Treatment Directions Explored

Clinicians treating people with schizophrenia today have vastly better drugs and therapies at their disposal than those available a mere twenty-five years ago. Nevertheless, the search for improved approaches continues, with researchers experimenting with new drugs, and ways of combining older therapies with new ones. NARSAD investigators are among those leading the effort in exploring novel ways of treating schizophrenia.

Joseph Levine, M.D., Ben Gurion University (NARSAD 2004 Independent Investigator), is conducting a double-blind trial study of creatine as a possible new treatment for schizophrenia. Creatine plays a critical role in maintaining the stability of brain energy. Widely used for enhancing sports performance, creatine has been studied for treating neurological, neuromuscular and heart disease, with patients experiencing few side effects. Results from previous studies of people taking creatine orally for several weeks, show a significant increase in concentrations of the chemical across brain regions. Dr. Levine believes these findings suggest that creatine may be useful for modifying brain metabolism in people with various brain disorders – including schizophrenia and major depression. He and his team aim to help determine if creatine – which affects brain energy metabolism and may also enhance cognition – offers promise as a new therapeutic strategy for schizophrenia treatment.

For treatment-resistant schizophrenia patients, Pesach Lichtenberg, M.D.,

see NARSAD on page 15

NARSAD from page 14

Sarah Herzog Memorial Hospital (NARSAD 2005 Young Investigator) is researching possible uses of D-Serine. The search for more effective schizophrenia drugs has led researchers to examine the role of glutamine receptors in the brain. Glutamine is an amino acid considered to be a brain fuel. Glutamine has been used therapeutically for alcoholism, mild depression and to reduce the craving for sweets, and is important for metabolic functioning and muscle maintenance. Drugs which inhibit glutamine receptors, such as phencyclidine – commonly known as PCP or "angel dust" – cause schizophrenia-like symptoms. On the other hand, substances which stimulate these receptors, such as glycine or D-Serine, when added to newer antipsychotic drugs reduce the depression, cognitive, and other negative symptoms of schizophrenia. Dr. Lichtenberg's team will study whether D-Serine alone – rather than in combination with antipsychotic drugs – might benefit schizophrenia patients. His project will enhance understanding of the role of glutamine receptors in schizophrenia, and may lead the way toward innovative treatment strategies.

Conclusions

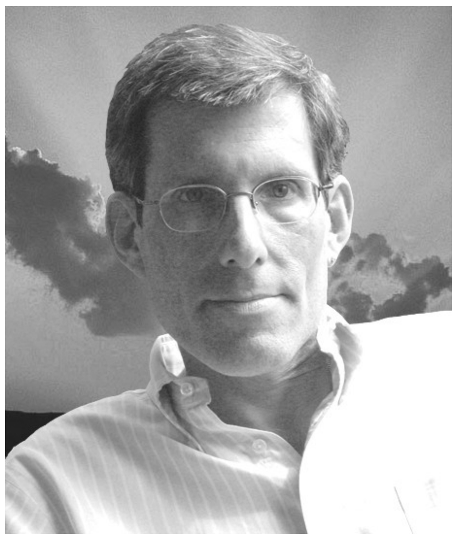
Schizophrenia is a uniquely challenging illness to understand and treat, given the complexities of the human brain. Over the past twenty-five years, research scientists have amassed vast new knowledge of the brain, which has led to significant, concrete improvements in treatments available for schizophrenia and other brain and behavior disorders. New understanding of schizophrenia risk factors and underlying susceptibilities may help make it possible to identify those individuals who are at risk for the illness, and prevent them from developing it. For those living with schizophrenia, new treatment approaches offer hope for fuller, more productive lives. □

NARSAD The Mental Health Research Association, is the largest donor-supported organization in the world devoted exclusively to supporting scientific research on brain and behavior disorders. Since 1987, NARSAD has awarded $180.3 million in research grants to 2,090 scientists at 336 leading universities, institutions and teaching hospitals in the United States and in 23 other countries. By raising and distributing funds for research on psychiatric brain disorders, the pace has accelerated resulting in greater knowledge of brain functioning, neurochemistry, new/improved treatments and genetic origins. Constance E. Lieber has served as President of NARSAD since 1989.

"A Voice of Sanity"
A Consumer Advocacy Column

Back to Being Disabled

By Joshua Koerner
Executive Director, CHOICE



Joshua Koerner

Until April of this year I was a Medicare beneficiary. Soon after becoming the director of a mental health agency I ceased to qualify for Medicaid or Section 8 or SSI, but the Social Security work incentives laws are such that despite a steady income and a work history going back to October 1996 I continued to qualify for Medicare until a few months ago.

I made full use of it. Medicare was my primary insurance. I also had company medical insurance, but rarely if ever did it pay for anything. This includes my psychiatrist, whom I have been seeing since 1999. When I began seeing him my psychiatrist also accepted my agency's health insurance plan; he was, as they say, "in network". But at some point in the last two years he became fed up with my company HMO: apparently they take a long time to pay, and they probably put doctors through all kinds of indignities. As the benefits administrator for my agency, I know they put me through plenty of indignities: always insisting that whatever I'm asking of them could be accomplished more easily and quickly by using their web site, although this is rarely the case, always insisting I've never filed documents I know I have. The only thing they always accomplish, without fail, is making me wait on hold.

The fact that my doctor no longer accepted my company's health insurance didn't affect me at all; he was still being paid by Medicare. I paid nothing. The idea that I was using Medicare didn't bother me; in fact, whenever I took Metro North, an average of once a week, I'd use my Medicare card to qualify for the disabled rate (the ticket is stamped with a "D"). Money is money, I thought, and as one of the "working disabled" there wasn't any sense in not taking advantage of the one benefit I had left.

My Medicare benefit finally ran out in April. If I wanted to continue receiving it, I would have to pay an out of pocket premium of roughly $300 a month. Wow, that's a bite, isn't it? I called Social Security to check it out; they said it was an obscure provision of the law of which most people did not take advantage: anyone who could afford it was working and covered under their company plan.

I liked the sound of that. This, finally, would be the complete and total end of my disabled status. I talked to my psychiatrist about it; when I was no longer on Medicare, he would be billing me his full rate of $175; insurance would pay half, and at four sessions a month that comes to $350, just a little more than the Medicare premium.

Of course, the reason private insurance only pays half is that the State if New York has never shown the political will to pass parity legislation. Whenever I speak at colleges and explain advocacy issues, I point out that Rosa Parks' refusal to ride in the back of the bus was the beginning of the modern civil rights movement, but at least Ms. Parks got to ride all the way to her destination; it wasn't as if they threw her out halfway there. But never mind: that's an injustice every working person seeking mental health treatment faces, and now I was going to be just another working person. I allowed the Medicare coverage to expire, and awaited my first bill.

It was a whopper. My psychiatrist is good at many things, but staying up to date on his billing isn't one them. My first bill was for thirteen sessions, totaling over two grand. I immediately called my health insurance company. I was going to be submitting my first claim -- me, the grown up -- non-disabled worker. That's when I got an even bigger shock. My company insurance does cover 50% --- *for network providers.* For out of network they pay 50% *to a maximum of $25* per session..

What?? Because my guy was out of network, they would only reimburse $25 a session. I nearly had a heart attack (for which I would have been covered 100%). The sickening irony was that several years ago I negotiated that HMO contract myself; no one else on the staff was seeing an out of network provider, and I had Medicare, so I thought, here's a way to save the company some money.

It was time to become disabled again, and quickly. I called Social Security; they sent me an "application for premium hospital insurance for the working disabled". It includes a ten page "report of continuing disability interview" that I was supposed to fill out. I hadn't seen one of these in years. Reading it made me queasy.

> ***"Recreational Activities and Hobbies (TV, radio, newspapers, books, fishing, bowling, musical instruments, etc.)" Fishing? Bowling? I guess that's what the government thinks disabled people do; we go bowling. We fish, because it doesn't stress us out too much.***

"In the areas below, describe your daily activities and state what and how much you do of each; how often you do it, and any assistance you require.

"PERSONAL MOBILITY (walking, moving about, exercising your legs, etc.)" Well, let's see: I've been doing a lot of pacing back and forth, trying to figure out how I'm going to pay my shrink bill. Does that count?

"PERSONAL NEEDS (dressing, bathing, etc)." I take a shower every day. I don't shave on the weekends. OK, I don't always shower on the weekends, either.

"RECREATIONAL ACTIVITES AND HOBBIES (TV, radio, newspapers, books, fishing, bowling, musical instruments, etc.)" Fishing? Bowling? I guess that's what the government thinks disabled people do; we go bowling. We fish, because it doesn't stress us out too much.

The thought of having to describe my daily activities to some faceless Social Security bureaucrat made me ill. But there was more: "I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of all my medical records, also education records and other information related to my ability to perform tasks". I thought, this is why people don't file for SSI benefits. It's gross. It's sickening. You have to answer all these questions and let them poke around in your life and justify why you think you're disabled.

But I can't afford $150 an hour. That's insane. I wanted to talk to my psychiatrist about it, but I couldn't afford to.

CHOICE of New Rochelle, New York, is a nonprofit consumer advocacy organization dedicated to helping people with mental illness. You may reach Mr. Koerner at (914) 576-0173. □

Initiatives from page 9

routine prescription of such a regimen. Therefore, OMH recently implemented a policy at all State-operated psychiatric centers which states that if a treating psychiatrist determines that a third antipsychotic medication is necessary for an individual, prior approval must be obtained from both the facility Clinical Director and OMH Chief Medical Officer. Facilities were also asked to develop plans for review and monitoring of multiple antipsychotic use.

Not only will this new policy possibly reduce problems with side effects or drug-drug interactions, it will make people's medication regimens practical in terms of everyday life and after discharge, make it easier for them to follow their physician's prescribed recommendations. Living with schizophrenia or another serious mental illness in itself presents numerous challenges, and it makes sense that clinicians make every effort to minimize those challenges by simplifying an individual's life in terms of medication and dosing regimens. □

Second Chance from page 6

evidence on treatment effectiveness involves rehabilitative treatment of seriously mentally ill persons; these interventions are rarely used outside of academic medical centers. Creating a system wherein evidence-based interventions are used across the continuum of care for individuals with disabling psychiatric conditions would have major public health and financial benefits, including lowered relapse rates. It is, therefore, an extremely important next step to dedicate monies to the training and supervision of staff at both the housing provider and day treatment settings to provide a more seamless continuum of care. The Second Chance Program is an important first step in returning long-stay hospital patients to the community, but much work still needs to be done.

For further information, please contact Andrew Bloch, MSW, Program Coordinator at 914-997-5738 or abloch@nyp.org. □

Legislation from page 9

of the elder boom," summed up State Senator Thomas P. Morahan, a leading proponent of the Act, pointing out that his district has an elderly population that has doubled in the past thirty years.

"I am proud to support this important legislation. Older adults with mental illness are a diverse population who are seriously underserved within the mental health system of the state and as the population grows older, so will the need for comprehensive geriatric mental health services," said Assemblyman Steven Engelbright. □

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The NYSPA Report

Medicare's New Prescription Drug Benefit Heads Toward Reality

By Nick M. Meyers, Director
Department of Government Relations
American Psychiatric Association

Effective January 1, 2006, Medicare will undergo the single most significant change since the program was established in the 1960s when it offers new prescription drug coverage to 42 million elderly and disabled Americans. The new benefit is available to those people who have Medicare Part A and/or Part B, as well as "dual eligibles," those who qualify for both Medicare and Medicaid. Part D, as the drug benefit will be known, offers promise to help defray the increasing cost of drugs. Those with limited incomes will pay little, in some cases none, of the cost. Others will pay more, but the Medicare drug benefit may still be a good bargain. If you already have drug coverage, you may wish to keep it, but you should carefully compare what you are paying now against what you are likely to pay if you take Medicare Part D instead, and you should be aware that if you do not enroll in Part D by May, 2006, you may face added financial costs.

As with any new program of this magnitude, implementation is daunting and is likely to be confusing. Although the law covers all drugs and injectables (with limited exceptions), plans are required to offer at least two drugs in each therapeutic class or category. Physicians and patients can ask for a non-preferred drug to be covered, and there is an appeals process if beneficiaries are turned down. APA, our members – particularly including the members of the New York Psychiatric Association -- and our allies such as NAMI and NMHA, have expressed particular concern about the need for patients to have access to the full range of psychiatric medications available today. By law, Part D does not cover some anti-anxiety drugs used safely and effectively. We are working to fix this in Congress.

Nick M. Meyers

What can you do to be prepared for Part D? Here are a few suggestions:

- *Pay attention to your mail and the calendar.* Advance notices to dual eligibles that they are eligible for subsidies – and will pay little for covered drugs -- if they enroll in Part D are well underway. About 20 million beneficiaries will receive information about applying for a subsidy by the end of August. In October, Medicare will notify dual-eligibles that they need to enroll in Medicare Part D and should do so before the open enrollment date of November 15 or else they will be auto-enrolled, but can switch plans on or after January 2006. Open enrollment for everyone else commences November 15, 2005 and continues through May 2006. You will receive additional information in the fall.

- *Be aware that you may be eligible for subsidies that reduce your costs.* If you are a low-income beneficiary (and not a dual-eligible) you may be eligible for subsidies. For example, if your income is not more than $12,920 ($17,321/couple) AND your resources are below $6,000 ($9,000/couple) you will be eligible for subsidies that will mean you pay no monthly premium and between $3 and $5 for drugs. Other beneficiaries with incomes of up to 150 percent of the federal poverty level will also receive subsidies on a sliding scale. If you need help now, APA and other groups have joined forces to set up the Partnership for Prescription Assistance to help eligible individuals with their medication needs. Call toll-free 1-888-477-2669 for help.

- *Know where to go for information and help.* For official information, go to http://www.medicare.gov, also 1-800-633-4227. Many other organizations offer helpful information. Among the best are: NAMI, http://www.nami.org; and, NMHA, http://nmha.org. For general clearinghouse information, try the Medicare Rx Education Network, http://MedicareRxEducation.org.

It's prudent to expect rough spots as the Part D benefit gets up and running. Don't be afraid to ask for help, and above all else, don't ignore mail from Medicare. ☐

The NAMI-NYS Corner

Providing support to families and friends of individuals with mental illness and working to improve the quality of life for individuals with mental illness.

Helpline: 800-950-3228 (NY Only) • www.naminys.org • Families Helping Families

Research: Our Hope For The Future

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

J. David Seay, JD

Schizophrenia is the topic featured in this issue of *Mental Health News*, and I am pleased to be able to contribute something to it. Schizophrenia is one of the more onerous and difficult of the diagnoses known as Serious and Persistent Mental Illness, or SPMI. Once thought to be a degenerative and incurable disease, schizophrenia is now seen in a different light. Early diagnosis and consistent and persistent treatment can now allow persons with the diagnosis to recover or at least stabilize in a way that allows them to lead satisfying and productive lives in their communities. No longer does schizophrenia need to be seen as a death sentence or a diagnosis with no help, relegating its victims to lives locked away in institutions like they once were.

Despite these strides in understanding the disease and in diagnosis and treatment, schizophrenia remains a devastating brain disorder that, according to NAMI National, affects approximately 2.2 Million American adults, or about 1.1 percent of the population 18 and older. Schizophrenia interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others. Most people with schizophrenia suffer chronically or episodically throughout their lives, and are often stigmatized by a lack of public understanding or misunderstanding ("split personality," for example) about the disease. The World Health Organization has identified schizophrenia as one of the ten most debilitating diseases affecting human beings worldwide.

Symptoms of schizophrenia range from delusions and hallucinations, known as *positive symptoms* for their overt presence, to emotional flatness and a lack of interest in life, known as *negative symptoms* for their lack of certain characteristics that should be there but are not. Schizophrenia can also significantly affect the cognitive abilities of individuals, from the ability to remember and accomplish tasks, to attention span and staying motivated to achieve goals.

While we still do not know the specific causes of schizophrenia – leading researchers believe that is caused by a combination of problems including genetic vulnerability and environmental factors – it is clear that this no-fault disorder is not caused by bad parenting or personal weakness. Recent research has identified the first genes that appear to increase risk for schizophrenia, but like cancer and diabetes, the genes only increase the chances of becoming ill, and do not cause the illness all by themselves.

While at present there is no cure for schizophrenia, it is a highly treatable and manageable illness, thanks to breakthroughs in medication and treatment research. Through a combination of medication, therapy, and psychosocial rehabilitation, individuals with schizophrenia can and do lead productive lives. However, people may stop treatment because of medication side effects, disorganized thinking, or because they feel the medication is no longer working. People with schizophrenia who stop taking prescribed medication are at a high risk of relapse into an acute psychotic episode, which can lead to self-endangerment, hospitalization, or run-ins with the law. This is exacerbated by another physical symptom of the disease known as *anosognosia*, or the lack of awareness of the illness. Persons with anosognosia literally do not know that they are sick, thus not understanding why others, such as their doctors and family, think they should seek treatment or therapy or take medications. Those individuals are most at risk for the downward spirals of decompensation and relapse. And research shows that the more relapses and untreated episodes one has over a lifetime, the more severely damaged the brain becomes.

NAMI strongly believe that "research is our hope for the future," and perhaps nowhere does this hold more promise than with the disease schizophrenia. It is also a very important issue for NAMI since so many of our ill loved ones and members suffer from it. We commend Ira Minot and *Mental Health News* for shining the spotlight on schizophrenia. The most seriously mentally ill always run the risk of being forgotten by society and policy makers or shunted aside by providers who would prefer to deal with less sick and easier to treat patients. Priority and funding must continue to be given to the seriously and persistently mentally ill for it is they who need it the most.

Mark you calendar now for and make plans to attend NAMI-NYS's 23rd Annual Meeting and Educational Conference, *"Navigating in Rough Seas: Finding the Way to Recovery from Mental Illness."* It will be held October 28-30, 2005, at the Desmond Hotel and Conference Center in Albany. Friday, October 28th will be an all-day session on mental illness and the criminal justice system and will feature panel presentations on the Special Housing Units (SHUs) in prisons, revisiting the insanity defense in New York and services for MICA and other dual-diagnosed consumers. Saturday morning will feature the annual meeting and election of NAMI-NYS Directors. NYSOMH Commissioner Sharon Carpinello will speak at 11:00 that morning followed by a panel presentation on multicultural family perspectives on mental illness, a prominent luncheon speaker, twelve afternoon workshops and a reception and banquet. The banquet will feature Dr. Jeffrey Lieberman, Director of the Psychiatric Institute in New York City and world-renowned psychiatric research scientist and clinician, as well as presentation of the 2005 NAMI-NYS Awards. Sunday, October 30th will feature an all medical plenary session as well as the ever-popular "Ask the Doctor" session with Dr. Lewis Opler. Look for the brochure in the mail or call us to get one, at (800) 952-FACT or (518) 462-2000. People will also be able to register on line at our website www.naminys.org.

Enjoy the fall and the holidays. □

Media Award from page 11

things working against me above and beyond the already relentless grip that the illness of depression had on my life. Those three things were stigma, lack of information and a lack of hope that I would ever be well again."

It was your own experience and struggle that energized you to become a leader in the fight against all three obstacles to a life of empowerment and inspiration to others. In that determination was born the idea that grew into *Mental Health News*.

Mental Health News now has spread from Westchester to New York City and beyond. It has spawned a Spanish/bilingual language newspaper, *Salud Mental* that speaks to the Latino and Hispanic communities in their own language, breaking down cultural barriers to hope and recovery from mental illness.

In *Mental Health News*, you bring to your readership the personal stories of consumers and the opinions of academics and practitioners about the many aspects and manifestations of mental illness. You show the variety of people affected by mental illness and the varieties of people and services available in our communities for helping people live with their illnesses and create lives of meaning and hope. You are an informer and a provocateur; a bridge builder and a helper, an energizer and a guide.

Mental Health News has brought consumers and providers together as partners, an achievement which I have admired enormously.

By taking your personal struggles and bringing them into the light for others to see and understand a little better, you fight the fight against stigma. By bringing together in your publication the many strands of the mental health community, you proclaim the value of diversity; by bringing the best minds and best ideas to light in your publications, you are educating and informing the mental health world and the general public.

For all this and more, we salute you as a journalist and colleague. The Coalition is proud to present you with its 2005 Media Award for "helping to increase community awareness of mental health issues, for promoting the importance and effectiveness of community mental health and for advancing mental health policy reform." □

By Alan B. Siskind, Ph.D.
June 15, 2005

THE MENTAL HEALTH LAWYER

Why A Forum For Legal Discussion Is So Important

By Carolyn Reinach Wolf, Esq.

Carolyn Reinach Wolf, Esq.

As many readers may already know, this space is devoted to the “Ask the Lawyer” column, a forum for readers to submit questions regarding legal issues that invariably prove to be important to the majority of readers. We would like to take this opportunity to reintroduce the objectives of the “Ask the Lawyer” forum and call upon you to submit questions or topics that you would like to be addressed.

Why is a forum for legal discussion important? The laws in New York governing Mental Hygiene, Elder Law, Healthcare Law, and related topics are dynamic and change with some frequency. Kendra’s Law was set to expire in June, 2005, however the Governor signed a five year extension to this law. Medicaid, SSI, and other disability laws seem to change almost monthly and the laws that govern our privacy, insurance coverage, and access to healthcare impact individuals with mental illnesses and their loved ones on an ongoing basis. We believe it is important to have a forum where individuals can share their questions or concerns with other readers and receive a response that is authoritative and provides meaningful guidance.

While this article should not be construed as legal advice, it should provide a foundation from which the reader can make meaningful decisions and choose an appropriate course of action. We cannot respond to every question but will strive to create articles that address a broad range of legal issues. When submitting a question, please provide as much information as possible. Personal information will not be published and names will be changed to insure privacy.

In the past, readers have inquired about a broad range of legal topics from Mental Health Warrants to Kendra’s Law to Guardianships, as well as a variety of other issues relating to the Mental Hygiene Law. Other areas of interest which often relate to mental health issues come within the criminal or family law context or those issues relating to advance planning tools such as the Supplemental Needs Trust, Healthcare Proxy, Living Will or Power-of-Attorney.

Another area of questions about which we have received concern is the hiring of legal counsel. Although we have not yet devoted one of our columns to this yet, here are some suggestions…

If the need arises for you to hire legal counsel, be sure to choose an attorney who comes to you highly recommended. Do not choose one by chance, out of the phone book, or from a billboard. The majority of issues that concern our readers are far too important to be handled by an attorney who lacks familiarity or does not have expertise with the subject matter. Be sure to speak directly with the attorney and do not sign a retainer agreement or agree to give him/her the case until you feel absolutely comfortable with his/her legal skills, professionalism and background. If you are having difficulties finding an attorney, your local county or city bar association maintains an attorney referral network. Ask as many questions as needed before committing to an attorney. An attorney who lacks the patience or time to address your concerns is not worth hiring. Do not hesitate to request a fee schedule or explanation of a quote for legal services. An attorney must be forthcoming with you regarding the cost of legal services, court fees and other related disbursements.

Once you have committed to an attorney, what are your rights? You have the right to courteous and respectful service. You have the right to periodic updates on the progress of your case and the status of any proposed settlements. Most importantly, you have the right to competent representation.

With so many things to consider, one can never have enough information. Hopefully, this forum will get the reader heading in the right direction toward making fully informed decisions. Please keep those letters and e-mails coming.

Since the last issue, our firm name has changed from the Law Offices of Carolyn Reinach Wolf, P.C., to the law firm of Reinach Wolf, Rothman, and Stern LLP. Our firm’s members, Carolyn Reinach Wolf, Valerie Meakin Rothman, Alcine Panton, and myself remain committed to the mental health community and legal issues that touch our lives. Please feel free to e-mail any questions to DSTERN@RWRS.com or DKS.ESQ@verizon.net. I will confirm receipt of your e-mail. □

Family Involvement Improves Outcomes in Schizophrenia

By Carla Quail, LCSW
Assistant Executive Director
The Mental Health Association
of Westchester County

The New York State Office of Mental Health has made a commitment to families and consumers throughout the state to provide evidence-based family treatment. A partnership between the Office of Mental Health and The University of Rochester Medical Center's Family Institute and in collaboration with NAMI, The Family Psycho-education Project sought qualified agencies to implement multi-family psycho-education groups. This evidence-based practice has proven to lower rates of relapse, improve vocational and independent living outcomes, as well as, enhance the coping skills and communication of families. In the fall of 2003, the Office of Mental Health selected The Mental Health Association of Westchester County Inc., (MHA) to be one of only twenty-one sites in the state to provide this service to consumers and families.

MHA of Westchester has long been a leader in the treatment of people with serious mental illnesses. The Family Psycho-education Project offered MHA of Westchester and the families we serve a wonderful opportunity to implement truly effective family interventions. MHA's plan, which the Project firmly supported, was to train staff representatives from as many programs as possible within the agency in order to disseminate this service as comprehensively as possibly. In January of 2004, eight staff attended a two-day training in the Multi-Family Psycho-education Model. Today, thanks to the commitment and enthusiasm of MHA's consumers, families and staff, we have two multi-family groups running and are planning a third.

Multi-Family Psycho-education is not a new program. William McFarland, the originator of the model, developed multi-family psycho-education groups at least twenty years ago. The model provides families and consumers with education about mental illness and methods of coping and support in a structured environment. Families learn to address problems through concrete, strategic, and solution driven methods. Facilitators of Multi-family Psycho-education groups form collegial relationships with families and consumers. The model is dependent upon the successful restructuring of the traditional therapist role. Staff, families and consumers work together as equal parts of a triangle, in an effort to improve the quality of life of the consumer and family.

The original model was developed for families going through the first episode of a family member's illness. MHA had to modify some of the original model to adapt to an outpatient setting, where most of the clients and families have been in treatment for some time. MHA reached out to families through direct conversations with our clients, through letters to people the clients identified as "family", and finally through invitations to what we called "Family Nights". MHA's Family Nights became a very successful vehicle by which we engaged families. At least 75% of the families that attended a Family Night joined a Multi-Family Psycho-education Group. At Family Nights, we would meet and socialize with families, describe the model and its benefits and answer questions about the nature of the program. Once families committed to the program, the facilitators began joining sessions with families. This is where the relationships are established that connect the family to the facilitator and begin to acculturate the family to the model. Finally, all of the families come together for a Survival Skills Workshop. This workshop educates families about all facets of schizophrenia and from here the formal groups begin.

MHA has been running Multi-Family Psycho-education Groups for most of this year. Families make a commitment to attend for eighteen months and to date we have not had any families drop out of the program. Many families site the education piece of the program as the most novel and helpful component. Others find the problem solving techniques to be useful in many areas of their lives. Not enough time has elapsed to assess outcomes, but our next project is to look at relapse rates and vocational/ independent living status of participants at the beginning and one-year mark. We anticipate seeing some positive changes.

In addition to the benefits to consumers and families, staff have benefited greatly from this program. The opportunity to work collaboratively with people from across the agency, the chance to try something new and see it through to implementation, the input of regular contact and supervision from an outside consultant, and the significant benefit to consumers and their families has contributed to high staff morale. Just as all of the families have remained engaged and active in the program, so have the staff.

Many models of family involvement exist in the treatment and support group community, all providing wonderful opportunities for consumers and families. MHA has found this particular model to offer our families and staff much needed support, education and solutions. MHA anticipates that this model will grow within our agency and, hopefully, other agencies will take on this initiative as well.

For more information about the Multi-Family Psycho-education program please contact Carla Quail, LCSW Project Coordinator at MHA of Westchester (9140345-5900 x244). □

Schizophrenia from page 1

remember how involved or vivacious a person was before they became ill. The sudden onset of severe psychotic symptoms is referred to as an "acute" phase of schizophrenia. "Psychosis," a common condition in schizophrenia, is a state of mental impairment marked by hallucinations, which are disturbances of sensory perception, and/or delusions, which are false yet strongly held personal beliefs that result from an inability to separate real from unreal experiences. Less obvious symptoms, such as social isolation or withdrawal, or unusual speech, thinking, or behavior, may precede, be seen along with, or follow the psychotic symptoms. Some people have only one such psychotic episode; others have many episodes during a lifetime, but lead relatively normal lives during the interim periods. However, the individual with "chronic" schizophrenia, or a continuous or recurring pattern of illness, often does not fully recover normal functioning and typically requires long-term treatment, generally including medication, to control the symptoms.

Making a Diagnosis

It is important to rule out other illnesses, as sometimes people suffer severe mental symptoms or even psychosis due to undetected underlying medical conditions. For this reason, a medical history should be taken and a physical examination and laboratory tests should be done to rule out other possible causes of the symptoms before concluding that a person has schizophrenia. In addition, since commonly abused drugs may cause symptoms resembling schizophrenia, blood or urine samples from the person can be tested at hospitals or physicians' offices for the presence of these drugs.

At times, it is difficult to tell one mental disorder from another. For instance, some people with symptoms of schizophrenia exhibit prolonged extremes of elated or depressed mood, and it is important to determine whether such a patient has schizophrenia or actually has a manic-depressive (or bipolar) disorder or major depressive disorder. Persons whose symptoms cannot be clearly categorized are sometimes diagnosed as having a "schizoaffective disorder."

Can Children Have Schizophrenia?

Children over the age of five can develop schizophrenia, but it is very rare before adolescence. Although some people who later develop schizophrenia may have seemed different from other children at an early age, the psychotic symptoms of schizophrenia—hallucinations and delusions—are extremely uncommon before adolescence.

The World of People With Schizophrenia

Distorted Perceptions of Reality

People with schizophrenia may have perceptions of reality that are strikingly different from the reality seen and shared by others around them. Living in a world distorted by hallucinations and delusions, individuals with schizophrenia may feel frightened, anxious, and confused.

In part because of the unusual realities they experience, people with schizophrenia may behave very differently at various times. Sometimes they may seem distant, detached, or preoccupied and may even sit as rigidly as a stone, not moving for hours or uttering a sound. Other times they may move about constantly—always occupied, appearing wide-awake, vigilant, and alert.

Hallucinations and Illusions

Hallucinations and illusions are disturbances of perception that are common in people suffering from schizophrenia. Hallucinations are perceptions that occur without connection to an appropriate source. Although hallucinations can occur in any sensory form—auditory (sound), visual (sight), tactile (touch), gustatory (taste), and olfactory (smell)—hearing voices that other people do not hear is the most common type of hallucination in schizophrenia. Voices may describe the patient's activities, carry on a conversation, warn of impending dangers, or even issue orders to the individual. Illusions, on the other hand, occur when a sensory stimulus is present but is incorrectly interpreted by the individual.

Delusions

Delusions are false personal beliefs that are not subject to reason or contradictory evidence and are not explained by a person's usual cultural concepts. Delusions may take on different themes. For example, patients suffering from paranoid-type symptoms—roughly one-third of people with schizophrenia—often have delusions of persecution, or false and irrational beliefs that they are being cheated, harassed, poisoned, or conspired against. These patients may believe that they, or a member of the family or someone close to them, are the focus of this persecution. In addition, delusions of grandeur, in which a person may believe he or she is a famous or important figure, may occur in schizophrenia. Sometimes the delusions experienced by people with schizophrenia are quite bizarre; for instance, believing that a neighbor is controlling their behavior with magnetic waves; that people on television are directing special messages to them; or that their thoughts are being broadcast aloud to others.

Disordered Thinking

Schizophrenia often affects a person's ability to "think straight." Thoughts may come and go rapidly; the person may not be able to concentrate on one thought for very long and may be easily distracted, unable to focus attention.

People with schizophrenia may not be able to sort out what is relevant and what is not relevant to a situation. The person may be unable to connect thoughts into logical sequences, with thoughts becoming disorganized and fragmented. This lack of logical continuity of thought,

see Schizophrenia on page 41

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"Fawns in Gorilla Suits"
Strategies and Techniques for Working with Aggressive Children

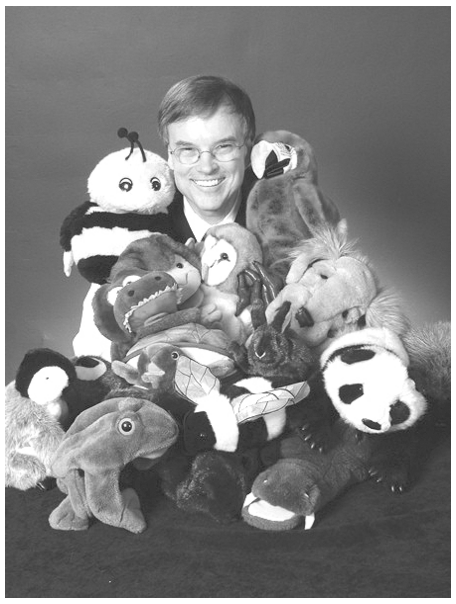
By David A. Crenshaw, PhD, ABPP

In my 35-plus years of treating troubled children, I have identified a group of children that I have come to refer to as "fawns in gorilla suits." These are the children whose horror-show-harsh lives have exposed them to repeated abuse, deprivation, severe trauma, and often multiple out-of-home placements. Their sense of trust is shattered.

Like a fawn, their core self is very vulnerable – they are often frightened, but, paradoxically, they put on the gorilla suit (aggression) to keep others, even those who seek to help and befriend them, at a distance – because they can't bear to be hurt again. For 30 years I worked in two different residential treatment centers, and many of the children that I treated during that time fit this profile. My professional quest has been to help this population of children – to identify strategies that will reach the "fawn", and to create opportunities for the fawn to learn when it is safe and prudent "to take off the gorilla suit" and when it is not. The goal is not to take the gorilla suit away; that would be too big a step and leave the child too exposed. Rather, the objective is to teach children to discriminate between people and situations that can be trusted and when mistrust and caution is adaptive and warranted.

And, so, many years ago, with the "fawn in the gorilla suit" in mind, I began the project of gathering information and practical ideas that would serve to engage children who are highly anxious, aggressive, defiant, oppositional, and resistant to the therapeutic process.

As a child and family therapist, I began developing specific strategies to use in my practice to address the wounds of the "fawns." Verbal skills are rarely the strong suit of anxious and/or impulsive, action-oriented kids, but given the proper tools, these same children can express their feelings, thoughts, and fantasies. Sometimes, what therapists consider as 'resistance' is actually the therapist's failure to provide the proper structure, within an appropriate context, that facilitates communication leading to meaningful dialogue – and it is "dialogue" that is critical for healing. Aggressive and anxious children, often distrustful of others, are usually reluctant to share their private thoughts, feelings, and fantasies. Often, they lack the skills to identify and label the sometimes frightening inhabitants of their inner-world. Others may be in touch with the thoughts and feelings that trouble them, but are unable to find the words to express them. In addition, they often feel that their inner-world is too scary to share with another, even a trusted person.



David A. Crenshaw, PhD, ABPP

I have always approached the understanding and treatment of children from an integrative theoretical framework. Much can be learned from a wide range of theoretical and practical approaches to therapy. The techniques and strategies that I have found most effective in building bridges to a child's inner-life, and those that will stimulate other therapists to develop their own strategies to connect with these "disconnected" children, have now been compiled in three recently published books: *Understanding and Treating the Aggression of Children: Fawns in Gorilla Suits* and the *Handbook of Play Therapy with Aggressive Children* (published by Jason Aronson, 2005) which are co-authored with my long-time colleague John B. Mordock, and *Engaging Resistant Children in Therapy* (published by Rhinebeck Child and Family Center Publications, 2004.) – the first Volume in The Child and Family Therapy Guidebook Series.

The Decision Grid

One of the strategies for deciding the pace at which a child should be engaged in therapy can be found in The Child/Play Therapy Decision Grid, which is explained more succinctly in *A Handbook for Play Therapy with Aggressive Children*. This was developed to guide child therapists in titrating the level and intensity of therapy for a specific child at a particular point in time taking into account the child's resources including coping skills, sophistication and maturity of defenses, family and interpersonal supports, ego strengths, and degree of external stress in current life. These factors can change and shift as the therapy proceeds and sometimes adjustments are required even within a single session. Two tracks of therapy are identified within the Grid, the Coping Track and the Invitational Track. This model was inspired by the work of Beverly James who discussed similar concepts without integrating them into a decision grid. The Coping Track is basically a psychoeducational approach to therapy with emphasis on building ego strengths, coping skills, defenses, problem-solving skills, and pro-social skills with special emphasis on empathy, in my view the most important of all the pro-social skills.

The Invitational Track invites the child to go as far as she/he can at any one point in time in approaching the painful, disturbing, or traumatic events of his or her life. Criteria for determining when a child is ready for the Coping or Invitational Tracks are also spelled out in *A Handbook for Play Therapy* with Aggressive Children. The decision grid is intended to guide therapists in a fluid and dynamic manner that allows for the flexibility needed when working with children. The arrows in both tracks point both up and down, as well as across tracks, because when a child is dealing with some topics he/she may be able to work within the Invitational Track although the pace may need to be slowed or stepped up, but with other emotionally evocative topics she/he may need to move back to the Coping Track for more work with building defenses since she/he may become overwhelmed or emotionally flooded.

Goal-Directed Intervention Groups

Another feature of the ever-evolving "fawn project" is to organize the practical strategies within goal-directed intervention groups. Attention is being paid to areas where extremely aggressive children are particularly deficient, including: 1) Establishing a therapeutic alliance; 2) Building, modeling, teaching, identifying, highlighting and reinforcing defenses and coping resources; 3) Teaching the language of feelings; 4) Facilitating expression and modulation of affect; 5) Modeling and teaching of symbolization; 6) "Tickling" the self-observer; 7) Accessing the inner world of the child; 8) Addressing profound losses; 9) Confronting traumatic events through contained trauma-re-enactments and development of a trauma narrative; 10) Addressing shame and guilt;

see Strategies on page 26

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 • FALL 2005

SEPTEMBER 2005

SPECIAL TRAINING

Thursday, September 29th • 9:30 am - 12:00 pm

Child Abuse Identification and Reporting

Valerie Saltz, L.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 Mental Health Counselors, Marriage and Family Therapists, Creative Arts Therapists, Psychoanalysts, Licensed Social Workers, Physicians, Dentists, Dental Hygienists, Chiropractors, Psychologists, RN's, School Administrators, Teachers, etc. A State Education Department Certificate of Completion will be given at the end of the class.

Fee: $45.00 payable to the Four Winds Foundation, a not-for-profit organization

OCTOBER 2005

A COMMUNITY SERVICE

Thursday, October 6th • 2:00 - 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 confidential consultation with a mental health professional, and an educational presentation (screening is modified for children).

For information, or to schedule a confidential appointment, please call 1-800-546-1754 ext. 2413.

Free of Charge • Open to the Public

GRAND ROUNDS

Friday, October 14th • 9:30 - 11:00 am

Alcohol Use in the Elderly

The Werner and Elaine Dannheisser Memorial Lecture Series

JoAnne Markle, M.D., Chief Resident in Psychiatry, Albany Medical Center

The prevalence of alcohol abuse in the elderly is not as widely accepted as the prevalence of abuse in younger people. This lecture will explore socio-demographic factors of alcohol use in older adults.

- Participants will learn about the epidemiology of alcoholism in the overall elderly population and among certain sub-populations of elderly patients.
- Participants will learn about the interface of alcoholism with medical illnesses in the elderly as well as enhanced means of screening for covert alcohol use.
- Participants will learn about treatment modalities for alcoholism in the elderly.

Fee: $20.00 payable to the Four Winds Foundation, a not-for-profit organization

1.5 CME Credits Available

This lecture is made possible by a Grant from The Werner and Elaine Dannheisser Testamentary Trust Fund.

OCTOBER 2005

Save the Date!

Nursing Career Day

Tuesday, October 18th • 4:00 - 7:00 pm

Experience Four Winds firsthand during this informal event.

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Refreshments, Tours, an Opportunity to Meet with Nursing Leadership

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RSVP by October 11th at 1-800-546-1754 ext. 2413

GRAND ROUNDS

Friday, October 21st • 9:30 - 11:00 am

Unlocking the Chains of Addiction Through Attachment Based Treatment

Karen B. Walant, Ph.D., B.C.D, L.C.S.W., Private Practice, Ridgefield, CT

The etiology of addiction is multifaceted, with both genetic and environmental roots. Integrating attachment theory, the self-medicating hypothesis and neurobiology brings an enriched knowledge base for clinicians. This lecture will present key theoretical constructs that anchor the treatment, and specific treatment strategies for both substance abusers and codependents. This presentation will enable participants:

- To understand the integration between attachment theory, the self-medicating hypothesis, and neurobiology.
- To expose the bias and assumptions that view attachment needs as regressive and unhealthy, thereby redirecting and refocusing the treatment on exploring and deepening the therapeutic relationship.
- To examine spirituality as it relates to the psychodynamics of addiction.

Fee: $15.00 payable to Four Winds Hospital

1.5 CME Credits Available

Albert Einstein College of Medicine designates this continuing medical education activity for a maximum of 2.0 category 1 credits towards the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity.

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Albert Einstein College of Medicine and Four Winds Hospital. Albert Einstein College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

These programs will be of interest to: physicians, psychologists, nurse practitioners, social workers, mental health providers, EAP's, education professionals, school counselors, RN's and consumers.

Community and Professional Education Programs

OCTOBER 2005

GRAND ROUNDS

Friday, October 28th • 9:30 - 11:00 am

Dialectical Behavioral Therapy for the Treatment of Self Destructive Behaviors in Children and Adolescents

Kerry Murray Pertchik, Psy.D., Coordinator of Four Winds Saratoga DBT Training and Clinical Psychologist, Four Winds Saratoga

At the conclusion of this program participants should:

- Gain an understanding of Dialectical Behavioral Therapy's Bio-Social Theory and how this relates to pervasive self-destructive behaviors.
- Become familiar with the Dialectical Dilemmas of Borderline Personality Disorder.
- Gain an understanding of how Dialectical Behavioral Therapy can be used in an adolescent milieu.

Fee: $15.00 payable to Four Winds Hospital

1.5 CME Credits Available

NOVEMBER 2005

GRAND ROUNDS

Friday, November 4th • 9:30 - 11:00 am

The Ups and Downs of Raising a Bipolar Child

Candida Fink, M.D., Co-author of the book "The Ups and Downs of Raising a Bipolar Child" and "Bipolar for Dummies", Private Practice, New Rochelle, NY

Current treatment modalities, strategies for professionals and caregivers, diagnostic criteria in children and adolescents, signs and symptoms of early detection and current psychopharmacology trends will be discussed.

- Participants will learn the current issues in diagnosis and classification of pediatric bipolar disorder.
- Participants will learn current trends in psychopharmacology and the newest research information.
- Participants will learn management/support strategies for day-to-day-challenges.

Fee: $20.00 payable to The Four Winds Foundation, a not-for-profit organization

1.5 CME Credits Available

All of the Grand Rounds, Special Trainings and Special Events will be held at the Four Winds Hospital Conference Center unless otherwise noted.

Registration is Required for All Programs. Please Call 1-800-546-1754 ext. 2413.

NOVEMBER 2005

GRAND ROUNDS

Please Note: 2 Hours

Friday, November 18th • 9:30 - 11:30 am

25 *MORE* of the Best Play Therapy Techniques for Working with Aggressive Children

David A. Crenshaw, Ph.D., Director, Rhinebeck Child and Family Center, LLC and President, New York State Association for Play Therapy

Back by popular demand, Dr. Crenshaw will share 25 more of his most successful techniques in meeting the challenge of engaging defiant, oppositional, and aggressive children in therapy.

- Participants will learn at least 5 new evocative therapy strategies to touch the hearts and souls of children.
- Participants will learn at least 5 new projective drawings and storytelling techniques to engage resistant and aggressive children.
- Participants will learn at least 5 new strategies for facilitating the development of self and other-empathy with children.

Fee: $20.00 payable to the Four Winds Foundation, a not-for-profit organization

2.0 CME Credits Available

DECEMBER 2005

GRAND ROUNDS

Friday, December 2nd • 9:30 - 11:00 am

Management of Clinical Aggression in Children and Adolescents: State of the Science

Peter Jensen, M.D., Ruane Professor for the Implementation of Science for Child and Adolescent Mental Health in the Field of Psychiatry, New York State Psychiatric Institute, Columbia University, New York, NY

At the conclusion of this program, participants should:

- Be able to describe how one should proceed in providing treatment for various psychiatric disorders complicated by severe clinical aggression (e.g., TRAAY guidelines).
- Be able to recognize clinical indications for using 2nd generation atypicals, mood stabilizers, and other psychotropic agents in managing aggression in children and adolescents.
- Be able to evaluate the evidence for safety and efficacy of non-pharmacologic and pharmacologic treatments for aggression in children and adolescents.
- Be able to describe "tools" to assist clinicians in implementing optimal treatments for clinical aggression, and illustrate how they are used.

Fee: $15.00 payable to Four Winds Hospital

1.5 CME Credits Available

Are You Interested in Volunteering?

JOIN US ON

Wednesday, October 26, 2005

10:00 am - 12:00 pm or 5:30 - 7:30 pm

to learn more about the exciting Volunteer Opportunities at Four Winds!

Strategies from page 23

11) Facilitating the development of empathy; 12) Reworking identity, seeking meaning, and perspective; 13) Facilitating and preparing for termination of therapy.

In light of Alan Kazdin's recent review indicating that there are now over two thousand studies supporting the crucial role of the therapeutic alliance in psychotherapy outcome research, these interventions offer potentially valuable tools to strengthen the therapeutic alliance as a result of their child-friendly format, and their focus on emotionally meaningful themes and issues.

On May 6, 2005 during a Grand Rounds presentation at Four Winds Hospital on "25 of the Best Play Therapy Techniques for Working with Aggressive Children" the following strategies and techniques were presented to an audience of nearly 200 fellow clinicians. You may be familiar with some of these ideas, the use of therapeutic stories as an effective tool in child therapy, and the use of projective drawings are a series of techniques designed to enable even the most inhibited, guarded, or uncooperative child to find a face-saving way to meaningfully participate in therapy. To many children, therapy is similar to being brought to the principal's office! Therapy is related to punishment. Perhaps the most important intervention a therapist can make is to change the adversarial orientation of the child toward the therapist to a collaborative one. The projective drawing and storytelling series can be used in both family and group therapy, as well as individual therapy. Projective Drawing and Storytelling Techniques are explained further in *Engaging Resistant Children in Therapy*, but some of the ideas, and the goals of the exercises are briefly outlined here:

Techniques	Intervention Groups
Wave Breathing (O'Connor)	Building Defenses/Coping
Angry Arthur (Ornam)	"Tickling" the Self-Observer
Furious Fredâ (Franklin Learning Systems)	Building Defenses, Coping, Affect Modulation
The "Volcano Speaks"	Building Defenses/ Language of Feelings/ Modulation
Storm Clouds	Same as above
Dragon Breathing Fire	Same as above
Angry Monster Roars	Same as above
The Alligator Flips its Lid	Affect Expression/ Modulation; Teaching the Language of Feelings
Tommy Turtle's Secret Coping Club	Building Defenses/ Language of Feelings
Reaming Them Out!	Affect Expression/ Modulation; Teaching the Language of Feelings
Movie Auditions	Affect Expression/ Modulation
The Magic Key	Symbolization/Accessing Inner World/Addressing Loss
The Boat in a Storm (Oaklander)	Accessing Inner World/ Symbolization
Your Place (Oaklander)	Same as above
Color-Your-Life (O'Connor)	Same as above
The Endless Search	Loss/Attachment
A Tale of Revenge	Symbolization/ Accessing Inner World/Affect Expression/Modulation
The Little Pig that Didn't Fit	Addressing Loss Issues, Symbolization, Affect Expression/Modulation
The Misunderstood Mouse	Same as above
The Animal that Nobody Could Hug	Same as above
Blow-Up Bernie	Symbolization/Affect Expression/Modulation/ Coping Skills
Behind Closed Doors	Same as above
The Fair Trial	Addressing Shame/Guilt
Godzilla has Gone TooFar this Time!	Affect Modulation/ Re-Working Identity
Party Hats on Monsters	Affect Modulation/ Symbolization/ Trauma Work

Engaging the Hearts of Kids

The strategies discussed in this article have been developed for the purpose of engaging not just the minds, but also the hearts of children. If therapy is sterile, dry, and too cerebral, let alone manualized, it will not reach the inner place where children in their essence live. It will not reach the inner recesses of their hearts and souls that is the home of what James Garbarino (1999) calls "the divine spark." To engage children in a meaningful way, to create moments of transformation and change in the therapy process, we have to learn the language of the heart.

Integrative Model

These specific techniques can fit logically and coherently within any number of models of psychotherapy that are empirically supported. I do not advocate for one approach or another but rather describe strategies that may be used in such diverse therapy approaches as psychodynamic, narrative, cognitive-behavior, trauma-informed treatment, solution-focused therapies, Ericksonian approaches, family systems, play therapy, Gestalt, and creative arts therapies as well as others.

This is not a stand-alone or all encompassing approach to therapy but a compilation of clinically useful strategies that can thoughtfully be included in a wide variety of treatment approaches and protocols to address specific issues and facilitate progress toward a defined goal.

Child-Friendly Cognitive Behavioral Therapy

The purpose of the "fawn project" is to offer practical ideas to help therapists engage children who are highly anxious, aggressive, defiant, oppositional, and "resistant" to the therapeutic process. Some of the strategies have been developed in response to Janine Shelby's characterization of CBT techniques as not being "child-friendly." A number of the evocative strategies in my book were designed with this purpose in mind, to embed CBT strategies in a playful, engaging, and child-responsive format.

Not a Cookbook Approach

These interventions are not meant to be used in a cookbook approach or to be a substitute for training and supervised experience. I wish to emphasize that entering the inner world of troubled children, a world filled with emotionally laden material, especially trauma related material, should be undertaken only by therapists who have met rigorous standards of training and experience and who have been supervised by qualified child clinicians licensed and credentialed in a mental health discipline. The work can be arduous and emotionally taxing, but if we are able to reach 'the fawn" it will also be rewarding and we will grow in clinical courage and confidence. □

David A. Crenshaw, PhD, ABPP, RPT-S is Founder and Director of Rhinebeck Child and Family Center, LLC. Visit his website at www.rhinebeckcfc.com for more information on his writings, published books, speaking engagements and how to contact him.

The Mental Health News

New York City Section

Regaining A Life: Orlando's Story

By Denise Kreitzman
The Mental Health Association
of Nassau County

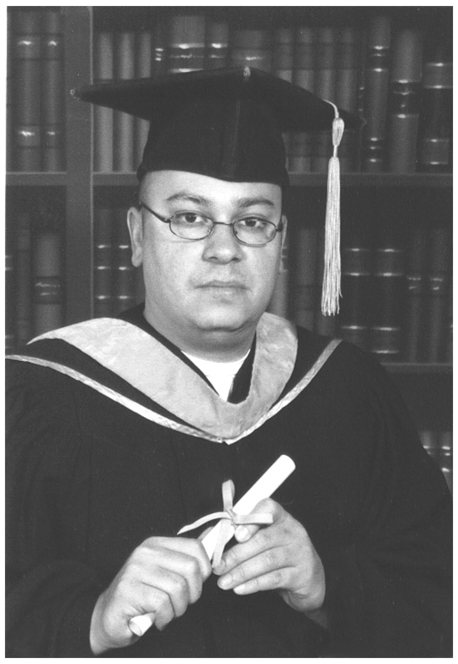
The skies threaten rain and it's uncertain whether the State University of New York at Old Westbury will hold their graduation ceremony outdoors. Orlando Morales waits in cap and gown with hundreds of other graduating seniors.

Somewhere in the overflowing crowd sits Orlando's family. But there's a gulf of difference in the meaning of this day for their son and the families that surround them.

Orlando, in his early thirties, is older than most graduates, but for those who know him, he is one of the most spectacularly successful students of the day. His experiences stray far from those of his peers. Diagnosed with schizophrenia in his late teens, Orlando has been to a terrifying hell and back.

Schizophrenia is a chronic, severe and disabling brain disease. In the United States, approximately 1 percent of the population develops schizophrenia during their lifetime – and more than 2 million Americans suffer from the illness in a given year.

Uncontrollably gripped by this serious disorder, Orlando's day-to-day life was an unrelenting nightmare. For years, resisting treatment, schizophrenia ruled Orlando's world. He was either in jail, on a psychiatric ward or wandering the streets. Internal voices controlled his thoughts and his behavior. They told Orlando unimaginable things - burying his rational thinking in a toxic dust. The voices said his food was poisoned and ordered Orlando not to eat; they pronounced him the King of Puerto Rico and warned that people were conspiring to kill him. His irrational beliefs, delusions and hallucinations, (all symptoms of his disturbance), transformed Orlando from a bright young man into a chaotic human being...an easy prey for sneak attacks of paranoia that frightened him and, in turn, frightened others. (Not everyone with schizophrenia experiences Orlando's fate. With a combination of therapy, medication and support, people serious mental illnesses can live a dignified life in the community).


Orlando Morales

Striving to keep him from harm's way, Orlando was sent to yet another psychiatric hospital. Determined to relieve his symptoms, the staff at Pilgrim State Hospital endeavored to maintain Orlando's compliance with medications and therapy. Several months after admission, Orlando picked up a pamphlet on group homes in the day room. Unbeknownst to him and others, Orlando was beginning to separate real from unreal experience. The pamphlet triggered pre-illness memories. Orlando remembered how much he had loved mathematics in high school and how he excelled as a

see Orlando's Story on page 40

New Medicare "Part D" Prescription Drug Plan Coming This January

Could Have Profound Impact on Individuals Receiving Mental Health Services

By Karyn Krampitz
IT Projects Director, The Coalition of
Voluntary Mental Health Agencies

On January 1, 2006, as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, a new voluntary Medicare prescription drug program referred to as Medicare Part D, goes into effect for all Medicare eligible consumers. The program, administered by the Centers for Medicare and Medicaid Services (CMS), will offer prescription drugs to all Medicare recipients at a relatively low premium cost. Medicare recipients include the elderly over 65 as well as disabled individuals who are below the federal poverty level who are under 65 and who are eligible for both Medicare and Medicaid (referred to as dual eligibles). It is estimated that there are 7 million dual eligible consumers nationwide; more than half a million – 570,000 - reside in New York State many of which live with psychiatric disabilities.

Prescription Plans


Karyn Krampitz

Part D prescription plans will be offered by private companies, not the federal government or a state government. We expect there will be many different plan offerings in New York State; making a choice may be difficult for consumers. Adding to the confusion, insurers will bombard the market with their drug plan solicitations in October 2005. The enrollment period begins November 15, 2005 and runs until May 15, 2006. Individuals who enroll after May 15, 2006, will be subject to a lifelong penalty of 1% for each month that enrollment is delayed. Dual eligibles will be allowed to change plans as often as once a month, as plan formularies may change during the year. All others will only be able to change plans once a year.

Initially there was great concern that a limited number of drugs would be made available in each drug class and what effect this would have on the behavioral heath community. This concern was based directly on the initial regulations which only required a plan to include at least two drugs in each class. There are also entire classes of drugs which are excluded from any Medicare Part D plan such as benzodiazepines (anti-anxiety) and barbiturates.

In response to outcries from the mental heath community and others, CMS recently clarified their policy to state that plans should offer "all or substantially all" drugs in the following 6 categories: antidepressant, antipsychotic, anticonvulsant, anticancer, immunosuppressant and HIV/AIDS. These categories should include both generic and older branded drugs. (Pharmacological classes are associated with therapeutic categories. Some classes may be associated with multiple categories, like Beta Blockers which are a class associated primarily with cardiovascular agents, yet are often used for other indications as well.)

A few states, including New York, have agreed to offer some sort of a "wrap-around" prescription drug program. The New York State wrap-around will at a minimum include some of the drugs which are currently available through Medicaid but which have been specifically excluded from the Medicare program (such as the benzodiazepines and barbiturates). The New York State Department of Health has also indicated that they may cover drugs not included in a plan's formulary, but has not yet determined how this will be implemented.

Major Change

The major thrust is that all Medicare recipients who currently receive prescriptions through Medicaid will lose their Medicaid prescription benefit on December 31, 2005. So, while the Medicare Part D program is "voluntary" for most Medicare recipients it will be the only prescription drug program available to those dual eligible individuals losing their Medicaid coverage. This could have a profound impact on

see Medicare on page 38

Innovations in The Treatment of Schizophrenia: One Size Does Not Fit All

By Ellen Stoller, Assistant VP
Community Services, Training
& Consumer Affairs, F.E.G.S.
Health and Human Services System

Just as we understand philosophically the principle that every human being is unique, we remain sensitive that every adult with schizophrenia is unique. During the mid-twentieth century – a period of large-scale institutionalization-- this reality was often forgotten under the pressure to deal with large populations.

In today's community programs, the uniqueness of the person at the center of treatment planning needs to be underscored at every stage. Once a person is stable on medication, treatment professionals focus on finding out who this person is and what motivates him/her. We all have "on buttons"…what buttons need to be pushed to turn you on, to help you do your best work, and to motivate you to achieve your goals? These questions led F.E.G.S. Health and Human Services System to seek new approaches for dealing with individual differences when working with adults with schizophrenia.

Medication

Although medication can help us with much of the management and treatment of schizophrenia, negative symptoms of the illness can continue to impede success in attaining life goals such as schooling, jobs, relationships, etc. These negative symptoms include:

- Loss of motivation
- Inability to experience pleasure
- Blunted affect and communication
- Lack of concentration
- Inability to stay on task
- Lack of problem solving skills

In order to help reverse these symptoms, we need to find the actions or relationships that motivate people to care about themselves and others. Psychiatrists, as part of the treatment team, consider which medications are more effective in addressing the symptoms of schizophrenia. Then comes reconnecting to people, interests and the world; these are key components in the treatment of any illness.

Currently there are three areas we focus on to help our clients cope with their illness, succeed in their life goals, and make new connections to others. These are:

- Cognitive Remediation
- Family Psychoeducation
- Creative Arts

Dr. Jonas Waizer

> *"When people experience a long-term serious psychiatric illness, and their illness is further compounded by becoming removed from day-to-day life, their thinking skills may be impaired and affect their ability for sustained and organized thought. Fortunately, the bleak prognosis for full recovery has dramatically improved in the past several years because of new psychotropic medications that allow them to better manage their symptoms. More recently, we are finding that progress in regaining thinking skills can be accelerated through the use of computers by clients, guided by professionals, who use learning software programs to promote cognitive rehabilitation. When clients use these programs, they stimulate the parts of their brains that are needed to function in the world, such as concentration and memory, sequencing, logical analysis and task management."*
>
> *Dr. Jonas Waizer*
> *Chief Operating Officer*
> *F.E.G.S.*
> *Health and Human Services System*

Cognitive Remediation

According to Dr. Jonas Waizer, Chief Operating Officer at F.E.G.S., "When people experience a long-term serious psychiatric illness, and their illness is further compounded by becoming removed from day-to-day life, their thinking skills may be impaired and affect their ability for sustained and organized thought. Fortunately, the bleak prognosis for full recovery has dramatically improved in the past several years because of new psychotropic medications that allow them to better manage their symptoms. More recently, we are finding that progress in regaining thinking skills can be accelerated through the use of computers by clients, guided by professionals, who use learning software programs to promote cognitive rehabilitation. When clients use these programs, they stimulate the parts of their brains that are needed to function in the world, such as concentration and memory, sequencing, logical analysis and task management."

Working closely with a team of neuropsychological specialists, our Rehabilitation Practitioners have been trained to provide the innovative clinical techniques developed by Alice Medalia, Ph.D., Director of Neuropsychology at the Department of Psychiatry at Albert Einstein College of Medicine in the Bronx, an authority in the field of cognitive rehabilitation. We use popular computer software such as *Where in the World is Carmen Sandiego?, Stocktopus,* and *Sim City* that are experienced by consumers as fun and games while promoting the necessary skills. We find that either damaged or unused thinking skills can be repaired in the context of an enjoyable learning experience. Memory retention, sustaining attention, problem solving, concentration, sequential planning and even reading skills all improve.

Michael B. wrote in the Consumer Lab Newsletter "I like the program *Math for the Real World* because it has many features and different ways of answering problems. The way they do it is really fun and helps me with my problem solving and attention and how to manage money!"

Consumers attend the Cognitive Rehabilitation center twice a week for one hour under the tutelage of a professional. Consumers experience the computers as their personal, patient teachers, who offer consistent feedback that is non-judgmental and non-threatening. The feedback is designed not only to tell consumers if they are not doing something right, but more importantly to offer suggestions on how to approach the problem when done again.

In general, the psychiatric recovery program assists consumers in making informed choices about where they wish to live, learn, work or socialize in the community, while providing the support and skills to achieve these goals. The skills gained in the cognitive training accelerate consumers' progress toward greater autonomy for desired life goals -- built around independent living skills that require planning ahead, organizing and keeping a schedule, budgeting, shopping, paying the bills, and educational and vocational pursuits.

Consumers who have gone through the cognitive training demonstrate significant improvement in their ability to make plans, carry out complex tasks, and think in a more organized way. An overall improvement of their psychiatric picture helps them to rebuild more productive and fulfilling lives.

Family Psychoeducation

William McFarlane, M.D. Professor of Psychiatry at the University of Vermont, designed Family Psychoeducation specifically for families where one family member has schizophrenia. Originally researched over twenty years ago, when Dr. McFarlane was Director of the Biosocial Treatment Research Division of the New York State Psychiatric Institute it is an Evidence Based Practice. For the past year or so, F.E.G.S. has been using Family Psychoeducation techniques and Multi-Family groups to reconnect clients with their families and educate families about the illness and how to cope with it. This technique has proven to be an enormous boon to our clients. As a staff member reported about a group he co-led in July 2005:

"Our second family session went extremely well. We had 21 in attendance and only one absence. The group started with 10 minutes of easy socialization, followed by the prescribed go around to each person discussing how the illness has impacted their lives. The input was abundant, emotional, and varied. Some of the responses:

- "It has been so difficult to know how to talk with him (the client) not knowing how he will react"
- "My illness has been the major burden of my life and has affected everything"
- "When I first got sick and went into the hospital, I thought—this is it, this is where I will spend the rest of my life."
- "We never even really realized my son's illness or talked about it until we came here"
- "My brother is very dependent and my mother is always enabling him. It makes me so angry—it's so hard to have patience with them."

Gaining a better understanding of what schizophrenia is, talking about and dispelling the myth that the family is to blame, and learning problem solving skills has helped our families and clients begin to work together.

Creative Arts

A third way that F.E.G.S. helps ameliorate the negative effects of schizophrenia is through creative arts interventions. From September 2004 to February 2005, 12 clients with severe and persistent mental illness met once a week to work on a drama project with resident artist, Arthur Stimling, a theater director by profession, and three staff members. The final result of the five months of warm-ups, acting exercises and discussions

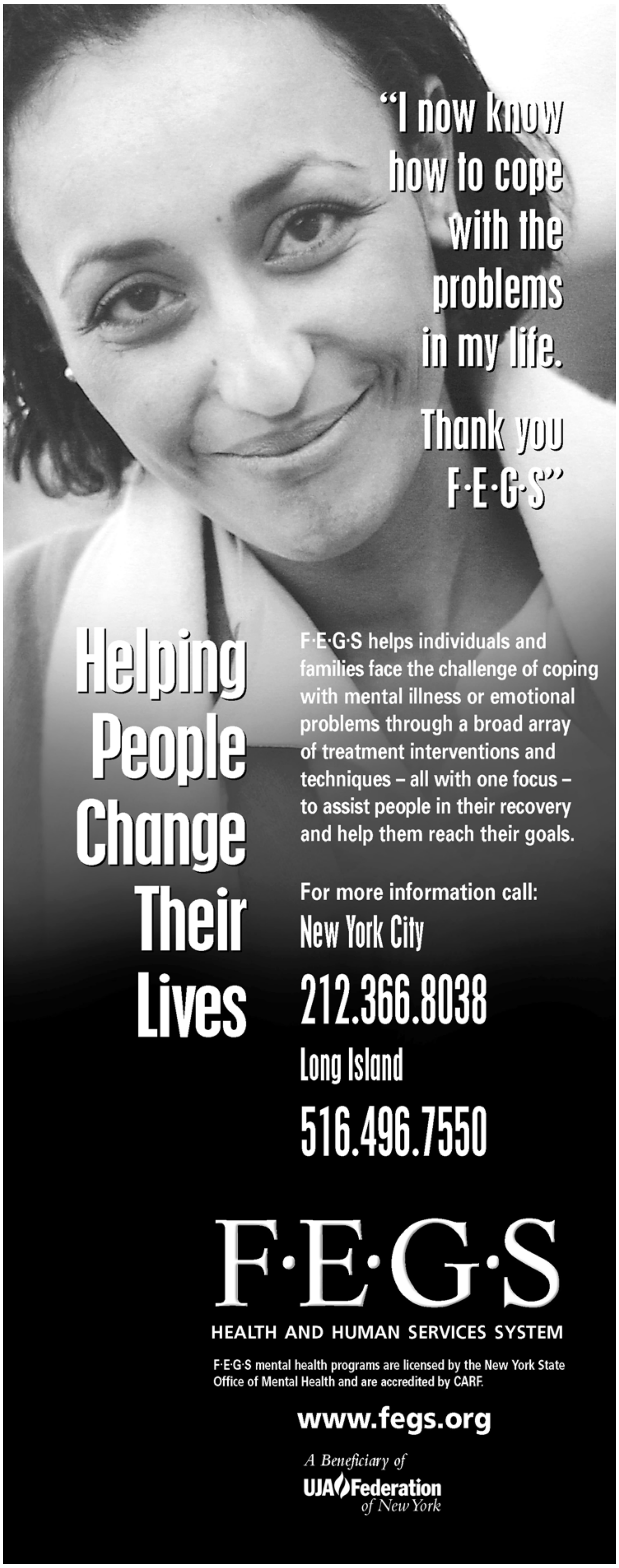
see Innovations on page 29

Innovations from page 28

was a play called "The Guest House" that was performed twice for peers, family, friends, and the executive staff of F.E.G.S. As one of the staff participants in this project, I watched first hand as clients "came out of their shells." I saw clients learn new skills. I saw clients who previously slept through group staying wide awake and participating for the full two-hour workshop. Staff noticed that clients' attendance improved, anxiety decreased, and impulse control increased. Clients talked to each other, not just the group leader and staff, they supported each other, shared scripts, shared praise, and took risks. This group of seriously mentally ill adults became connected to, involved in, and passionate about acting. It helped them grow, learn things about themselves, and connect to other people in a new way. Similar results can be found helping clients connect to music, poetry, painting, and drawing.

Schizophrenia is still not an easy illness to treat. While medications are key, people with schizophrenia need to be presented with a spectrum of options for treatment and management of their illness.

To make treatment work, staff must have high expectations and a willingness to become expert in many treatment modalities. No one size fits all clients. At F.E.G.S., we use a variety of approaches and continue to learn, from others in the professional field and from our clients and their families, just what works for each individual. □



F·E·G·S helps individuals and families face the challenge of coping with mental illness or emotional problems through a broad array of treatment interventions and techniques – all with one focus – to assist people in their recovery and help them reach their goals.

For more information call:
New York City
212.366.8038
Long Island
516.496.7550

F·E·G·S
HEALTH AND HUMAN SERVICES SYSTEM

F·E·G·S mental health programs are licensed by the New York State Office of Mental Health and are accredited by CARF.

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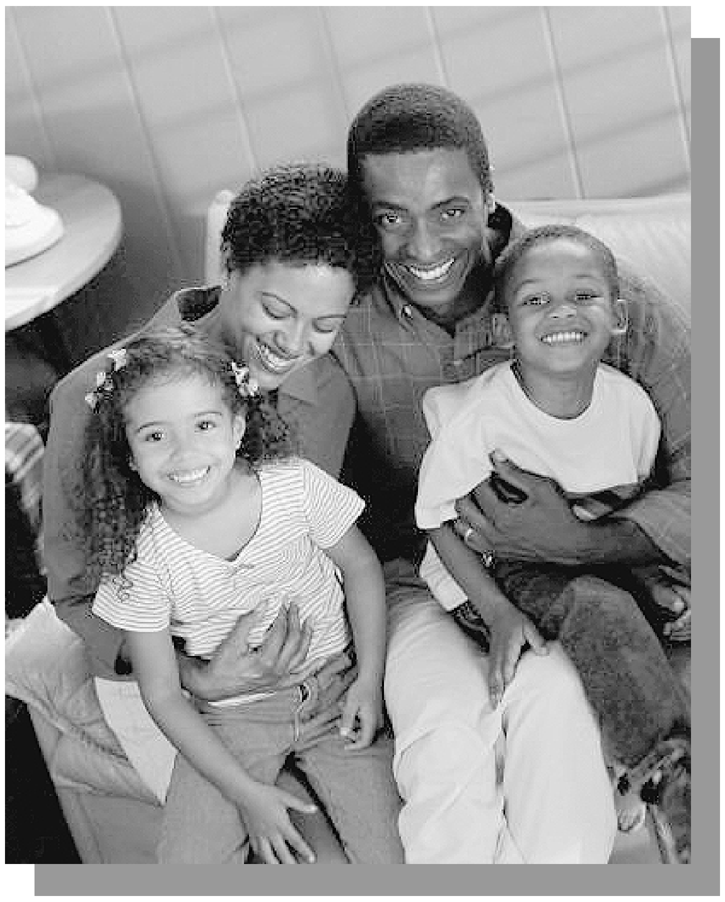
Giselle Stolper, Executive Director
Mental Health Association of New York City

Jonas Waizer, PhD, Chief Operating Officer
F.E.G.S. Health and Human Services System

Joyce Wale, Assistant Vice President - Behavioral Health
New York City Health & Hospitals Corporation



the mental health association
of new york city, inc.

Delivering Science-Based Information About Schizophrenia to Providers and Consumers

By Giselle Stolper, Executive Director
The Mental Health Association
Of New York City

Giselle Stolper

The National Institute of Mental Health estimates that 1.1 percent of Americans suffer from schizophrenia. In New York State, we can then estimate that approximately 220,000 residents are diagnosed with the illness, 58,000 of whom live in New York City. Many more individuals are diagnosed with depression or other anxiety-related disorders, but these illnesses do not come with the stigma associated with an illness like schizophrenia.

Schizophrenia remains a mysterious and frightening disease to many people, who may not know that the illness rarely results in violent or destructive behavior, for instance, and that treatment works. Part of the problem is that schizophrenia lacks the mainstream acceptance that other mental illnesses, such as depression or bipolar disorder, have acquired in recent years. Not only is depression more common, thanks to the public disclosure of celebrities including Brooke Shields, Terry Bradshaw and Mike Wallace, more people than ever are aware of the symptoms of depression and how to get treatment. Jane Pauley now considers herself a spokesperson for bipolar disorder, an admirable role for her to assume as one of our nation's leading media personalities.

While schizophrenia may still have a ways to go to achieve broad-scale understanding and acceptance, in the past 20 years mental health advocates, agencies, researchers, and consumers have built a strong support network for those who are diagnosed with the disorder. In addition, research is rigorously underway to help us understand schizophrenia's cause and cure.

The Mental Health Association of New York City is honored to play an active role in these efforts as a participant in the National Institute of Mental Health (NIMH) Outreach Partnership Program. As a partner to NIMH, the MHA of NYC works in tandem with other mental health associations around the state to disseminate important information about research underway both to inform practitioners and consumers of studies in progress, and to recruit volunteers for clinical trials and other projects.

The NIMH Outreach Partnership Program acts as a nationwide network of mental health organizations like ours to build the bridge between research and practice, while shedding light on diseases such as schizophrenia. In New York State, the MHA of NYC works with other mental health organizations, MHA affiliates, to bring information about the latest research to all stakeholders.

About the National Institute of Mental Health Outreach Partnership Program

This program is a vital element in the broad NIMH outreach effort to deliver science-based information to the public, health professionals, constituency groups, and all interested stakeholders. Through its Outreach Partners and the National Partners the program strives to:

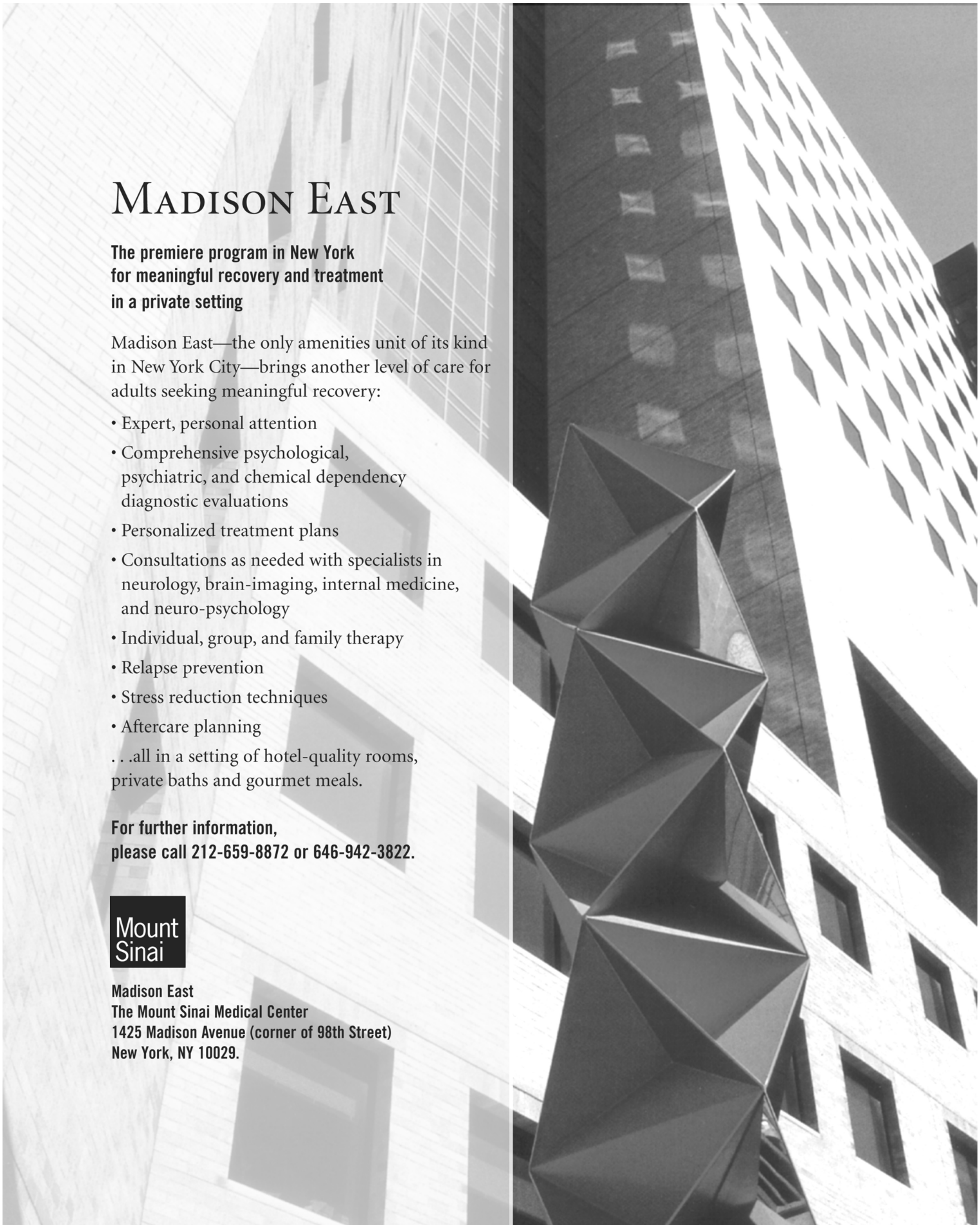
- Disseminate science-based information on mental illnesses, alcoholism, and drug abuse to consumers, families, and policy makers at the state and local level.
- Support the understanding of brain disorders, specifically mental illnesses and substance abuse disorders, and the importance of accurate diagnosis and treatment.
- Reduce the stigma and discrimination associated with mental disorders, alcoholism, and drug addiction.
- Encourage individuals with symptoms of mental disorders, alcoholism, and drug addiction to seek help.
- Eliminate disparities that exist in access to care and health outcomes due to race, culture, age, geographical location, and gender.

The NIMH has eight studies currently in progress addressing the origins and treatment alternatives for schizophrenia for people of all ages. Two treatment studies are underway to test the effectiveness of particular medications on children ages 8 through 19 with schizophrenia or other psychoses. Six evaluation studies now in progress will assess the effect of medications on memory retention and brain functioning; ascertain the impact of genetics on an individual's predisposition toward schizophrenia; and identify the underlying biology of the illness overall. To learn more about the studies underway or to volunteer as a participant, visit the NIMH Web site at www.nimh.nih.gov.

Information dissemination to consumers through a network of national, state and local partners also assists in dispelling myths about mental illness and promoting access to treatment. The NIMH offers high-quality brochures and fact sheets addressing the full range of emotional disorders. The MHA of NYC's public education team distributes these materials at mental health screenings, health fairs and seminars. Clients of the MHA of NYC's family service programs may gather relevant materials at our fully stocked resource libraries located at MHA of NYC sites in Manhattan and the Bronx.

As an outreach partner with the National Institute of Mental Health, the MHA of NYC is working to promote research, education and access to treatment for people with mental illness.

Learn more about the NIMH including the Partnership Outreach Program, research studies underway and how to participate as a subject, and available materials for all mental illnesses, at www.nimh.nih.gov. To find out about support networks for people diagnosed with schizophrenia, or for referrals to treatment call 1-800-LIFENET, the mental health crisis, information and referral hotline operated by the MHA of NYC. □



A Self-help Model to Serve The Dually Diagnosed

By The Jewish Board of Family and Children's Services

To meet the needs of individuals being discharged from psychiatric hospitals during the deinstitutionalization of the early 1980s, the Jewish Board of Family and Children's Services opened its first day treatment program in the Bronx. Today that program, the Bronx REAL, is a comprehensive center offering a full range of support, rehabilitation, and housing services. It stands as a model for the provision of meaningful and effective services for individuals living with a serious mental illness. It is part of the agency's citywide array of treatment and residential programs located in Brooklyn, Manhattan and Queens, in addition to the Bronx. The division, led by director Susan Bear, includes continuing day treatment, intensive psychiatric rehabilitation, intensive case management, consumer self-help programs, mental health clinics, transition and supportive housing.

JBFCS programs offer services tailored to meet each consumer's individual needs and reflect the communities in which they are located. Over the past twenty years, with advances in our understanding of the treatment of psychiatric illness, JBFCS programs have continually changed to meet the evolving needs of its consumers. Experience has led to refinement of programming and development of new approaches to treatment. One such area which has developed in recent years is the treatment of those with dual diagnoses, mental illness and chemical addiction. One such program has made an enormous difference and is now an integral part of the Bronx REAL continuum of services.

The Bronx REAL Center (Rehabilitation and Education in the Art of Living) offers a full range of support services. Founded on a deep respect for the individual person and the healing power of community, the Center provides a continuum of care for individuals diagnosed with a serious and persistent mental illness The program serves adults 18 years and older who demonstrate functional impairments such as difficulties in self-care, daily living and social and vocational functioning. By offering its full range of services "under one roof", the Center stands as a model for effectively meeting the changing needs of individuals living with persistent mental illness. Seamless movement between programs gives consumers a sense of security and confidence in staff they have come to know and trust, in a building that for many feels like home. Having this comprehensive center has strengthened each of the individual programs of the Bronx REAL.

Staff came to appreciate the ever-growing evidence that Bronx REAL consumers diagnosed with schizophrenia were also combatting addiction. The Bronx REAL faced this challenge head on, leading to the creation of REAL Recovery.

The Bronx REAL Recovery Consumer Self-Help Program, beginning its seventh year of operation, is a MICA (mentally ill/chemically addicted) program known as REAL Recovery. It was designed to increase the overall effectiveness of the Center by improving its outreach to and collaboration with those consumers with both a psychiatric disorder and histories of substance abuse who desire support in order to maintain their abstinence. The staff has created an environment where consumers of the Self-Help Program facilitate a helping support system for other consumers who may be at greater risk of psychiatric or substance abuse relapses and inpatient treatments.

REEAL Recovery was designed to:

- Facilitate the opportunity for consumers with dual diagnoses to achieve dual recovery and prevent relapses of both disorders

- Stress the importance of clients helping each other in the formal setting of groups and peer counseling and in the informal connection of the milieu. The program strives to provide an atmosphere for rehabilitation through goal attainment, selfempowerment, and skill mastery by allowing consumers to consistently participate and take leadership roles in the running of the program

- Assist members in obtaining better integration into existing community supports and treatments in order to achieve improved stability in their dual disorders

- Provide a forum for members to carry a message of recovery to others who experience dual disorders and to support healthful and drug-free endeavors (social, recreational, educational, and vocational) in all members

The program aims to increase the length of time in drug/alcohol sobriety; reduce the frequency of inpatient psychiatric and detoxification interventions, help consumers better articulate their drug/alcohol cravings to peers and staff; increase consumers medication compliance; increase the availability and frequency of peer socialization experiences among recovery-minded consumers; and increase use of community supports.

REAL Recovery is a program which has seen a great deal of success over the seven years since it was created helping consumers live more productive lives while coping with a mental illness, particularly schizophrenia, and an addiction. Consumers and staff together have created a safe and supportive community based on trust and caring which integrates the latest thinking in the field of psychiatry and integrates the tools learned over the 20 years since the Bronx REAL first opened its doors. □

Westchester County Department of Community Mental Health
"Here To Help You"

Staff Writer
Mental Health News

The Westchester County Department of Community Mental Health (DCMH) has been helping individuals and families living with schizophrenia for the past fifty-one years. We not only provide direct clinical services but have instituted structures that enable those individuals to obtain case management and housing services throughout the county through our single point of access system (SPOA). We have developed programs to help individuals who have been involved with the criminal justice system to get appropriate mental health and/or substance abuse treatment thus avoiding recidivism. The *TASC* program (Treatment Alternatives for Safer Communities) and *Alternatives to Incarceration* are two voluntary programs offered to help individuals with mental illness avoid jail. We also have developed programs to help homeless individuals with mental illness to gain supports and seek out treatment with the help of our case managers.

Westchester County also works through not for profit agencies located in your community to deliver quality services. Our department obtains and manages funding for services from New York State offices and other sources such as the federal government. We help local agencies meet financial and legal requirements for using public monies.

According to Dr. Jennifer Schaffer, Commissioner of DCMH, "our goal is to help anyone who may be suffering from serious mental illness," Types of these illnesses include schizophrenia, bi-polar disorder, major depression schizo-affective disorder, developmental disabilities, and mental retardation. In addition, people with alcohol, and substance abuse problems are helped. "We also help individuals with anxiety, depression, phobias, adjustment disorders, and other psychiatric disorders—and our mission in all of these areas is to make sure that individuals and families receive the necessary treatment and supports needed, added Dr. Schaffer.

Jennifer Schaffer, PhD

Westchester County DCMH offers direct mental health treatment services to our residents. We have four outpatient clinics that serve children, adolescents and adults. Our clinics are located in Mount Vernon (914) 813-6220, Yonkers (914) 231-2925, Mount Kisco (914) 864-7101, and Peekskill (914) 862-5130. All of our clinics are able to provide evaluations for medication, verbal therapies and Spanish speaking services. Our Peekskill clinic is also able to provide mental health services to individuals who have both mental health problems and developmental disabilities. Various types of insurance and Medicaid are accepted and no one is refused help if unable to pay.

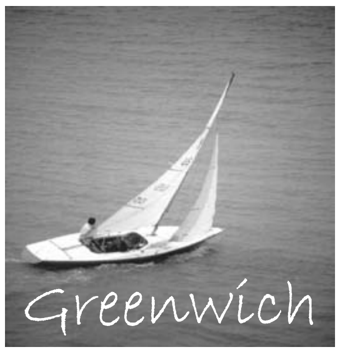
DCMH is also the single point of access for persons with mental illness seeking housing and/or case management services. We have an application process and work with all agencies in the county who provide these services. We have staff available to help you with this as well. Please call (914) 995-5278.

If you or anyone in your family has trouble with alcohol and/or substance abuse problems, our department can assist you in finding the right place for you to begin getting help. We can also refer family members looking for support and general information to the appropriate places to learn about addiction disorders. For more information please call (914) 995-5258. If you or your family member is suffering from both a mental illness and an alcohol substance abuse disorder please call (914) 995-2703 for help.

The Westchester County Department of Community Mental Health is a resource for all those who live in Westchester County. We are here to help you find the services that you and your family may need. Many services are now available for Spanish speaking individuals and families. Our main number is (914) 995-5221 and our website, www.westchestergov.com/mentalhealth/ has valuable information.

Mary DeVivo, C.S.W., is the Coordinator of Community Education for our department; she can be reached at (914) 995-4534. She is also available to assist in finding speakers for local groups to educate you about our department and/or any mental health topics that groups may interested in. □

For Suicide Help
Call (800) 273-TALK



Mental Health News
The Connecticut Section
Hartford BRIDGEPORT Stamford Kent New London

We Are Not Our Illnesses, We Are Not Our Diagnoses: Lessons About Mental Illness Taught by Residents of A Forensic Program

By David M. Howe, LCSW, Director
Organizational & Staff Development
Connecticut Valley Hospital
Whiting Forensic Division
Connecticut Department of Mental Health and Addiction Services

More than two hundred people call the Whiting Forensic Division of Connecticut Valley Hospital home. Half live under conditions of maximum security, half in medium security. Most were found not guilty by reason of mental disease or defect; a smaller group was found not competent to stand trial. In its thirty-year history, Whiting has transitioned from an autonomous institute with a primary mission of custody, to a division within a larger state psychiatric hospital whose primary mission is to promote the recovery of individuals with severe and persistent mental illness.

In recent years, the recovery mission and treatment philosophy of the Connecticut Department of Mental Health and Addiction Services have made exciting inroads in the forensic arena, resulting in a transition from one culture to another. Although many staff approached the transition away from custody and control with trepidation, a gradual shift is taking place that is benefiting residents, staff, and administrators alike. A number of emblematic activities have taken place that illustrate the benefits of the new culture. They include the creation of a resident/staff steering committee that represents all residents and communicates and negotiates with staff and administrators around all aspects of their lives at Whiting; the development of a staff training curriculum focused on the indignities of institutional life entitled “Through the Eyes of Another”; and another focused on the adverse impact of hallucinatory experiences, entitled “Coping with Disturbing Voices”. We describe below another such activity, namely the creation of a film containing personal accounts of residents’ struggles with mental illness.

Systematic institutional self-examination revealed that nurses and mental health workers possessed solid psychiatric knowledge about severe mental illness but a limited appreciation of its impact on people's lives. To overcome this, we turned to the “experts” for help, namely our patients. A number of them had completed an advocacy program entitled “Recovery Speaks”. The Recovery Speaks group (RS) assisted by a social worker, a chaplain, and an advocacy instructor decided to develop a video account of their experience with illness. "Understanding Schizophrenia" is a 30-minute DVD. All group members have struggled with schizophrenic illness or another psychotic illness. RS worked on the project for two hours every other week for a few months. RS used the outline of the program "Illness Management & Recovery" (IMR) as a rough template of topics to cover. That program was chosen because of its clear language and its enlightening descriptions of symptoms. The group also benefited from the valuable input of the primary author of the program, Susan Gingerich.

In an initial version of the video, RS members read the text of the IMR program in front of a digital camera manned by our chaplain, speaking into a hand-held microphone. After a rough start, members got increasingly comfortable with the written material and with the camera. As the group practiced, it cut back on the text reading. Speakers became increasingly adept at selecting personal experiences to speak directly and extemporaneously to the audience. In the final version, all on-screen reading was eliminated. Video chapter titles that describe symptoms are read off-screen by members of the group. As the project evolved, participants also became increasingly thoughtful about and at ease with giving feedback to other members about how to communicate effectively with the audience through the camera.

The strength of this presentation lies in its unscripted nature and its spontaneity, which is the format participants chose. They clearly communicate their eagerness to participate in a dialogue built on “here I am” and “this is who I am.” There is no window dressing or concern for choosing comments for a particular audience.

As soon as the first presenter starts speaking, an intimate connection is established between the panel members and the audience. It is borne of the very personal accounts of the symptoms of schizophrenia each speaker gives. The comments hit home because the audience can read in the presenters’ facial expressions, tone of voice, and body language, the feelings behind them. As one speaker relates that “I didn’t know what schizophrenia was….even after I had it…it was very vague to me”, he opens the door for viewers to appreciate the individual manifestation of illness.

In the words of the panel members, stigma is transformed from an abstract concept to a painful reality. One panel member recalled his family driving by a place identified as “the insane asylum…crazy people live there.” Experiences with family and friends, following the onset of illness, were described with the sensitivity of reaction apparent.

One of the most powerful moments in the presentation was the segment on the impact of treatment and hospital staff upon the course of hospitalization. Anyone experienced with healthcare settings can appreciate the statement: “some staff members, I’m excited when they come in and I look forward to it. Others, I just as soon they didn’t come in.” One speaker eloquently described the value of “compassionate challenges” and “being real”. Examples were given of the positive impact of “focusing on what you can do” and that “diamond in the rough who helped you set goals.”

Recovery is described in a very real and personal language that touches viewers. From the plea that “it is *so* very, very important to be encouraged” to the benefits of developing coping and people-skills, and the recognition that “we brought ourselves here, but we can also help ourselves out of here”, the

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The Story of L.A.
A Client at Connecticut Valley Hospital

By L.A.
Middletown, Connecticut

My name is L.A. I am a client on the Traumatic Brain Injury unit at Connecticut Valley Hospital (CVH). I was asked to talk about how my recovery process is going.

Let me tell you a little about my history. I have had a mental illness since the age of 20. I was put in a psych hospital because I was a suicide risk. I spent 3 years at Norwich State Hospital which was a really hard life for me back then. I don't really want to talk about it. Let's just say I have come a long way.

I have been at CVH for 3 years now. When I first got here I was a total wreck. I was very depressed and stayed in bed a lot not caring about myself. I was a total wreck until the past year.

Now I look forward to life. Each day is a new beginning. I have developed a relationship with my heavenly father. Plus I love to read spiritual books as well as the "Chicken Soup Books" series. I've learned to love myself more and hate myself less. I've been doing really well now. I stay real busy by working at separate things. I like feeling like this inside—happy and content! Plus I don't feel so stupid anymore. I take that bad attention off myself and put it on things I know I can do and I do them.

Our unit has a monthly newsletter called "Cottage Press". I really enjoy doing it each month. I look forward to looking up different materials for articles for this newsletter. I have learned a lot about things doing this.

About a month ago I went to a recovery council. There was a lady named Mary Ellen Copeland. She was talking about recovery. Listening to her I knew I had a chance.

She has a book out called *WRAP: Wellness Recovery Action Plan.* It has helped me very much.

I would like to thank CVH for all the work they have done for me and other clients. They take us all in the community to movies, horseback riding, fishing, shopping, sailing, and more.

I really enjoyed the horseback riding we got to do. It was my favorite. It helped my self confidence and self esteem.

We get to go to Page Hall a lot. There is a social club two times a week there. It's so fun seeing people there and playing games with staff and friends. We also go to Recovery Council there once a month. I spoke about things that interest me once at the council.

I have a lot more friends now including staff who will take some time to talk to me when I need it. They tell me "good job L.A., Keep it up!" I plan not to let them down or myself.

CVH has a lot of wonderful people working here: The doctors, nurses, mental health workers, and the whole treatment team. The support I get from everyone here helps me so much.

God bless you all very much. □

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discussants take proud responsibility for themselves without pointing fingers. As we hear "I'm one of the lucky ones who had the opportunity to work on the quality of my life," the audience feels the threads of relatedness that connect us all.

About 350 people have seen the video thus far. Consumers, advocates, clinicians, CT Dept. of Mental Health and Addiction Services dignitaries, community members, medical residents, newly hired CVH employees, and others have reacted overwhelmingly with enthusiasm. The RS members feel a justified sense of pride and accomplishment, as do the project facilitators. They describe their feat as a personal victory and as solid evidence of their progress on the road to recovery. The project represents a significant move away from an old paternalistic stance in patient care towards a collaborative one. We are finally letting our patients inform us of what helps them, and we are all the better for it.

We wish to give special thanks for help in writing to: Richard N. Bennett, MPA, Director, Whiting Forensic Division, CT Valley Hospital, and Marc Hillbrand, Ph.D., Chair of Psychology, CT Valley Hospital □

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enabling them to live independently," Ms. Platz adds.

Stephen P. Fahey, President and CEO, notes "I am pleased that Joyce will lead expansion of our community residential services and look forward to Hall-Brooke continuing to make significant contributions in promoting the health and well-being for persons with behavioral health issues. I can think of no person better qualified to lead Hall-Brooke in this important level of services. Joyce made significant contributions to Hall-Brooke in various roles over the years and her expertise in mental health management, budgeting, grants management, and program development, has been invaluable."

Ms. Platz holds a degree from the University of Connecticut in Human Development and Family Relations and a Certificate of Advanced Study from Fairfield University in Health Care Administration. She lives in Fairfield with her husband and their daughter. □

Reflections from page 5

littering of empty paper candy wrappers. There were no poems written by her hand, the only evidence of her life was her illness and her overwhelming obsessions.

My father left home when I was nineteen. Filled with, among other things, guilt about his genes and the disease that he believed he had passed on to me. When all is said and done, he has been my greatest loss. Yet, what saved me from the depths of mental illness was my own passionate determination to find some form of communication with the outside world. I was driven towards the desire to create and to touch fingertips with an attendant soul. Luckily, there were those nearby who were waiting. Art is a universal language made viable and authentic by it's propensity towards an immediate connection. The acknowledgment and receiving of that connection can be a profound experience for an individual in isolation. Despite family genetics and the thirty years of arduous and unrelenting perseverance through a gamut of dysfunction, I survived and I emerged. As a small child I often dreamed about saving a human life, including the fallen birds in the woods outside my family home. I wanted to be a doctor and a healer. I wanted to make a difference in someone else's life. Little did I know at that time, that it was my life that I had to save.

Left with a major loss, perhaps, but despite my father's absence, despite his own limitations and his own personal vulnerabilities, he managed to pass on to me in the years I had with him as a child, was the one tool that would help pry me out from the grips of psychosis. It's the one tool that each and every one of us need so desperately in this changing world in which we live. He gave me a love of art and a profound respect for nature and the creative spirit!

Turning over rocks as a child, I was always amazed how so many intricate, little creatures could survive and carry on their daily routines under such an enormous weight.

Turning over the human mind can be as equally bewildering. Being diagnosed repeatedly with Paranoid Schizophrenia was like being given a death sentence. Though I was never actually told my diagnosis until years later. In 1976, during an inpatient stay at Butler Hospital in Providence, Rhode Island, when I failed to recognize my brother who had come to visit me, he was pulled aside by staff and told, "get used to seeing your sister like this because this is how she will always be." My father, a few years later, was told in front of me, that I would probably be institutionalized for the remainder of my life.

Today, as I sit here in my home of twenty years, it is a beautifully serene, bright summer day. My cat, Africa, is sound asleep at my side and I am perfectly content.

Were they wrong with their diagnosis? If so, how does one explain ten years of severe psychosis and deterioration and twenty years of reinvention and recovery? Learning how to brush my teeth, change my underwear, speak, eat, walk, and think differently? How does one explain an ego that is left thoroughly ravaged with more holes than Swiss cheese? Had they miscalculated somehow? Certainly, if you meet me today, you might think so. Or, was the diagnosis right and their expectations for human survival wrong??

Even under the enormous weight we all carry, we are the ones ultimately responsible to reevaluate the fate of the human mind and heart. How we experience our reality is our own. If we are determined to move beyond limitations, we must question our expectations. There is enough evidence out there to suggest immense human resilience.

Like the tiny ants, dragging around their daily burdens under the weight of those gigantic rocks. Or the tree limb that wraps itself around a fence to get to the light. We underestimate the potential, the enormous vitality, resourcefulness and creativity of life. A thrust towards optimism is what is needed. To build a fire underneath ourselves and to finally acknowledge and give honor to the individual unique strength in each of us to survive, endure and excel.

In 2004, Susan Weinreich received the Eli Lilly Reintegration Award for "Artistic Achievement" and the Westchester County Mental Health Award. Ms. Weinreich's work is in the collection of countless individuals and institutions including Four Winds Hospital in Katonah, NY and Eli Lilly and Company in Indianapolis, Indiana. Her upcoming exhibition of drawings opens October 7, 2005 at the Northern Westchester Center for the Arts in Mt. Kisco, NY. for more information about her work please visit www.susanweinreich.com □

Medicare from page 27

individuals receiving mental health services, as they may lose coverage for some of the drugs upon which they have relied.

By the middle of November 2005, CMS will automatically enroll the dual eligible population (Medicare/caid) into one of the low cost Medicare Part D plans in their region. Unfortunately the enrollment process will not take into consideration the unique medication needs of an individual. It will instead be a random plan which has a low cost factor for the federal government. Dually eligible individuals will have the opportunity during the six weeks from November 15 to December 31, 2005 to look at the various plans offered and select another one if it better suits their needs.

Potential Pitfalls

The Coalition is concerned about the effect these changes will have, particularly on the dual eligibles and especially on mental health consumers. While it is believed that drug plans will offer a broad choice in the six categories specifically identified by CMS, there is still a strong possibility that certain other necessary drugs will not be available and this will put the consumer at risk. Provider agencies will need to be prepared to assist the consumer in making the best choice possible to minimize potential destabilization.

Consumers will have several opportunities to have non-formulary drugs covered by their plan. First the consumer or his/her doctor may ask the plan provider for an exception (coverage determination) for a drug not included in the plan's listing. The response from the plan provider should be issued within 24 hours for an expedited case or within 72 hours for a standard review. If that fails, the consumer may go through an appeals process which goes beyond the plan provider to an Independent Review Entity, then an Administrative Law Judge and finally the Medicare Appeals Council. The Coalition is very concerned that NY State has not finalized any safety net plans to provide the necessary medications to a consumer during what could be an extended appeals process.

The Cost

For a general policy, expect premiums to be about $37 per month, or about $444 per year. After an initial $250 deductible, individuals will pay a 25% co-payment for drug costs between $250 and $2,250. Individuals then pay 100% of the next $2,850 in drug costs, up to $5,100. After that, "catastrophic" coverage kicks in and Medicaid will cover 95% of the drug costs with the individual responsible for a co-pay of between $2 to $5.

Financial Help

Because the dual eligible population by definition consists of individuals with low incomes, the government created a Low Income Subsidy (LIS) program which will eliminate the premiums and deductibles required of others enrolling in Medicare Part D. The dual eligibles, along with Medicare consumers who have Medicare Savings Plans (MSP) or receive Supplemental Security Income (SSI), will be automatically enrolled in the Low Income Subsidy program. Dual eligibles will be required to make small co-payments of either $1 to $3 or $2 to $5, depending on their particular income levels. They will not be responsible for annual premiums or deductibles.

For non-dual eligible individuals with incomes between 135% and 150% of the Federal Poverty Level (FPL) and assets below $10,000 for individuals ($20,000 for couples), there will be a sliding scale premium, $50 deductible, 15% co-pay for drug costs between $50 and $5,100 and co-pays of $2 to $5 for catastrophic coverage over $5,100. People whose incomes are under 135% with assets below $6,000 for individuals ($9,000 for couples), will have no annual premium, no deductible, $2 / $5 co-payments up to $5,100 and 100% coverage over $5,100.

The entire process will likely be very confusing to Medicare consumers. Providers will need to be prepared to assist consumers applying for the low income subsidy and in making the appropriate decisions regarding plan selection. The Coalition has many resources listed on our website www.cvmha.org. Just click on the Medicare Part D button.

The Coalition questions CMS's decision to include dual eligibles in Part D at all. Consumers with both Medicare and Medicaid coverage did not need "fixing;" their services and prescriptions were already covered. So why did CMS include them? The speculation is because there was minimal enrollment in prescription discount drug card programs, CMS needed "buy-in" from consumers to encourage insurance plans to participate. The 7 million dually eligible individuals around the country who lose their Medicaid pharmacy coverage on December 31, 2005 would guarantee an initial enrollment. Now the dual eligible population will be subject to co-pays, which may be a hardship, and potential destabilizing changes and interruptions in medication.

The Coalition of Voluntary Mental Health Agencies, Inc. is the umbrella advocacy organization of New York's mental health community, representing over 100 non-profit community based mental health agencies that serve more than 300,000 clients in the five boroughs of New York City and its environs. Founded in 1972, The Coalition is membership supported along with foundation and government funding for special purpose advocacy and assistance projects. □

The
Coalition
of Voluntary
Mental Health
Agencies, Inc.

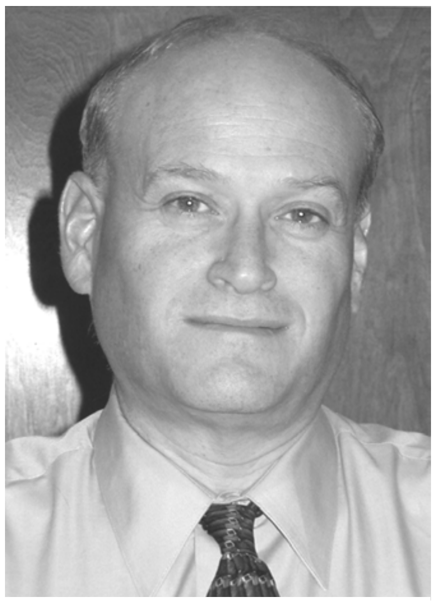
Stopping The Stigma of Schizophrenia

By Glenn Liebman
Executive Director, Mental Health Association in New York State

As a follow up to the President's New Freedom Report, a group of national advocacy organizations including the National Mental Health Association put out a roadmap for transformation. The lead quote from the report was that, "1 out of every 2 Americans who need mental health treatment does not receive it." That is a startling number. We already know from prior statistics that in a given year, that there are over 20% of Americans who have mental illness. If you combine these two numbers, it means that ten percent of the population (close to thirty million people) of the United States have a diagnosable mental illness that goes untreated every year.

The number one reason cited for not seeking treatment is the stigma associated with mental illness. Nowhere is this more evident than with individuals with schizophrenia. In a society, where people are willing to speak out and our open about many things, few still have the courage to openly talk about mental illness. Mental illness continues to be one of the last bastions of stigma in our society.

Everywhere in society, we see examples of the stigma of mental illness. Many of us are familiar with the Crazy Vermont Teddy Bear who came with his own commitment papers. Due to the work of the Vermont MHA and Vermont NAMI, they were able to raise the visibility of this issue and point out how offensive it is to the millions of people with mental illness and their loved ones including the over 2.5 million Americans with a schizophrenia diagnosis.



Glenn Liebman

Stigma examples are rampant in all aspects of society from the clothes we wear to the movies we see. One of the most popular selling tee shirts and sweatshirts among teenagers is one that says--Psych Ward. All you have to do is turn on the television or go to the movies to see examples of people with mental illness as violent, out of control maniacs who are likely to kill their victims for no good reason.

The worst stigma of all happens at the earliest of age. Television shows geared to children are filled with references to people being crazy, psycho, nuts, wacko, etc. As the father of a ten year old son, I find that very offensive and I am glad my son is also cognizant of this stigma. Much of the conversations that I here in my son's school and among his peers is describing people as nuts and psycho. How can we ask people to be courageous and openly talk about their mental illness when even at the earliest of ages, there is such stigma associated with the illness. Thankfully, there has long been an invaluable resource that identifies stigma issues throughout the country---the National Stigma Clearinghouse.

Then when we have celebrities who have the courage to come forward and talk about their mental illness such as Brooke Shields, Carrie Fisher and Lorraine Bracco. Then you have other celebrities like Tom Cruise and Kristie Alley, (who are about as much experts on psychiatry as I am on acting), telling the world that there is no such thing as mental illness and that antidepressants and other medication don't work. Talk about adding to the stigma of mental illness.

We have to use all of our resources to combat this stigma and tell people the real story about mental illness and recovery. We throw around the word hero a lot in our society. I am a sports fanatic but do I think that Derek Jeter or Peyton Manning are heroes--of course not. The real heroes are the individuals with schizophrenia and other mental illnesses who openly talk about their illness and work hard to get better every day. Because of their examples of hard work and courage on daily basis, we know that people do recover. There are arrays of services available to help enhance recovery---case management, psychosocial supports, self help, drop in centers, housing, employment, education, counseling and better medications with fewer side effects than in the past. The recovery rate for mental illness, based on research from the National Advisory Mental Health Council, is higher than the treatment success rate for many physical illnesses.

We need to get out the message of recovery and engage those millions of Americans who are afraid to seek treatment. How do we do this? We must create a statewide campaign to end the stigma of mental illness. The Mental Health Association in New York State is fighting for a bill in the New York State legislature that would create a tax check off in the New York State Tax forms that would provide for a specific funding stream dedicated to a public awareness campaign to end the stigma of mental illness. There are other ways as well. We must continue to go out to the community and talk to our friends and colleagues in other fields about mental illness. Another great avenue for ending stigma is by joining the Timothy's Law Campaign which calls for the ending of discriminatory practices in insurance coverage for mental illness.

There is such a compelling message of hope and recovery to tell to the general public and to the large number of people with mental illness who do not seek treatment because of the stigma associated with the illness. We need all of us in the field to work together to end this stigma. Please contact us and support our efforts to create tax check-off to fund anti stigma efforts.

To help show your support for our mission and anti-stigma efforts, we invite you to participate in our upcoming events.

On the evening of October 20th at the Marriott Hotel in Albany, we will be holding our awards dinner and the showing of the documentary *Out of the Shadows*, a compelling story about one women's journey through the mental health system as detailed by her daughter, film maker, Susan Smiley . For those who have not seen the documentary, we urge you to see it and witness this moving story about perseverance and hope.

On October 21st, also at the Marriott Hotel, our organization is holding a one day conference on topics that are relevant to all of use in the mental health system including Medicare Part D, PROS, Juvenile Justice and Childhood Depression.

For more information, contact us at (518) 434--0439, ext. 22 or log onto our web page at mhanys.org. We hope to see you there. □

New Context from page 1

useful ways. In the recovery paradigm, these contributions are seen as important parts of a person's broader efforts to reclaim his or her life. Treatment contributes to recovery, but should not be confused with it. Mental health providers offer treatment; the authority and responsibility for recovery remains in the hands of the person trying to recover.

When mental health providers first hear about recovery principles, they often insist that this is what they have been doing all along. As early as the late Eighteenth Century, didn't Pinel unchain psychiatric patients and begin espousing what came to be called "moral treatment"? At the beginning of the Nineteenth Century, did not this movement give rise to hospitals where people were to be treated with greater kindness and dignity than had been the custom? All true; and yet many people who have experienced our mental health system first-hand have terrible stories to tell. These experiences range from the subtly obnoxious to the hideously appalling. To assume, however, that the beacon of science has now been cast on the dark happenings of past years would be to miss some essential human dilemmas involved in delivering mental health services.

It should probably not come as a complete surprise that delivering mental health services has sometimes strayed into practices that are not helpful to people. Originally, mental health care was more about protecting society than caring for people with illnesses. When doors are locked and not everyone has the keys, bad things sometimes happen. People have always had a tendency to abuse power under these circumstances. Western Medicine has always leaned towards authoritarian traditions. Anyone who has spent time in any sort of hospital knows the experience of staff barging into rooms without knocking and other deviations from common courtesy. In our society, also, respect is largely based on money, power and position. People who cannot compete successfully for these currencies are often felt to lack character.

Many forces, then, have led mental health providers to unintentionally undermine the efforts of people to recover aspects of their lives lost through the ravages of psychiatric illnesses like schizophrenia. It seems likely that it will require relatively dramatic measures to change this situation. Making these efforts even more elusive are the rising expectations of insurance and accrediting agencies. Insurers, after all, are accustomed to paying for "treating illnesses," not for helping people realize their hopes and dreams.

Before suggesting what sorts of measures might result in useful changes to how mental health services are delivered, it is important to emphasize that we are not considering here changes in treatment; we are talking about changes in the CONTEXT for treatment. It remains the province of mental health providers to provide the same sorts of pharmacological, psychological and psychosocial interventions that we have offered for years; that is, after all, what we know how to do. What, then, must we do differently?

My first suggestion involves a change of attitude. To whatever extent our educations have left us feeling like powerful healers, we should replace this with a sense of being humble technical consultants. If we have somehow come to view the people with whom we work with discouragement and pity, we should try to replace this with respect for the courage that so many people maintain in the face of daunting disappointments and challenges. If we have become infused with excitement about the glorious science that guides our work, we should remind ourselves of how crude it remains. And finally, if the foolish and highly-publicized assaults on our professions have rendered us defensively self-righteous, we should remember the darkness that repeatedly creeps into our offices and hospitals.

If all we change is our attitude, however, it would be safe to predict that

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change would be subtle at best. Let me suggest a few examples of concrete changes in clinical practice that might make a difference.

I have suggested that the problems with traditional practice lie not so much in the technical interventions themselves, but rather in the lack of a clear context for treatment. Look, for example, at a competently composed treatment plan and you will tend to see an adequate accounting of the relevant clinical interventions (e.g., medications, psychotherapies, rehabilitative work, case management, etc.). It is much less likely, however, that you will find an accounting of the person's hopes and dreams and a coherent roadmap for their pursuit.

Practical readers might well be rolling their eyes at this point and asking a realistic question like, "Has this moron forgotten that we need to get paid, and that we face JCAHO accreditation every few years?" Clearly, these issues cannot be ignored. If anything, our treatment plans need to be more attuned with the "best practices" being constantly redefined by research. And we need to justify continuation of expensive interventions more than ever before.

So here's the point: treatment plans (and everyday progress notes, for that matter) need to accomplish both sorts of tasks: the technical justification for treatment (not new) and the human context for treatment (definitely new). These two distinct challenges cannot be addressed through an artistic blending of clinically sophisticated and "client-centered" language. Instead, we need to recognize that a treatment plan needs to include both kinds of elements. They need to be addressed separately, and the relationships between these two aspects of the treatment plan must be discussed explicitly.

At Capitol Region Mental Health Center, in Hartford, Connecticut, we have begun the ambitious task of defining the very real practice changes required to integrate excellent clinical care into more meaningful life contexts. While it would be pretentious at this early stage to attempt to define the best way to compose treatment plans, it seems relevant to report on how we have reached a point of genuine optimism.

Over the past few years, several people who have struggled with severe psychiatric illness have worked their way on to the staff of Capitol Region. They form what we call the Peer Support Program, and have come to be accepted as important members of our treatment teams. (The considerable challenges inherent in this process warrant separate discussion.)

A plan to interject their input into our existing treatment planning process was implemented and studied over a six-month period. To our disappointment and surprise, we discovered that our treatment plans continued to reflect little recovery-oriented thinking.

A work group was assembled, including Peer Support staff and clinical staff who were considered to be both excellent authors of clinical documentation and receptive to recovery principles. With refreshing ease, we concluded that our treatment plans would include recovery principles only if we made fundamental changes both to the structure of the documents themselves and to the process by which treatment plans are written. Although it would be premature to report on the details of our efforts, it might be helpful to provide an example of a concrete change that is being introduced.

Before a treatment plan is begun, we will schedule a meeting that includes at least the person, family members and/or significant others, a Peer Support staff member, and the clinician. The main purpose of this meeting is to collect the goals for the treatment plan. Without dwelling on technical details, suffice it to say that these "goals" drive the treatment plan "objectives," which, in turn, drive the structure of everyday progress notes. The interests of the person in recovery drive the process, since the structure of the treatment plan and subsequent progress notes are both built on the list of goals.

For those who have never had the pleasure of constructing a more traditional treatment plan, it might be helpful to explain that these documents tend to be built on a "problem list" designed by the clinicians. (A person whose main interest is to "get off all meds," for example, might find this translated into a "problem" like "Medication non-compliance" and a matching "goal" like "Medication compliance.")

Our group recognizes the need to include such traditional constructs as "problems" in our new treatment plans (since insurers are accustomed to paying for treating them). We have come to believe, however, that it is critical to keep "goals" and "problems" distinct. Goals have to do with living; problems have to do with treatment. These two concepts are related, and that relationship needs to be expressed in the treatment plan. To confuse them, however, is to guarantee the creation of a treatment plan into which the life of a person seems to dissolve.

If your eyes, Gentle Reader, weren't rolling earlier, they are certainly glazed over by now. The point here, however, is not to argue for particular approaches to treatment planning or its documentation. It is, instead, to suggest that a meaningful shift towards recovery-oriented treatment requires a commitment to profound changes.

System change, however, is complicated, difficult, painful, expensive and unpopular. In an environment of constrained resources, only the most critical changes can be prioritized. At Capitol Region, we made a clear decision to establish implementation of recovery principles as a major strategy. Eventually, we hope to be able to demonstrate that this has increased our effectiveness in helping people regain valued aspects of their lives. Already, we are experiencing a growing vitality in our treatment planning. Initially received with polite skepticism, the recovery movement has firmly taken root. With just the right combination of water and sunlight – and a sophisticated sprinkling of fertilizer – we anticipate the growth of a whole new way of working, and, for persons in recovery, of finding more fulfillment in their lives.

We have come to believe that it is critical to keep "goals" and "problems" distinct. Goals have to do with living; problems have to do with treatment. These two concepts are related, and that relationship needs to be expressed in the treatment plan. To confuse them, however, is to guarantee the creation of a treatment plan into which the life of a person seems to dissolve. □

Capitol Region Mental Health Center is the local mental health authority of the State of Connecticut Department of Mental Health and Addiction Services serving the towns of Hartford, West Hartford, Farmington, Avon, Canton, and Simsbury. It is located at 500 Vine Street, Hartford, Connecticut. For further information about services, please contact us at (860) 297-0800 or visit us at www.dmhas.state.ct.us/crmhc.homepage.htm

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student before his dreams lost their altitude to a mental illness.

After years of battling his disorder, Orlando was ready to recover - break through the force field of schizophrenia and identify a plan. Advocating for himself after years of personal disregard, he requested, upon completion of his present treatment, to move to a group home close to his family on Long Island. Orlando's goal was to make up for years of lost opportunities. He transitioned to Garvey House, an adult group residence operated by the Mental Health Association of Nassau County. There he was encouraged to choose between a day program, vocational training, employment or College Bound, an introductory program for young adults with a psychiatric disability who want to start or return to college.

Orlando opted for College Bound, a cooperative venture between the Mental Health Association, Nassau Community College, the Nassau County Department of Mental Health, Mental Retardation and Developmental Disabilities and the New York State Office of Mental Health. College Bound offers students an opportunity to enter a two-year academic program with the advantage of attending college in self-contained classrooms with specially selected professors. Experienced staff members attend classes with students and are available to tutor them after class. Support groups are also provided to help students prepare to enter the world of work or continue their academic studies in a traditional college format.

> "Recovery is a combination of things. Getting better happens when you utilize the system to your advantage…to the best of your capabilities. That means compliance with meds, therapy and the internal drive to want to recover. I had to hit rock bottom before I came around and saw things realistically again. When that happened I wanted the stability, I wanted to be at my best. Once you start to get your old feelings back…feelings of wellness, you don't want any other conscious state. You want to be alert, vibrant and as far away from an altered state as possible. Most importantly, knowing that there's hope - that I could get better - kept me striving."
>
> *Orlando Morales*

Orlando embarked upon an ambitious quest. He would continue his therapy and medication management and attend Nassau Community College. He would work to keep the ghosts of his past at bay and receive a two-year degree. From there, he would transfer to a four-year school and perhaps, with a little luck and a great deal of grit and determination, go onto medical school.

Orlando kept his eye on the prize—a new life and recovery. With College Bound, Garvey House and his family at his side, Orlando graduated from Nassau Community College and entered SUNY (while also volunteering his time at a local hospital). He's the first one to say that "you just don't know what you're capable of until you get started."

One in five individuals diagnosed with schizophrenia can recover completely. Orlando made the cut. No longer locked in the isolation of his illness, he has become a soft-spoken, articulate and thoughtful young man who wants to be a physician because, as he says, "I've been on both sides."

At the SUNY graduation, the skies brightened and students, their families and friends were bathed in sunshine. It was a day of invigoration, of joy and hope for everyone, but especially for Orlando Morales. His new-found confidence, his achievements, his ambitions and even his scars were all hard-earned. Orlando's take on recovery says it best, "I believe in miracles, because I'm one of them."

The Mental Health Association of Nassau County has produced a short film chronicling Orlando's recovery entitled Orlando's Story: Regaining A Life. If you are interested in obtaining a copy, please contact the MHA at 516.489-2322, ext. 113. The Mental Health Association of Nassau County is a not-for-profit membership organization dedicated to improving mental health through advocacy, education, program development and the delivery of direct services. □

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termed "thought disorder," can make conversation very difficult and may contribute to social isolation. If people cannot make sense of what an individual is saying, they are likely to become uncomfortable and tend to leave that person alone.

Emotional Expression

People with schizophrenia often show "blunted" or "flat" affect. This refers to a severe reduction in emotional expressiveness. A person with schizophrenia may not show the signs of normal emotion, perhaps may speak in a monotonous voice, have diminished facial expressions, and appear extremely apathetic. The person may withdraw socially, avoiding contact with others; and when forced to interact, he or she may have nothing to say, reflecting "impoverished thought." Motivation can be greatly decreased, as can interest in or enjoyment of life. In some severe cases, a person can spend entire days doing nothing at all, even neglecting basic hygiene. These problems with emotional expression and motivation, which may be extremely troubling to family members and friends, are symptoms of schizophrenia—not character flaws or personal weaknesses.

Normal Versus Abnormal

At times, normal individuals may feel, think, or act in ways that resemble schizophrenia. Normal people may sometimes be unable to "think straight." They may become extremely anxious, for example, when speaking in front of groups and may feel confused, be unable to pull their thoughts together, and forget what they had intended to say. This is not schizophrenia. At the same time, people with schizophrenia do not always act abnormally. Indeed, some people with the illness can appear completely normal and be perfectly responsible, even while they experience hallucinations or delusions. An individual's behavior may change over time, becoming bizarre if medication is stopped and returning closer to normal when receiving appropriate treatment.

Are People With Schizophrenia Likely To Be Violent?

News and entertainment media tend to link mental illness and criminal violence; however, studies indicate that except for those persons with a record of criminal violence before becoming ill, and those with substance abuse or alcohol problems, people with Schizophrenia are not especially prone to violence.

Most individuals with schizophrenia are not violent; more typically, they are withdrawn and prefer to be left alone. Most violent crimes are not committed by persons with schizophrenia, and most persons with schizophrenia do not commit violent crimes.

Substance abuse significantly raises the rate of violence in people with schizophrenia but also in people who do not have any mental illness. People with paranoid and psychotic symptoms, which can become worse if medications are discontinued, may also be at higher risk for violent behavior. When violence does occur, it is most frequently targeted at family members and friends, and more often takes place at home.

Substance Abuse

Substance abuse is a common concern of the family and friends of people with schizophrenia. Since some people who abuse drugs may show symptoms similar to those of schizophrenia, people with schizophrenia may be mistaken for people "high on drugs." while most researchers do not believe that substance abuse causes schizophrenia, people who have schizophrenia often abuse alcohol and/or drugs, and may have particularly bad reactions to certain drugs. Substance abuse can reduce the effectiveness of treatment for schizophrenia. Stimulants (such as amphetamines or cocaine) may cause major problems for patients with schizophrenia, as may PCP or marijuana. In fact, some people experience a worsening of their schizophrenic symptoms when they are taking such drugs. Substance abuse also reduces the likelihood that patients will follow the treatment plans recommended by their doctors.

Schizophrenia and Nicotine

The most common form of substance use disorder in people with schizophrenia is nicotine dependence due to smoking. While the prevalence of smoking in the U.S. population is about 25 to 30 percent, the prevalence among people with schizophrenia is approximately three times as high. Research has shown that the relationship between smoking and schizophrenia is complex. Although people with schizophrenia may smoke to self medicate their symptoms, smoking interferes with the response to antipsychotic drugs. Several studies have found that schizophrenia patients who smoke need higher doses of antipsychotic medication. Quitting smoking may be especially difficult for people with schizophrenia, because the symptoms of nicotine withdrawal may cause a temporary worsening of schizophrenia symptoms. However, smoking cessation strategies that include nicotine replacement methods may be effective. Doctors should carefully monitor medication dosage and response when patients with schizophrenia either start or stop smoking.

What About Suicide?

Suicide is a serious danger in people who have schizophrenia. If an individual tries to commit suicide or threatens to do so, professional help should be sought immediately. People with schizophrenia have a higher rate of suicide than the general population. Approximately 10 percent of people with schizophrenia (especially younger adult males) commit suicide. Unfortunately, the prediction of suicide in people with schizophrenia can be especially difficult.

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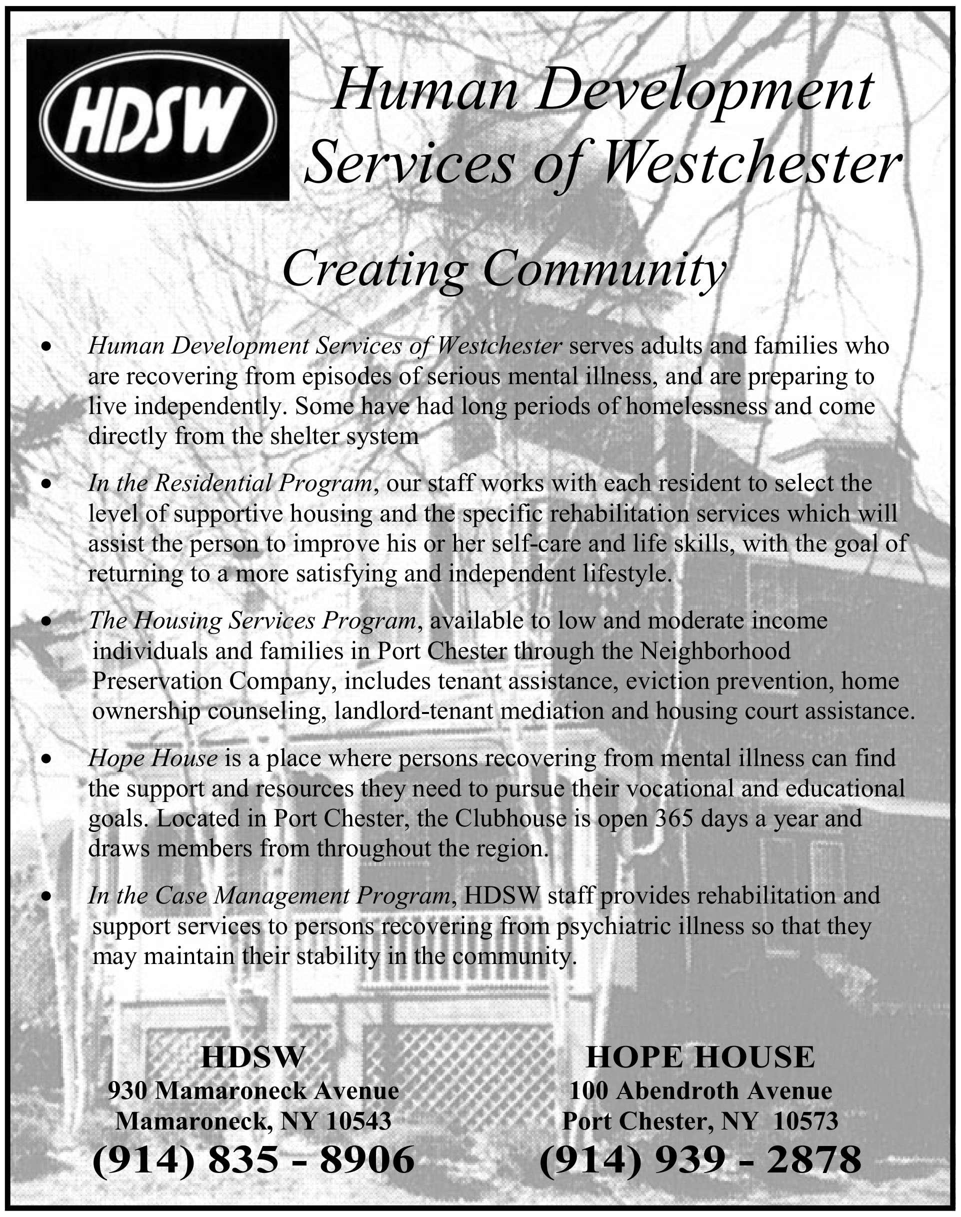

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What Causes Schizophrenia?

There is no known single cause of schizophrenia. Many diseases, such as heart disease, result from an interplay of genetic, environmental, and behavioral factors; and this may be the case for schizophrenia as well. Scientists do not yet understand all of the factors necessary to produce schizophrenia, but all the tools of modern biomedical research are being used to search for genes, critical moments in brain development, and environmental factors that may lead to the illness.

Is Schizophrenia Inherited?

It has long been known that schizophrenia runs in families. People who have a close relative with schizophrenia are more likely to develop the disorder than are people who have no relatives with the illness. For example, a monozygotic (identical) twin of a person with schizophrenia has the highest risk—40 to 50 percent—of developing the illness. A child whose parent has schizophrenia has about a 10 percent chance. By comparison, the risk of schizophrenia in the general population is about 1 percent.

Scientists are studying genetic factors in schizophrenia. It appears likely that multiple genes are involved in creating a predisposition to develop the disorder. In addition, factors such as prenatal difficulties like intrauterine starvation or viral infections, perinatal complications, and various nonspecific stressors, seem to influence the development of schizophrenia. However, it is not yet understood how the genetic predisposition is transmitted, and it cannot yet be accurately predicted whether a given person will or will not develop the disorder.

Several regions of the human genome are being investigated to identify genes that may confer susceptibility for schizophrenia. The strongest evidence to date leads to chromosomes 13 and 6 but remains unconfirmed. Identification of specific genes involved in the development of schizophrenia will provide important clues into what goes wrong in the brain to produce and sustain the illness and will guide the development of new and better treatments. To learn more about the genetic basis for schizophrenia, the NIMH has established a Schizophrenia Genetics Initiative that is gathering data from a large number of families of people with the illness.

Is Schizophrenia Associated With a Chemical Defect in the Brain?

Basic knowledge about brain chemistry and its link to schizophrenia is expanding rapidly. Neurotransmitters, substances that allow communication between nerve cells, have long been thought to be involved in the development of schizophrenia. It is likely, although not yet certain, that the disorder is associated with some imbalance of the complex, interrelated chemical systems of the brain, perhaps involving the neurotransmitters dopamine and glutamate. This area of research is promising.

Is Schizophrenia Caused by a Physical Abnormality in the Brain?

There have been dramatic advances in neuroimaging technology that permit scientists to study brain structure and function in living individuals. Many studies of people with schizophrenia have found abnormalities in brain structure (for example, enlargement of the fluid-filled cavities, called the ventricles, in the interior of the brain, and decreased size of certain brain regions) or function (for example, decreased metabolic activity in certain brain regions). It should be emphasized that these abnormalities are quite subtle and are not characteristic of all people with schizophrenia, nor do they occur only in individuals with this illness. Microscopic studies of brain tissue after death have also shown small changes in distribution or number of brain cells in people with schizophrenia. It appears that many (but probably not all) of these changes are present before an individual becomes ill, and schizophrenia may be, in part, a disorder in development of the brain.

Developmental neurobiologists funded by the National Institute of Mental Health (NIMH) have found that schizophrenia may be a developmental disorder resulting when neurons form inappropriate connections during fetal development. These errors may lie dormant until puberty, when changes in the brain that occur normally during this critical stage of maturation interact adversely with the faulty connections. This research has spurred efforts to identify prenatal factors that may have some bearing on the apparent developmental abnormality.

In other studies, investigators using brain-imaging techniques have found evidence of early biochemical changes that may precede the onset of disease symptoms, prompting examination of the neural circuits that are most likely to be involved in producing those symptoms. Scientists working at the molecular level, meanwhile, are exploring the genetic basis for abnormalities in brain development and in the neurotransmitter systems regulating brain function.

How Is It Treated?

Since schizophrenia may not be a single condition and its causes are not yet known, current treatment methods are based on both clinical research and experience. These approaches are chosen on the basis of their ability to reduce the symptoms of schizophrenia and to lessen the chances that symptoms will return.

What About Medications?

Antipsychotic medications have been available since the mid-1950s. They have greatly improved the outlook for individual patients. These medications reduce the psychotic symptoms of schizophrenia and usually allow the patient to function more effectively and

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appropriately. Antipsychotic drugs are the best treatment now available, but they do not “cure” schizophrenia or ensure that there will be no further psychotic episodes. The choice and dosage of medication can be made only by a qualified physician who is well trained in the medical treatment of mental disorders. The dosage of medication is individualized for each patient, since people may vary a great deal in the amount of drug needed to reduce symptoms without producing troublesome side effects.

The large majority of people with schizophrenia show substantial improvement when treated with antipsychotic drugs. Some patients, however, are not helped very much by the medications and a few do not seem to need them. It is difficult to predict which patients will fall into these two groups and to distinguish them from the large majority of patients who do benefit from treatment with antipsychotic drugs.

A number of new antipsychotic drugs (the so-called “atypical antipsychotics”) have been introduced since 1990. The first of these, clozapine (Clozaril®), has been shown to be more effective than other antipsychotics, although the possibility of severe side effects—in particular, a condition called agranulocytosis (loss of the white blood cells that fight infection)—requires that patients be monitored with blood tests every one or two weeks. Even newer antipsychotic drugs, such as risperidone (Risperdal®) and olanzapine (Zyprexa®), are safer than the older drugs or clozapine, and they also may be better tolerated. They may or may not treat the illness as well as clozapine, however. Several additional antipsychotics are currently under development.

Antipsychotic drugs are often very effective in treating certain symptoms of schizophrenia, particularly hallucinations and delusions; unfortunately, the drugs may not be as helpful with other symptoms, such as reduced motivation and emotional expressiveness. Indeed, the older antipsychotics (which also went by the name of “neuroleptics”), medicines like haloperidol (Haldol®) or chlorpromazine (Thorazine®), may even produce side effects that resemble the more difficult to treat symptoms. Often, lowering the dose or switching to a different medicine may reduce these side effects; the newer medicines, including olanzapine (Zyprexa®), quetiapine (Seroquel®), and risperidone (Risperdal®), appear less likely to have this problem. Sometimes when people with schizophrenia become depressed, other symptoms can appear to worsen. The symptoms may improve with the addition of an antidepressant medication.

Patients and families sometimes become worried about the antipsychotic medications used to treat schizophrenia. In addition to concern about side effects, they may worry that such drugs could lead to addiction. However, antipsychotic medications do not produce a “high” (euphoria) or addictive behavior in people who take them.

Another misconception about antipsychotic drugs is that they act as a kind of mind control, or a “chemical straitjacket.” Anti-psychotic drugs used at the appropriate dosage do not “knock out” people or take away their free will. While these medications can be sedating, and while this effect can be useful when treatment is initiated particularly if an individual is quite agitated, the utility of the drugs is not due to sedation but to their ability to diminish the hallucinations, agitation, confusion, and delusions of a psychotic episode. Thus, antipsychotic medications should eventually help an individual with schizophrenia to deal with the world more rationally.

How Long Should People With Schizophrenia Take Antipsychotic Drugs?

Antipsychotic medications reduce the risk of future psychotic episodes in patients who have recovered from an acute episode. Even with continued drug treatment, some people who have recovered will suffer relapses. Far higher relapse rates are seen when medication is discontinued. In most cases, it would not be accurate to say that continued drug treatment “prevents” relapses; rather, it reduces their intensity and frequency. The treatment of severe psychotic symptoms generally requires higher dosages than those used for maintenance treatment. If symptoms reappear on a lower dosage, a temporary increase in dosage may prevent a full-blown relapse.

Because relapse of illness is more likely when antipsychotic medications are discontinued or taken irregularly, it is very important that people with schizophrenia work together with their doctors and family members to adhere to their treatment plan. Adherence to treatment refers to the degree to which patients follow the treatment plans decided upon with their doctors. Good adherence involves taking prescribed medication at the correct dose and proper times each day, attending clinic appointments, and/or carefully following other treatment procedures. Treatment adherence is often difficult for people with schizophrenia, but it can be made easier with the help of several strategies and can lead to improved quality of life.

There are a variety of reasons why people with schizophrenia may not adhere to treatment. Patients may not believe they are ill and may deny the need for medication, or they may have such disorganized thinking that they cannot remember to take their daily doses. Family members or friends may not understand schizophrenia and may inappropriately advise the person with schizophrenia to stop treatment when he or she is feeling better. Physicians, who play an important role in helping their patients adhere to treatment, may neglect to ask patients how often they are taking their medications, or may be unwilling to accommodate a patient’s request to change dosages or try a new treatment. Some patients report that side effects of the medications seem worse than the illness itself. Further, substance abuse can interfere with the effectiveness of treatment, leading patients to discontinue medications. When a complicated treatment plan is added to any of these factors, good adherence may become even more challenging.

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special program design and training they can play valuable roles helping older adults with psychiatric disabilities.

10. *Create new financing models:* Developing the capacity to serve a rapidly growing population and to use the best medical and psychosocial service models hinges on financing. Medicare reform is essential to overcome lack of parity, to assure adequate prescription drug coverage, to provide funding for innovative home and community-based psychosocial services, and to develop incentives or mandates for psychiatrists and other mental health professionals to serve Medicare beneficiaries. Changes are also needed in Medicaid, especially to support home-based mental health services and high quality mental health services in nursing homes and home health care.

Meeting the challenges posed by the aging of people with long-term psychiatric disabilities will not be easy. But these challenges will not emerge overnight. They will unfold gradually over the next quarter century. There is time for energetic and innovative planning. Think of the enormous expansion and reconfiguration of services for working-age adults (redesigned housing, rehabilitation, case management, peer support etc.) over the past quarter century. A similar transformation, focused on older adults, is needed, and possible, today. The Geriatric Mental Health Act lays the groundwork; now policy makers and stakeholders must seize the opportunity. We can get this done—if we start now.

Michael B. Friedman is the Director of the Center for Policy and Advocacy of The Mental Health Associations of NYC and Westchester. The opinions expressed in this column are his own and do not necessarily reflect the positions of the MHAs. Mr. Friedman can be reached at center@mhaofnyc.org.) □

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Fortunately, there are many strategies that patients, doctors, and families can use to improve adherence and prevent worsening of the illness. Some antipsychotic medications, including haloperidol (Haldol®), fluphenazine (Prolixin®), perphenazine (Trilafon®) and others, are available in long-acting injectable forms that eliminate the need to take pills every day. A major goal of current research on treatments for schizophrenia is to develop a wider variety of long-acting antipsychotics, especially the newer agents with milder side effects, which can be delivered through injection. Medication calendars or pill boxes labeled with the days of the week can help patients and caregivers know when medications have or have not been taken. Using electronic timers that beep when medications should be taken, or pairing medication taking with routine daily events like meals, can help patients remember and adhere to their dosing schedule. Engaging family members in observing oral medication taking by patients can help ensure adherence. In addition, through a variety of other methods of adherence monitoring, doctors can identify when pill taking is a problem for their patients and can work with them to make adherence easier. It is important to help motivate patients to continue taking their medications properly.

In addition to any of these adherence strategies, patient and family education about schizophrenia, its symptoms, and the medications being prescribed to treat the disease is an important part of the treatment process and helps support the rationale for good adherence.

What About Side Effects?

Antipsychotic drugs, like virtually all medications, have unwanted effects along with their beneficial effects. During the early phases of drug treatment, patients may be troubled by side effects such as drowsiness, restlessness, muscle spasms, tremor, dry mouth, or blurring of vision. Most of these can be corrected by lowering the dosage or can be controlled by other medications. Different patients have different treatment responses and side effects to various antipsychotic drugs. A patient may do better with one drug than another.

The long-term side effects of antipsychotic drugs may pose a considerably more serious problem. Tardive dyskinesia (TD) is a disorder characterized by involuntary movements most often affecting the mouth, lips, and tongue, and sometimes the trunk or other parts of the body such as arms and legs. It occurs in about 15 to 20 percent of patients who have been receiving the older, "typical" antipsychotic drugs for many years, but TD can also develop in patients who have been treated with these drugs for shorter periods of time. In most cases, the symptoms of TD are mild, and the patient may be unaware of the movements.

Antipsychotic medications developed in recent years all appear to have a much lower risk of producing TD than the older, traditional antipsychotics. The risk is not zero, however, and they can produce side effects of their own such as weight gain. In addition, if given at too high of a dose, the newer medications may lead to problems such as social withdrawal and symptoms resembling Parkinson's disease, a disorder that affects movement. Nevertheless, the newer antipsychotics are a significant advance in treatment, and their optimal use in people with schizophrenia is a subject of much current research.

What About Psychosocial Treatments?

Antipsychotic drugs have proven to be crucial in relieving the psychotic symptoms of schizophrenia—hallucinations, delusions, and incoherence—but are not consistent in relieving the behavioral symptoms of the disorder. Even when patients with schizophrenia are relatively free of psychotic symptoms, many still have extraordinary difficulty with communication, motivation, self-care, and establishing and maintaining relationships with others. Moreover, because patients with schizophrenia frequently become ill during the critical career-forming years of life (e.g., ages 18 to 35), they are less likely to complete the training required for skilled work. As a result, many with schizophrenia not only suffer thinking and emotional difficulties, but lack social and work skills and experience as well.

It is with these psychological, social, and occupational problems that psychosocial treatments may help most. While psychosocial approaches have limited value for acutely psychotic patients (those who are out of touch with reality or have prominent hallucinations or delusions), they may be useful for patients with less severe symptoms or for patients whose psychotic symptoms are under control. Numerous forms of psychosocial therapy are available for people with schizophrenia, and most focus on improving the patient's social functioning—whether in the hospital or community, at home, or on the job. Some of these approaches are described here. Unfortunately, the availability of different forms of treatment varies greatly from place to place.

Schizophrenia
Is Not "Split Personality"

There is a common notion that schizophrenia is the same as "split personality"—a Dr. Jekyll-Mr. Hyde switch in character. This is not correct.

Rehabilitation

Broadly defined, rehabilitation includes a wide array of non-medical interventions for those with schizophrenia. Rehabilitation programs emphasize social and vocational training to help patients and former patients overcome difficulties in these areas. Programs may include vocational counseling, job training, problem-solving and money management skills, use of public transportation, and social skills training. These approaches are important for the success of the community-centered treatment of schizophrenia, because they provide discharged patients with the skills

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necessary to lead productive lives outside the sheltered confines of a mental hospital.

Individual Psychotherapy

Individual psychotherapy involves regularly scheduled talks between the patient and a mental health professional such as a psychiatrist, psychologist, psychiatric social worker, or nurse. The sessions may focus on current or past problems, experiences, thoughts, feelings, or relationships. By sharing experiences with a trained empathic person—talking about their world with someone outside it—individuals with schizophrenia may gradually come to understand more about themselves and their problems. They can also learn to sort out the real from the unreal and distorted. Recent studies indicate that supportive, reality-oriented, individual psychotherapy, and cognitive-behavioral approaches that teach coping and problem-solving skills, can be beneficial for outpatients with schizophrenia. However, psychotherapy is not a substitute for antipsychotic medication; it is most helpful once drug treatment first has relieved a patient’s psychotic symptoms.

Family Education

Very often, patients with schizophrenia are discharged from the hospital into the care of their family; so it is important that family members learn all they can about schizophrenia and understand the difficulties and problems associated with the illness. It is also helpful for family members to learn ways to minimize the patient’s chance of relapse—for example, by using different treatment adherence strategies—and to be aware of the various kinds of outpatient and family services available in the period after hospitalization. Family “psychoeducation,” which includes teaching various coping strategies and problem-solving skills, may help families deal more effectively with their ill relative and may contribute to an improved outcome for the patient.

Self-Help Groups

Self-help groups for people and families dealing with schizophrenia are becoming increasingly common. Although not led by a professional therapist, these groups may be therapeutic because members provide continuing mutual support as well as comfort in knowing that they are not alone in the problems they face. Self-help groups may also serve other important functions. Families working together can more effectively serve as advocates for needed research and hospital and community treatment programs. Patients acting as a group rather than individually may be better able to dispel stigma and draw public attention to such abuses as discrimination against the mentally ill.

Family and peer support and advocacy groups are very active and provide useful information and assistance for patients and families of patients with schizophrenia and other mental disorders.

How Can Other People Help?

A patient's support system may come from several sources, including the family, a professional residential or day program provider, shelter operators, friends or roommates, professional case managers, churches and synagogues, and others. Because many patients live with their families, the following discussion frequently uses the term "family." However, this should not be taken to imply that families ought to be the primary support system.

There are numerous situations in which patients with schizophrenia may need help from people in their family or community. Often, a person with schizophrenia will resist treatment, believing that delusions or hallucinations are real and that psychiatric help is not required. At times, family or friends may need to take an active role in having them seen and evaluated by a professional. The issue of civil rights enters into any attempts to provide treatment. Laws protecting patients from involuntary commitment have become very strict, and families and community organizations may be frustrated in their efforts to see that a severely mentally ill individual gets needed help. These laws vary from state to state; but generally, when people are dangerous to themselves or others due to a mental disorder, the police can assist in getting them an emergency psychiatric evaluation and, if necessary, hospitalization. In some places, staff from a local community mental health center can evaluate an individual's illness at home if he or she will not voluntarily go in for treatment.

Sometimes only the family or others close to the person with schizophrenia will be aware of strange behavior or ideas that the person has expressed. Since patients may not volunteer such information during an examination, family members or friends should ask to speak with the person evaluating the patient so that all relevant information can be taken into account.

Ensuring that a person with schizophrenia continues to get treatment after hospitalization is also important. A patient may discontinue medications or stop going for follow-up treatment, often leading to a return of psychotic symptoms. Encouraging the patient to continue treatment and assisting him or her in the treatment process can positively influence recovery. Without treatment, some people with schizophrenia become so psychotic and disorganized that they cannot care for their basic needs, such as food, clothing, and shelter. All too often, people with severe mental illnesses such as schizophrenia end up on the streets or in jails, where they rarely receive the kinds of treatment they need.

Those close to people with schizophrenia are often unsure of how to respond when patients make statements that seem strange or are clearly false. For the individual with schizophrenia, the bizarre beliefs or hallucinations seem quite real—they are not just "imaginary fantasies." Instead of “going along with ” a person's delusions, family members or friends can tell the person that they do not see things the same way or do not agree with his or her conclusions, while acknowledging that things may appear otherwise to the patient.

It may also be useful for those who know the person with schizophrenia well to keep a record of what types of symptoms have appeared, what medications (including dosage) have been taken, and what effects various treatments have had. By knowing what symptoms have been present before, family members may know better what to look for in the future. Families may even be able to identify some "early warning signs" of potential relapses, such as increased withdrawal or changes in sleep patterns, even better and earlier than the patients themselves. Thus, return of psychosis may be detected early and treatment may prevent a full-blown relapse. Also, by knowing which medications have helped and which have caused troublesome side effects in the past, the family can help those treating the patient to find the best treatment more quickly.

In addition to involvement in seeking help, family, friends, and peer groups can provide support and encourage the person with schizophrenia to regain his or her abilities. It is important that goals be attainable, since a patient who feels pressured and/or repeatedly criticized by others will probably experience stress that may lead to a worsening of symptoms. Like anyone else, people with schizophrenia need to know when they are doing things right. A positive approach may be helpful and perhaps more effective in the long run than criticism. This advice applies to everyone who interacts with the person.

What Is The Outlook?

The outlook for people with schizophrenia has improved over the last 25 years. Although no totally effective therapy has yet been devised, it is important to remember that many people with the illness improve enough to lead independent, satisfying lives. As we learn more about the causes and treatments of schizophrenia, we should be able to help more patients achieve successful outcomes.

Studies that have followed people with schizophrenia for long periods, from the first episode to old age, reveal that a wide range of outcomes is possible. When large groups of patients are studied, certain factors tend to be associated with a better outcome—for example, a pre-illness history of normal social, school, and work adjustment. However, the current state of knowledge does not allow for a sufficiently accurate prediction of long-term outcome.

Given the complexity of schizophrenia, the major questions about this disorder—its cause or causes, prevention, and treatment—must be addressed with research. The public should beware of those offering "the cure" for (or "the cause" of) schizophrenia. Such claims can provoke unrealistic expectations that, when unfulfilled, lead to further disappointment. Although progress has been made toward better understanding and treatment of schizophrenia, continued investigation is urgently needed. As the lead Federal agency for research on mental disorders, NIMH conducts and supports a broad spectrum of mental illness research from molecular genetics to large-scale epidemiologic studies of populations. It is thought that this wide-ranging research effort, including basic studies on the brain, will continue to illuminate processes and principles important for understanding the causes of schizophrenia and for developing more effective treatments. □

This article was written by Melissa K. Spearing, M.H.S., of the Office of Communications, NIMH. Scientific information and review were provided by NIMH staff members David Shore, M.D. and John K. Hsiao, M.D.

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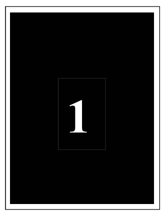

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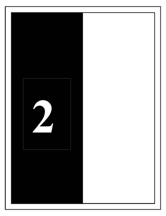

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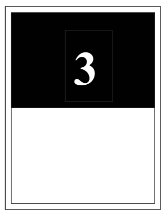

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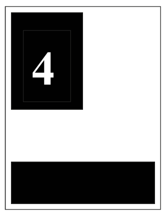

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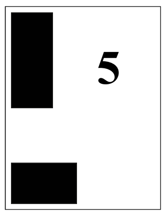

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