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FALL 2008 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 10 NO. 4

The Interrelationship Between Physical and Mental Health

The Diabetes Co-Morbidity Initiative

The Institute for Community Living Responds to Health Crisis

By Rosemarie Sultana-Cordero, LMHC
Jeanie Tse, MD
and Andrew Cleek, PsyD

Do you know someone who is living with diabetes? Most likely you do: About 1 in 3 people will develop diabetes during their lifetime. Moreover, it is more than twice as common in people with serious mental illness when compared to the general population.

These are some pretty staggering numbers, but here's another wake-up call: people with serious mental illness die 25 years younger than the general population. That puts the life expectancy of people with serious mental illness in the same ballpark as that of people in undeveloped countries like Sudan and Haiti. And one of the major causes of death is diabetes.

Clearly, this is a crisis! But crisis, as we all know, is an opportunity for change. The Institute for Community Living (ICL), working with the Urban Institute for Behavioral Health, is proud to be leading a New York State Health Foundation-funded project, the Diabetes Co-morbidity Initiative (DCI), to urgently improve diabetes care for consumers at 7 NYC agencies, including The Bridge, Comunilife, F.E.G.S., Jewish Board of Family and Children's Services, William F. Ryan Community Health Center, Services for the Underserved and Comunilife.

This project addresses type 2 diabetes mellitus, which usually begins in adulthood and is preventable. Type 2 diabetes results from the body's inability to keep blood glucose (sugar) under control. A glucose level that is too high damages blood vessels and nerves, leading to diabetes complications like: heart attacks, strokes, kidney failure, blindness and foot infections (worst case: amputation).

But keeping glucose in check can prevent complications and lead to a longer life! The trouble is: keeping glucose in check is not always easy. Although medication is available to maintain healthy glucose levels, behavioral changes involving diet and physical activity are also needed to manage this disease.

Why is diabetes more common in people who have mental illnesses?

Lifestyle factors like exercise and diet, in addition to diabetes-related genes passed down through families, put people at risk for developing Type 2 Diabetes. The risk of developing Type 2 Diabetes is higher for people with mental illness for a number of reasons. Low energy levels may make it difficult to be physically active. Changes in appetite and medication side effects can make it difficult to eat a healthy diet. Some of the medications used to treat mental illness have been shown to increase the risk for Type 2 Diabetes. Other factors including poverty have also been linked to increased risk. Furthermore, people with mental illness rarely receive the full range of interventions or coordination of care recommended to prevent and treat diabetes. It's a complicated problem. The solution will need to involve change at multiple levels: individuals, organizations and the community at large.

The Diabetes Co-morbidity Initiative (DCI)

The DCI approaches the diabetes crisis on multiple levels. On the individual level, it seeks to enhance the motivation and knowledge of people with serious mental illness to self-manage their diabetes. On an organizational level, it seeks to develop the skills of staff working with consumers with diabetes and to improve collaboration among health and mental health providers. On a community level, it seeks to develop awareness of the crisis and support for people with diabetes, and to provide easy-to-use educational materials to as many people as possible.

The DCI involves using a Diabetes Self-Management Workbook to help consumers improve their diabetes self-care and access quality medical care. This Workbook seeks to introduce a new approach in making lifestyle changes to self-manage diabetes. Visually appealing and easy to read (grade 5 level), it consists of 9 modules designed to guide consumers in setting achievable goals in the areas of:

- Understanding diabetes
- Caring for diabetes *and* mental health
- Choosing healthy foods
- Being physically active
- Taking medication
- Taking care of feet
- Checking glucose
- Having a sick day plan
- Quitting smoking

Each module uses motivational techniques to help consumers think about their experiences and values and how improving health behaviors might be relevant to achieving life goals. An awareness of the consumer's readiness or "stage of change" helps service providers to maintain a person-centered approach throughout the process. The modules also allow consumers to discuss barriers to changing health behaviors, and guide problem-solving around those barriers.

The Diabetes Self-Management Workbook is just one part of the DCI Toolkit. The tools help both the consumer and the consumer's treatment team to work together in coordinating diabetes care. These tools include the Diabetes Info Card, available as a pocket-sized or letter-sized card. This card allows consumers to record and track the six things they need to know about their diabetes, made easy to remember as the *ABCDEF's*: *A*1c, a measure of blood glucose control, *B*lood pressure, *C*holesterol, ki*D*ney function, *E*ye exams, and *F*oot exams.

The DCI Toolkit also includes form letters that consumers can bring to their primary care providers (PCP's) and psychiatrists, that introduce the consumer as a DCI participant, request relevant health information, and invite collaboration between providers. Tools developed specifically for mental health providers include the DCI Quik Guide, a laminated card with reminders on principles of person-centered care provision, including tips on ways to collaborate with consumers' providers, family, friends and other supports. These and other tools are available in English and Spanish.

The DCI Toolkit will be introduced at a total of roughly 30 mental health programs over the next two years, with an anticipated 30 participants at each program. A team of researchers will be studying whether or not using the DCI Toolkit results in better health for consumers with diabetes. Improvement in consumers' A1c levels, a measure of diabetes control, will be one of the main indicators of whether the Toolkit is effective. Changes in food choices, physical activity, foot care and smoking are just some of the other outcomes that will be studied.

see The Diabetes Initiative on page 37

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From The Publisher

The Mental Health Repercussions of the Current Economy And The Interrelationship Between Physical and Mental Health

By Ira Minot, LMSW
Founder and Executive Director
Mental Health News Education, Inc.

This issue of *Mental Health News* explores the interrelationship between physical and mental health. For treatment professionals and service providers, this theme brings forth the knowledge that people with mental illness suffer from the ills of poor physical health to a much greater degree than the general population. Many of the articles in this issue address this troubling health crisis. As a consumer myself, I share this concern and have been affected by it since I became ill with depression in 1989. Before I comment on that aspect of our theme, I can't help but touch upon the mental health repercussions of the current economic crisis.

Ira Minot, LMSW

The Current Economic Crisis and The Nation's Mental Health

As people in communities throughout our nation are feeling the extreme pinch of the economy, I find myself pausing to reflect upon the troubling mental health repercussions this is having on them. Here are just a few examples from recent evening news reports.

In one piece on the crisis in housing foreclosures, a well dressed, educated, middle aged woman in Florida was sitting in her kitchen with fear written across her face. "I might be homeless in a few weeks," she replied, "Nobody seems to be able to help me, and I don't really think that anyone cares."

Another piece reported on a woman from New York who managed the family's finances and had not told her husband how badly they had fallen behind in their mortgage payments. Without warning and with the knowledge that their home was about to go into foreclosure, she called their mortgage company to tell them that she had no other choice but to kill herself so that her family could collect on the insurance and keep their home. Soon after her call, the mortgage company called police to report her disturbing call. By the time police arrived, she had already taken her own life.

How sad and so real this story seemed to me. I know from my own experience with mental illness that there is nothing worse than feeling you will be unable to financially support yourself and your family, or that you will lose your home and have no place to live. The cost of feeding oneself (not to mention a family of three or four kids) has reached record highs, and thousands of people every day are being laid off from their jobs or losing their businesses across all levels of employment. This has surely lead to increased feelings of fear, stress, and loss for many. These negative emotions act as triggers, and can cause decay in both realms of our physical and mental health. A clear example of the cost of fear and stress can be seen in soldiers returning from Iraq and Afghanistan suffering from Posttraumatic Stress Disorders (PTSD). Unfortunately, we are likely to see a similar increase in cases of depression and suicide in people across the nation during these difficult economic times.

Cause and Effect

Economists analyze how the stock market responds to global fluctuations in the price of oil and how they are causing the price of bread and milk at the grocery store to rise. Similarly, treatment professionals and mental health service providers understand how people's emotional state respond to traumatic events in their lives. When someone loses their home or their job this cause and effect situation triggers ripple effects in people's physical and mental health. Some people will react with stomach upset and headaches while others will fall into depression.

As these ripple effects continue, we are now seeing other vital components of state budgets in crisis due to serious declines in revenues. Governors in many states are now calling for departments in all sectors to cut budgets. These dire situations are continuing to appear and are not likely to go away quietly. Talk and worry abounds within the mental health treatment and services community that already thin operational budgets will be cut even more and that many programs throughout the nation will suffer or have to be closed altogether. This does not bode well for individuals and families struggling with existing mental health problems, and for the ever increasing ranks of people that will be in need of mental health care who are victims of the current economic crisis.

Because each of us has different levels of physical and psychological strengths, understanding how and why people may or may not react to the fear and stress brought on by traumatic external events can be difficult.

If you think of it as a delicate tower of blocks that little children have so much fun building, our mind and bodies make up our own delicate and critical infrastructure. When one part of this structure begins to weaken, it can affect the other parts as well. As resilience to crisis varies tremendously from one person to another, the stress that triggers one person's headache or stomach upset may cause someone else to spiral into a deep depression. Many scientists believe it all comes down to genetics and body chemistry. We now understand that imbalances of serotonin in our brains are responsible for the onset of many forms of mental illness. These recent advances in our understanding of mental illness are leading to more efficacious and targeted medications used to treat mental illness. This is a plus for those who suffer and continues to lead us to understand that mental illness is a medical disease that can be treated.

Certainly, the tragic news reports I mentioned previously are troubling and should cause us to be more sensitive and vigilant to people going through tough economic times. As more and more people lose their homes, jobs, and fall closer to economic poverty, the mental health repercussions will surely continue to rise. Will we be able to meet their needs and provide the mental health services needed to help them survive?

The Decline in Physical Health for People with Serious Mental Illness

On the other side of this issues' theme, the recent "Morbidity and Mortality in People with Serious Mental Illness" report published in 2006 by the National Association of State Mental Health Program Directors (NASMHPD), revealed a serious decline in the physical health of people with serious mental illness (SMI) across the United States. This report found that people with SMI are dying 25 years earlier than the general population. This alarming report determined that people with SMI are falling victim to modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care.

As someone who survived a serious mental illness, I learned many things along the way. It is alarming to me when I think back on those years to the things I experienced personally and what I was able to witness firsthand within the ranks of my fellow consumers in treatment.

Before I fell ill to depression in my late 30's, I was in relatively good health. I was a smoker, but not to the compulsive degree that did develop during the darkest days of my 10-year ordeal. I was much thinner, did not have cardio-pulmonary disease, and did not suffer from rapidly declining dental health that caused me to lose many of my teeth.

As a consumer, I participated in years of day-treatment programs and inpatient stays in the hospital. I didn't pay much attention to it at the time, but looking back, I can recall that my fellow consumers and I were all smoking way too much, were not eating healthy foods, and we were certainly not involved in any regular exercise programs. Overweight and chain smoking patients were the norm and what you would see when you were in these programs. Our psychiatric illnesses prevented most of us from working and earning a decent living. Because of this, most consumers only had a few dollars a week from entitlement programs such as SSI, SSDI, Medicaid, and Medicare. What resources we did have that wasn't going to rent (even if you were in supportive housing), utilities and transportation, was spent on buying inexpensive and easy to prepare meals and cigarettes. In addition, few of us had good medical insurance plans and were continually short changed when it came to sufficient or preventive care. For example, few could afford or had insurance that covered dental health care. When a tooth became problematic, your only option was to have it pulled rather than having a more expensive reconstructive or cosmetic procedure. Losing your teeth this way is very humiliating to consumers and certainly adds to your already low self-esteem. These are all things that were brought out in the NASMHPD report.

One of the most important results of the NASMHPD report is that it has sounded a call to action in the mental health community. In this issue, we read about several promising programs that hope to assist consumers in controlling diabetes, or preventing it in the first place, by exercising, choosing a more healthy diet and quitting smoking. These programs are beginning to sprout up in day-treatment programs and are also following consumers in residential settings. I think this a good start, but needs to become a universal mind-set in mental health communities across the country.

Improving the assessment and treatment of SMI at the primary care level is becoming increasingly important. In addition, our inability to successfully house people with co-occurring serious mental and physical disorders has caused many to end up in nursing homes. More needs to be done to enable people to live in the community, and to improve access to medical *and* dental care. By increasing the levels of healthcare coverage now being provided to people with SMI, consumers who rely on government entitlement for their healthcare will have a better chance at fending off diabetes and cardiovascular disease and live healthier and longer lives.

We are eager to hear from you, so please write to us at mhnmail@aol.com and let us know what you think.

Good Luck in Your Recovery
Have a Wonderful Fall Season !!

MENTAL HEALTH NEWSDESK

Mental Health Leaders Meet to Support Bilingual Mental Health Education

Staff Writer
Mental Health News

Leaders from the Latino mental health community met on June 26th for the *3rd Annual Salud Mental Latino Mental Health Leadership Summit*. The event, hosted by the Jewish Board of Family and Children's Services (JBFCS) was designed to demonstrate the community's and mental health provider's support for *Salud Mental*, a mental health education quarterly publication. *Salud Mental* is the metro-NY region's only bilingual (Spanish) journal that is dedicated to providing information, education, advocacy and resources about mental health and substance abuse issues for individuals and families within the Latino community. The publication also targets its educational mission to treatment professionals and service providers to inform them about cultural competency and understanding the Latino/Hispanic culture and its impact on mental health services.

Welcoming remarks at the Summit were given by Paul Levine, LCSW, Executive Vice President and CEO of JBFCS, and Dr. Peter Campanelli, President and CEO of the Institute for Community Living, and Chairman of the Board of Mental Health News Education, Inc. (MHNE), the organization which publishes *Salud Mental*. Co-chairs for the Summit were Carmen Collado, LCSW, Director of Immigrant and Latino Services and Director of Public Policy and Government Relations at JBFCS, and Dr. Leo Leiderman, Director of Latino Treatment Services at Saint Vincent Catholic Medical Center in Westchester. Both Collado and Leiderman also serve on the MHNE Board.

Keynote speakers at the event included: Arlene González-Sánchez, Commissioner of the Nassau County Department of Mental Health, Chemical Dependency and Developmental Disabilities, Dr. David Rosin, Deputy Commissioner of Mental Hygiene Services of the NYC Department of Health and Mental Hygiene, and Dr. Rosa Gil, President of Comunilife.

A discussion session followed in which all participants at the Summit made suggestions on how to best format the publication's future goals and how to expand its geographic reach. According to Co-chair Carmen Collado, "We are extremely pleased that the community has come out to participate in this important event, and many excellent ideas and suggestions were shared in this process."

After a brief hiatus from its annual calendar, *Salud Mental* plans to renew its publishing schedule this winter following the successful completion of a feasibility study which is expected to commence after Labor Day. The study will engage

see Bilingual Education on page 34

New York State Agencies and Vet Centers Team Up To Provide Mental Health Screening To New York's National Guard Soldiers

By The New York State
Division of Veterans Affairs

The New York State Division of Veterans Affairs and New York State Office of Mental Health are teaming up with the New York State Division of Military and Naval Affairs to provide mental health screening to Citizen Soldiers returning from war zones.

The state agencies coordinated with the federal Department of Veterans Affairs to plug the screening process into the existing New York Army National Guard Yellow Ribbon Reintegration Program.

The new initiative begins this weekend, (August 1 and 2) with the Soldiers of Company B, 3rd Battalion, 126th Aviation Regiment based in Rochester, N.Y.

The troops will meet with clinical representatives from the U.S. Department of Veterans' Affairs Vet Centers to receive Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) Medical screening during their welcome home reintegration. The VA's Vet Centers across the state will support the effort with trained and licensed staff to help returning Guardsmen make the transition from Soldier to Citizen Soldier.

The Soldiers will hold their Reintegration session this Saturday, August 2, in Rochester. The Soldiers returned home this spring from a one-year mobilization and combat tour in Afghanistan.

The Vet Centers started this program with returning National Guard Soldiers in New Hampshire in 2004 and have since extended it to Massachusetts, Connecticut, Rhode Island, and Maine, said Dr. James Garrett, deputy regional Manager for the United States Department of Veterans Affairs Vet Center Northeast Region.

"This program has been very successful in several New England states in identifying Soldiers with readjustment problems and we are happy to expand it to New York," Garrett said. "We consider it a real privilege to be able to speak with these soldiers," he added.

PTSD is anxiety disorder that can develop after exposure to a terrifying event or ordeal such as combat operations. TBI is related to the effects of combat action or wounds impacting a Soldiers' head, especially in the vicinity of improvised explosive devices, artillery or rocket fire.

The Reintegration Program assures that Soldiers are provided opportunities for information about veterans' benefits, education and job opportunities, available support networks and the military transition from a full-time Soldier on active duty back to a traditional Citizen Soldier serving in a local community.

This latest expansion of the Yellow Ribbon Reintegration Program involved coordination with the NYS Division of Veterans' Affairs and the NYS Office of Mental Health, and the Vet Centers.

"The New York Army National Guard launched our reintegration program to help Soldiers make the transition from full-time Soldiers back to full-time Civilian less stressful," said Major General Joseph Taluto, the Adjutant General and commander of the New York National Guard. "We welcome the efforts of the Division of Veterans Affairs and the Office of Mental Health to make this already successful program more effective for our returning veterans."

"Adding our Vet Centers and their clinical screening capability into the mix of the National Guard's reintegration efforts takes New York's programs to assist its returning Guardsmen and their Families to unprecedented levels of support and care for their well-being," said Jim McDonough, Director of the New York State Division of Veterans' Affairs.

"This is exactly the type of cooperation between state and federal government that our Veterans expect of us. I am pleased that the Division of Veterans' Affairs can be an enabler of such well-rounded care for our returning Veterans," McDonough said.

Michael F. Hogan, PhD, Commissioner of the New York State Office of Mental Health, said: "The Office of Mental Health is pleased to partner with the Division of Veterans Affairs to offer mental health screenings as part of the New York Army National Guard Reintegration Program."

"As with all health problems, mental health issues are best dealt with early and close to home. Offering mental health screenings as part of the reintegration process will lead to early identification and support for those returning soldiers who are struggling to deal with the stresses of deployment and war," Hogan said.

The New York National Guard Yellow Ribbon Reintegration Program requires Soldiers to be present for paid assemblies at 30 and 60 days after their return from a combat zone, and invites families to attend as well. The sessions are held in a non-threatening, non-military environment, to provide Soldiers and families a chance to share experiences and talk frankly with each other and counselors about their experiences.

National Guard Soldiers are put back in touch with people who shared and understand their experience, at about the time the "honeymoon phase" of their

see Screening for Soldiers on page 34

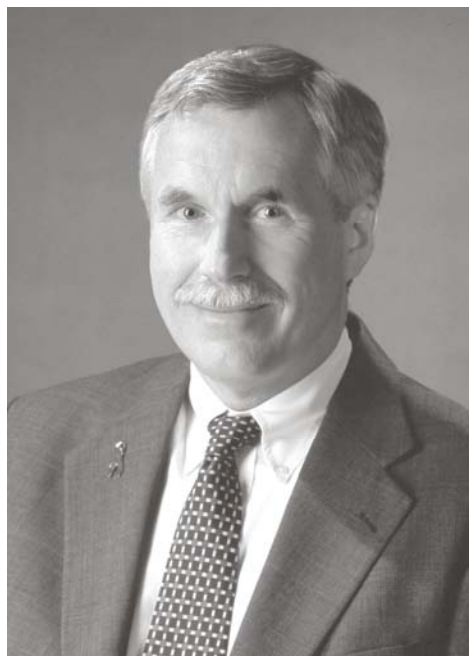
MENTAL HEALTH NEWSDESK

NYS Office of Mental Health and NYS Psychiatric Institute Establish Center to Promote Best Practices in Mental Health Services

Staff Writer
Mental health News

The New York State Office of Mental Health (OMH) and the New York State Psychiatric Institute (NYSPI) at Columbia University Medical Center, today announced the development of an Evidence-Based Practice Technical Assistance Center (EBP-TAC) to build upon OMH's plan to promote the widespread availability of evidence-based practices to improve mental health services, insure accountability, and promote recovery-oriented outcomes for consumers and families.

The Center, which will be housed within NYSPI's Division of Mental Health Services and Policy Research, will serve as a key resource to OMH and New York State's public mental health system by spreading those practices identified as being most critical to accomplishing system-transformation initiatives. The partnership with NYSPI provides unequalled access to expertise that will assist providers in developing the infrastructure and expertise needed to offer consumers and their families services that have strong evidence of success in achieving recovery.



Michael F. Hogan, PhD

OMH Commissioner Michael F. Hogan, PhD, said, "The Evidence-Based Practice Technical Assistance Center will help lead to better service outcomes for New Yorkers with a mental illness. We know that with appropriate treatment and supports, recovery from mental illness is possible. We also know that there are treatments and interventions that have been documented by scientific research to be effective, but oftentimes they are not being provided to individuals with mental illness. The Evidence-Based Practice Technical Assistance Center will work to bridge that gap by helping to bring treatments that work to the people that need them."

Susan Essock, PhD, Director of the Division of Mental Services and Policy Research, and Sharon Aungst, MS, the Center's Associate Director, have been charged with seeing through its primary functions, namely: building awareness, partnership, and consensus; assisting provider agencies in making organizational changes; supporting leadership to implement and sustain change; developing clinical staff and supervisory competency; promoting culturally relevant adaptations; and evaluating consumer and organizational outcomes, and intervention and implementation fidelity.

Already, EBP-TAC has begun assisting OMH in implementation of Wellness Self Management, designed to promote and sustain wellness self management services for adults with serious mental health problems. Wellness self management is a curriculum- based practice that expands upon the Illness Management and Recovery practice, one of the nationally recognized evidence-based practices developed in recent years. The program assists consumers in their recovery and results in a fundamental change in agencies' understanding and support of recovery-oriented services.

"The New York State Psychiatric Institute is proud to provide leadership support to the Office of Mental Health and the evidence-based practice technical assistance center," said Dr. Jeffrey Lieberman, Director of the New York State Psychiatric Institute. "This wonderful initiative will improve the quality and effectiveness of mental health services for thousands of citizens across the state. The new EBP-TAC will bring the latest knowledge from our science to help patients achieve recovery."

Older Treatment May Be More Effective In Preserving Sight for Some Patients with Diabetes

By The National Institute of Health

A promising new drug therapy used to treat abnormal swelling in the eye—a condition called diabetic macular edema—proved less effective than traditional laser treatments in a study funded by the National Eye Institute (NEI), part of the National Institutes of Health (NIH). The study, published online in July in the journal Ophthalmology, demonstrates that laser therapy is not only more effective than corticosteroids in the long term treatment of diabetic macular edema, but also has far fewer side effects.

Between 40 and 45 percent of the 18 million Americans diagnosed with diabetes have vision problems, such as diabetic macular edema. This condition occurs when the center part of the eye's retina called the macula swells — possibly leading to blindness. Ophthalmologists traditionally use lasers to reduce the swelling in areas of the macula. However, starting around five years ago, early reports of success in treating diabetic macular edema with injections of a corticosteroid called triamcinolone led to the rise in popularity of this alternative therapy. This is the first study to compare the long-term benefits of both treatments and evaluate their potential side effects. While triamcinolone was used in this study, there is no scientific rationale at this time that one corticosteroid preparation should be substantially different from another.

"Results of this study should confirm the use of laser treatment for diabetic macular edema and will have a significant impact on quality of life for tens of thousands of people being treated for diabetic macular edema in the United States each year," according to Paul A. Sieving, M.D., Ph.D., director of the NEI. Only diabetic macular edema was examined as part of this study. Macular edema from conditions other than diabetes may respond to corticosteroid treatment and laser treatment differently.

A total of 693 patients with diabetic macular edema participated in the study at 88 sites across the United States. Each person was randomly assigned to corticosteroid or traditional laser treatment. Following the treatment, investigators tested each patient to determine whether the procedure had prevented substantial vision loss. Investigators defined substantial vision loss as reading at least two less lines on a standard eye chart two years after entering the study. In the corticosteroid-treated group, 28 percent experienced substantial vision loss as compared to 19 percent in the laser-treated group. In addition, about one-third of the eyes treated with laser therapy showed substantial improvement in vision. Laser treatment had previously been perceived to prevent further vision loss, but not to improve vision. Improvements in vision were not found in the only prior study evaluating laser treatment for diabetic macular edema because most subjects enrolled in that study already had good to excellent visual acuity and therefore, no room to improve.

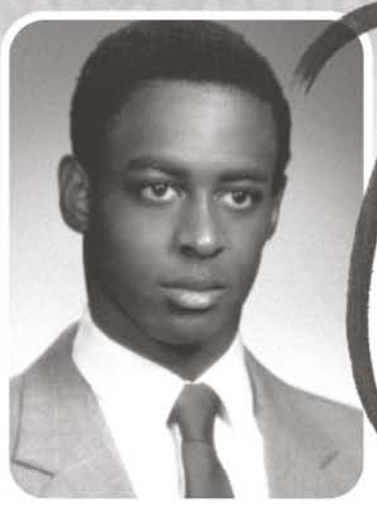
"Many of the investigators were surprised by the results," said Dr. Michael Ip, associate professor of ophthalmology at the University of Wisconsin, and chair of this protocol for the Diabetic Retinopathy Clinical Research Network (DRCR.net). "These findings substantiate the importance of laser treatment in the management of diabetic macular edema." The DRCR.net is a collaborative network, supported by the NEI, dedicated to facilitating multicenter clinical research of diabetic retinopathy, diabetic macular edema and associated conditions.

The corticosteroid-treated group was also far more likely to experience side effects. In fact, 51 percent of the corticosteroid-treated group had cataract surgery compared to 13 percent of those in the laser-treated group. In addition, almost half of the corticosteroid-treated group had increased eye pressure, which may lead to glaucoma. One-third of this group needed eye drop medications to lower their eye pressure. The laser-treated group had significantly less of a problem with eye pressure, as 8 percent of the group required eye drop medications.

Researchers found that, while not as effective as the laser treatment, corticosteroid treatment did provide some benefit. "Our findings raise the possibility that combining laser with corticosteroids might produce greater benefit," said Dr. Neil Bressler, chair of the Diabetic Retinopathy Clinical Research Network and professor of ophthalmology at The Johns Hopkins University. The Diabetic Retinopathy Clinical Research Network is conducting a study that is comparing a combination of corticosteroids and laser with laser alone.

For more information on the Diabetic Retinopathy Clinical Research Network visit www.drcr.net. The National Eye Institute (NEI) is the lead agency for vision research that leads to sight-saving treatments and plays a key role in reducing visual impairment and blindness. For more information, visit the NEI Website at www.nei.nih.gov/.

Lisa Dow
National Honor Society, Flag Twirler



Peter Dressler
Varsity Basketball, Chess Club

Laura Ducharme
Varsity Football Cheer Squad, Varsity Basketball Cheer Squad, Homecoming Queen, Diagnosed with mental illness in 1995.

Todd Dunzello
Marching Band, Drama Club

Scott Durfee
National Honor Society, Photography Club, Diagnosed with mental illness in 2001.

Katie Esteves
Senior Chorus, Varsity Softball, Track and Field

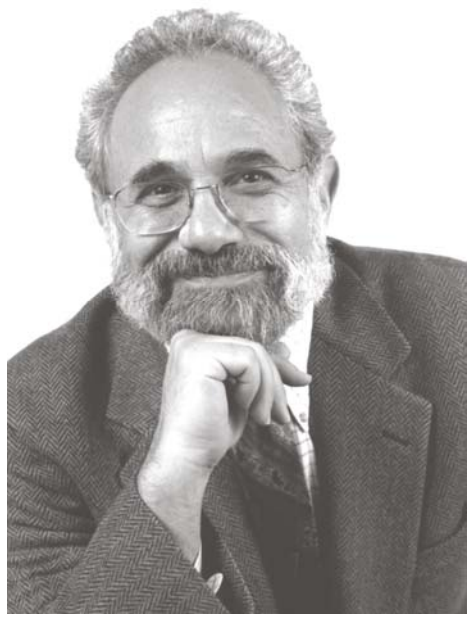
Charles Evans
A/V Support, Math Club

Aura Fong
National Honor Society, Computer Club, Young Adult Council

POINT OF VIEW

Physical Health Should Be a Priority of the Mental Health System and Mental Health Should Be a Priority of the Health System

By Michael B. Friedman, LMSW



Michael B. Friedman, LMSW

Over the past couple of years, it has become increasingly clear that physical health needs to be a priority of the mental health system and that mental health needs to be a priority of the health system. Why it took so long to realize this is not entirely clear to me, because the basic facts have been known for quite some time. In part, it's that we've all been busy with other important matters like building an array of mental health services and supports to enable people with serious mental illness to live in the community. The development of housing, rehabilitation, outpatient treatment, inpatient services in general hospitals, improved quality of care in state hospitals, case management, and assertive outreach into the community have all been—and still are—vital areas of development for the mental health system. The other reason for the delay, of course, has been the perception that the health system is responsible for physical health and the mental health system is responsible for mental health. Neither system thought of itself as responsible for the considerable overlap between the two. So money didn't get invested in integrated services.

Why is it so important that policy shift to emphasize integration of physical and mental health services? A number of reasons have emerged including: (1) The low life expectancy of people with severe, long-term mental illnesses, (2) the cost of care for, and the suffering of, people with co-occurring severe behavioral and physical disorders, (3) the impact of mental and substance abuse disorders on the outcomes for people with serious, chronic physical health disorders—such as diabetes, (4) the large part that mental and behavioral disorders play in the placement of people in nursing homes, which are designed for people with physical disabilities but occupied by a lot of people with mental and behavioral problems, and (5) the fact that most people with mental disorders go first to their primary care physicians, who, unfortunately, often fail to identify mental illness or to treat it adequately.

Low Life Expectancy

It has been known for a quarter century or more that people with serious, long-term mental illnesses have a lower life expectancy than the general population. Until recently the number most often claimed was 10 years—a matter of great concern. But a recent study has resulted in the truly alarming claim that life expectancy is 25 years lower for this population. I'm not sure why the number has changed so dramatically. Let's hope it's an artifact of research rather than an indication that life expectancy has gone down over the past quarter of a century, a period during which there has been a considerable reduction of inpatient services and a growth of community-based mental health services.

Although there have been different emphases on the causes of low life expectancy in different studies, it is reasonably clear that they include poor health, poor health care, exposure to the risks of street life, suicide, and "accidents", often overdoses of medication.

A comprehensive approach to increasing life expectancy needs to address all of these causes. But attention to health is particularly important. People with serious mental illness are at high risk of obesity (in part because of the medications they take), hypertension, diabetes, heart disease, pulmonary problems, and communicable diseases such as HIV/AIDS. Addressing these issues with preventive interventions such as diet and exercise is at least as important as improving health care for this population.

High Cost Cases

The rising cost of health care has become a matter of major social concern—even for the Presidential candidates. At the state level the primary concern is Medicaid costs. We have known for some time that a small portion of the covered population incurs the vast majority of the costs of Medicaid. (The 20-80 rule-of-thumb appears to be a modern metaphysical principle.) We have also known for years that people with disabilities and older people receive the most costly care (not to be confused with the best care.) Recently, John Billings did a study of Medicaid spending in NYC that revealed that the people on whom the most money is spent are not just disabled, but people with co-occurring serious health, mental health, and substance use disorders. This is true for all age groups—children, working age adults, and older adults.

It appears that many of these people get intensive health and mental health services intermittently. A crisis brings them to emergency rooms and to long periods of hospitalization, after which they often disappear for a while, only to re-emerge in crisis later. Many have not gotten the services that might sustain them in relative health in the interim.

Clearly, integrated physical health, mental health, and substance abuse services are needed at all points of contact with this population—in emergency rooms, during inpatient care, and in community-based services. Outreach is particularly important to this population.

What's tricky about this is that a number of studies have indicated that providing integrated services to everyone with serious co-occurring disorders does not result in cost savings—although it does improve lives for no or very little additional cost. As a result, Professor Billings and others have been working on the development of a method to predict who will be the high cost cases in the near future, which could be used to target services to those people. This, hopefully, would reduce costs and make it possible to reinvest the savings over time in increasing services to more and more people. Of course, it's also possible that the state would take the savings so as to reduce the state budget.

Chronic Health Problems

More and more studies done over the past decade indicate that people who have chronic physical illnesses such as diabetes, heart disease, and neuro-muscular disorders with co-occurring depression are (1) at much higher risk for disability and premature mortality and (2) have much higher costs for their physical health care than people with the same chronic conditions who are not depressed.

Unfortunately, neither primary care physicians nor medical specialists generally have expertise in identifying or treating mental and/or substance use disorders that can seriously complicate their patients' physical health. The solutions? Better prepared health care providers and increased collaboration between health and mental health professionals. More on this in my comments on primary care below.

Long-Term Care

In the effort to contain the costs of Medicaid, one of the major targets is long-term care, which includes not only nursing homes but also day care, case management, and home health care. One way in which federal and state governments have approached reducing Medicaid costs is by decreasing the number of people eligible for Medicaid. This includes making it more difficult for people to transfer assets so as to become eligible for Medicaid prior to becoming impoverished.

The other major effort is to reduce utilization of nursing homes by enabling people to remain in their own homes longer. Both home health care, case management in the home, and day care are intended to do that. This process is known sometimes as "long-term care reform" and sometimes as "long-term care restructuring." (It is important to note that this restructuring effort is done not only to save Medicaid dollars, but also to make it possible for people to live where they want to live—generally in the community.)

The success of long-term care restructuring depends, of course, on identifying and addressing the reasons why people go to nursing homes, and public policy seems to be built on the notion that people go to nursing homes because of physical disabilities, including Alzheimer's disease. This, however, is a very partial truth. 50% or more of people in nursing homes have mental illnesses, such as depression, anxiety, and psychoses in addition to physical disabilities. And many are there only because of mental disabilities. Sadly these conditions are often ineffectively addressed before placement in nursing homes as well as when people are in the homes.

The most important reasons why many—perhaps most—people are in nursing homes are (1) that their behavior creates a mix of risks and annoyances that those providing support in the community can't handle, (2) that they don't have families that can provide the supportive care they need in the community, and (3) that there are not enough alternatives to housing people with disabilities in institutions.

The placement of people with "difficult" behaviors in institutions reflects in large part the inadequate training of staff who provide services in the home to deal with mental and behavioral problems. There is little doubt in my mind that the development of home care providers and day care workers with specialized expertise would significantly reduce referrals to institutions.

Similarly, I have no doubt that providing support for family caregivers—who provide 80% of the care for people with disabilities—would result in sustaining people in places they want to live in the community. Some disabled older adults don't have family, of course. In other cases families who have tried their very best to provide care ultimately burn out. They are at high risk for depression, anxiety disorders, and physical illnesses that rob them of their ability to bear the stress.

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The NYSPA Report: Healthy Minds Series on NY Public Television's WLIW 21

By Jeffrey Borenstein, MD
CEO and Medical Director
Holliswood Hospital

I am privileged to serve as the host of Healthy Minds, a public television series which premiered in the Fall of 2006 on producing station WLIW, Channel 21. As a psychiatrist and as an active member of the New York State Psychiatric Association, I am very much aware of the importance of educational outreach to the public. I believe that in the past, we as a field, have not been proactive in reaching out to the public using the powerful medium of television. For this reason, I worked to help create and develop the Healthy Minds television series. The series aims to remove the stigma that can prevent patients and their families from seeking help for mental disorders. Everyone is touched by psychiatric conditions, either themselves or a loved one. I want people to know that with help, there is hope. I have had the opportunity to interview people who share their personal experiences and have also interviewed leading researchers and experts who provide the latest up-to-date information about diagnosis and treatment. Episodes cover a wide range of topics, including schizophrenia, bipolar disorder, depression, post traumatic stress disorder, Alzheimer's Disease, chemical dependency, attention deficit disorder, anxiety disorders, insomnia, and suicide prevention.

The response to the series has been beyond my wildest dreams. I have received many e-mails and phone calls from people who have seen the show and have been touched by our message. A common theme is that the show has helped to open up conversations among family members—silence has been replaced by communication among loved ones. The series has struck a chord with the public. People are hungry for information – presented in a thoughtful, user-friendly way – about psychiatric conditions. I am pleased that my vision of reaching out to the public through television has helped to reduce stigma and encourage people to seek help rather than suffer in silence.

In the premier episode, I had the opportunity to interview veteran news reporter Mike Wallace and his wife Mary in the intimacy of their home. Mike has written about and spoken about his experience with depression, but during the interview both Mike and Mary spoke in very great detail about what it was like to live with depression. They spoke about Mike's suicide attempt which resulted in a hospitalization. He spoke about the issue of stigma – his own physician said he should not publicly acknowledge his treatment for depression – "it would be bad for your image." Mary spoke about how difficult it is for the spouse of a person with depression. How the spouse can feel isolated from friends. She even recommended that family members consider getting treatment for themselves to help

Jeffrey Borenstein, MD

get through the stress of a loved one's illness. Mike spoke about how treatment -- medication and talk therapy -- helped him recover from depression. He also spoke about the importance of exercise and how staying active also helped his recovery. Most striking to me is that with treatment Mike has had many years of a full, healthy and happy life.

I also interviewed Jane Pauley, who shared her experience with bipolar disorder. Jane has also spoken publicly about her illness and in the interview shared personal feelings about how her illness affected her family. She spoke about being diagnosed with bipolar disorder and what this meant to her and her family. She shared what it was like for her to be hospitalized and her ultimate recovery. Jane shared her insights about ongoing treatment for bipolar disorder and by extension other psychiatric conditions. She is very much aware of potential early symptoms and will intervene at the earliest signs of trouble. She spoke about the importance of sleep, making sure she had a good routine to insure a full night's sleep and also the importance of dealing with stress. She has avoided a relapse by carefully monitoring her condition.

In addition to well known people, I also had the opportunity to interview other people who have recovered from psychiatric conditions as well as family members. The experts who participated include two Noble Laurettes – Dr. Eric Kandel of Columbia University and Dr. Paul Greengard of Rockerfeller University.

The first season of Healthy Minds was honored with four prestigious Telly Awards. Tellys recognize the very best local, regional, and cable television programs, as well as video and film productions. "Healthy Minds reflects a core mission of public television, providing access to information that directly impacts the lives of families in the communities we serve," said WLIW President and General Manager Terrel Cass. "We hope this series will serve as a resource for families and healthcare providers to open lines of communication." Healthy Minds is made possible in part by NARSAD, Value Options, New York Academy of Medicine, The van Ameringen Foundation and by the New York State Office of Mental Health. The series is available for broadcast on other Public Televisions Stations. Your local station can contact the Executive Producer, Theresa Statz-Smith (516-367-2100, ext. 8481; StatzT@wliw.org). All thirteen episodes of season one can be viewed on line at www.wliw.org/healthyminds.

We are currently in production for a second season. We are working on a two-part episode on the important topic of autism and the autism spectrum disorders. This will include interviews with families, educators, and experts. The goal is to shed light on this condition, especially what steps families can take to ensure that their child reaches their highest potential.

Guests for the second season include: Commissioner Michael F. Hogan of the NYS Office of Mental Health, Commissioner Karen M. Carpenter-Palumbo of the NYS Office of Alcoholism and Substance Abuse, Dr. Lloyd Sederer, Medical Director of NYS OMH, Dr. Jeffrey Lieberman of Columbia, Dr. Dolores Malaspian of NYU, Dr. Alice Medalia of the Lieber Center at Columbia, and Dr. Judy Rapaport of the National Institute of Mental Health. We also will have interviews with Dominic Carter of the cable news channel, NY 1, who speaks about his mother who had schizophrenia and William Cope Moyers, who is the Executive Director at Hazeldon, who speaks about his recovery from chemical dependency. The second season is scheduled to premier on Sunday, October 12 at 9:30 a.m.

Dr. Jeffrey Borenstein, a board certified psychiatrist, is the CEO/Medical Director of Holliswood Hospital. He is a graduate of Harvard University and New York University School of Medicine. Dr. Borenstein serves as the Chair of the Mental Health Services Council of New York State and on the Commissioner's Medical Advisory Panel of the Office of Alcoholism and Substance Abuse Services. Dr. Borenstein serves as the Editor of Psychiatric Quarterly and as the Editor of the New York State Psychiatric Association Bulletin. He also serves as the President of the National Association of Psychiatric Health Systems and is a Fellow of the New York Academy of Medicine and serves as the Chair of the Section on Psychiatry at the Academy.

THE MENTAL HEALTH LAWYER

Guardianships for Incapacitated Persons and The Limitations On a Guardian's Ability to Consent To or Refuse Psychiatric Treatment

By Douglas K. Stern, Esq.
and Carolyn Reinach-Wolf, Esq.

Many times people lose the capacity to make personal and financial decisions on their own behalf. Often times this occurs as a result of declining mental faculties, such as when the person reaches an advanced age, suffers from mental illness, or experiences traumatic or unexpected injury. Regardless of the reason, when an individual loses the ability to make decisions on their own someone must step in to act as a surrogate and make these necessary decisions for the person who no lacks the mental or physical capacity to do so on their own. These decisions can include where to live, what medical procedures are appropriate, can and how should the person travel, as well as simple financial transactions such as banking and the payment of bills. Under New York State Mental Hygiene Law, Article 81, someone concerned with the welfare of a person who is alleged to have lost the capacity to make decisions for him or herself ("alleged Incapacitated Person") can petition the Court to have a guardian appointed to make many if not all of these decisions.

Article 81 of the Mental Hygiene Law permits the appointment of a guardian for an Incapacitated Person to oversee financial and/or health care decision making. The court has discretion to grant as broad or as limited an array of powers as deemed necessary in order to protect the health and finances of the alleged incapacitated person. Prior to the enactment of Article 81 in 1993, the law only allowed for a heavy handed and clumsy, all or nothing, framework. The court could only deem the alleged incapacitated person either capable to make decisions for him or herself or, totally incapacitated without the ability to make any decisions whatsoever. With the passage of Article 81, the law now permits the court to narrowly tailor the powers a guardian possesses to fit the capabilities and limitations of the alleged incapacitated person. The efficacy of Article 81 lies in its flexibility, allowing judicial decision makers to tailor a guardianship individually to the case at hand.

Despite the seemingly amenable nature of Article 81, designed to fit any particular situation, outside the laws purview is psychiatric care and treatment in an inpatient setting as well as providing psychiatric medication to an individual over their objection. This is true both for psychotropic medication and electro-convulsive therapy (ECT). As the statute is written, Article 81 would appear to allow for a guardian to make decisions regarding psychiatric medications and ECT. However, courts have interpreted the statute in such a way so as to eliminate a guardian's ability to possess this authority.

Douglas K. Stern, Esq.

This article will discuss, in broad terms, what is required for a court to appoint a guardian to make personal and/or financial decisions for an Incapacitated Person. It will also discuss the limitations on a guardian's authority as it relates to psychiatric treatment and end of life decisions and the reasons for these limitations.

When a Guardian May Be Appointed

A court may appoint a guardian when it is presented with facts which convince the court, by clear and convincing evidence, that the subject of the guardianship is likely to suffer harm because: (1) the person is unable to care for their personal or property needs; and (2) the person cannot adequately understand and appreciate the nature and consequences of their own inability. In addition, if the person recognizes their own need for assistance with personal and financial decisions and consents to the appointment of a guardian the court can provide them with a guardian in accordance with the person's functional limitations and ability to manage his or her property.

The court, in reaching a decision on incapacity, will take into account the person's functional limitations and abilities, such as managing his or her activities of daily living (dressing, feeding, toileting, etc.). Moreover, the court will also take into consideration the persons wishes, preferences, value choices.

Some powers the court may grant to a guardian are the power to make gifts, decide where the person can live, make decisions regarding major medical treatment, decide if the person can travel or have a driver's license, initiate lawsuits, sell property, pay bills, and apply for government benefits. This is certainly not an exhaustive list of powers. As stated earlier, the court can grant as wide or narrow a set of powers to the guardian as the court deems necessary in order to meet the particular functional capabilities and limitations of the alleged Incapacitated Person.

Limitations on A Guardian's Power As it Relates to Psychiatric Care and Treatment and End of Life Issues

Article 81, specifically excludes the power to involuntarily commit an individual to a psychiatric institution. While a guardian may have the general power to choose the place where the incapacitated person may live, this does not include involuntary psychiatric hospitalization. If the guardian believes the Incapacitated Person for whom he or she is responsible requires care and treatment in a psychiatric hospital the guardian must pursue options available in Article 9 of the Mental Hygiene Law, which govern involuntary psychiatric treatment.

More controversial has been a guardian's power to consent to or refuse treatment of the Incapacitated Person with psychiatric medications and/or ECT treatment. The guardianship statute, as written, actually allows for a guardian to be granted the power to "consent to or refuse generally accepted routine or major medical treatment", which includes "the administration of psychotropic medication or ECT".

However, despite this clear language in the statute, New York courts have concluded that this power cannot be granted to a guardian. In other words, the courts have interpreted the statute so as to remove this authority and therefore, a court cannot grant a guardian the authority to accept or reject psychiatric treatment on behalf of an incapacitated person. While a guardian cannot be granted this power, if the incapacitated person is involuntarily confined to a psychiatric hospital, the hospital can apply to the court for an order to treat the person with medication or ECT over the person's objection.

The Court's reasoning for removing this authority from the guardianship law was based upon prior case law regarding the involuntary treatment of psychiatric patients. In a landmark case, Rivers v. Katz, the Court of Appeals, New York's highest court, concluded that only if a court finds that a person (1) lacks the capacity to make a reasoned decision regarding the risks and benefits of the proposed medication, (2) the benefits of the

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The Effects of Depression on Physical and Mental Health

By Lisette Rodriguez, MS, APRN
Patient Care Director, The Women's Program
NewYork Presbyterian - Westchester Division

Depression is a significant and pervasive problem across educational, socioeconomic, racial and ethnic groups. The Diagnostic and Statistical Manual Fourth Edition (DSM IV) has helped to standardize the definition of depression across practice disciplines such as medicine, psychiatry, nursing and social work. Depression is defined as a mood disorder or a sad affective state with loss of pleasure or interest in activities for a period of two weeks or more. This disorder is unrelated to the effects of a substance or bereavement and can manifest itself as a single or recurrent episode (American Psychiatric Association, 1994). To be diagnosed with depression, according to the DSM IV, the following five or more symptoms need to be present: persistent sadness, insomnia, irritability, low self esteem, appetite changes, worthlessness, loss of interest, or thoughts of suicide.

Women, in particular, have diverse needs in relation to their emotional and mental health. Quite often women occupy various social roles such as wife, mother, caretaker and professional to name just a few. These roles can be complex and stressful as women are juggling multiple responsibilities among their own needs. This commonly results in women's own needs being pushed aside to care for others and depression sets in.

Depression can lead to serious physical consequences for individuals affected by the disorder. The risk of death from heart disease, stroke or respiratory disorder is higher among people with depression as depressed people are more likely to engage in behaviors such as smoking, drug use, overuse of alcohol, limited or no exercise and poor nutrition (Sederer et al. 2007). In addition, depression can lead to lost worker productivity, disability, unemployment, poor physical health and suicide (Greenberg, Stiglin, Finkelstein & Berndt, 1993).

Suicide is another serous consequence of depression and it is one of the top ten leading causes of death in ages 10-64 years old in the United States (CDC, 2005). Approximately 50% of depressed persons report feelings of wanting to die, 33 % consider suicide and 8.8 % attempt suicide (Hasin, Goodwin, Stinson, & Grant, 2005). Approximately 90% of those who commit suicide are depressed (Gaynes et al. 2004).

According to World Health Organization (2000), depression is the fourth most disabling illness worldwide. The cost of depression to society is also quite substantial when factoring in increased use of expensive emergency services, inpatient care, high Medicaid utilization, unemployment, disability and low work performance in individuals who are depressed. People diagnosed with depression have general medical costs twice those of healthy individuals and visit hospital emergency rooms with significantly greater frequency (U.S. Department of Health & Human Services, 2001). According to the National Institute of Mental Health (2006), the cost of depression in the United States is estimated to be 83 billion dollars which has a tremendous economic impact to society.

Well-known Psychiatrist and Theorist Aaron T. Beck explains depression within the context of an affective state that can be regarded as the consequence which the individual views self, views the world and views the future. A negative view of oneself, the world and the future therefore, are the three components of the cognitive triad that lead to depression.

The gold standard therapy for depression is Beck's Cognitive Behavioral Therapy which is touted to be effective and teachable with relative ease. The premise behind Cognitive Behavioral Therapy is to replace and/or reframe negatively biased or distorted views with more realistic, achievable, adaptive, and pleasure giving views. The goal is to help depressed individual feel less depressed as negative thoughts are reframed into more positive ones. This therapy, combined with antidepressant medications, has been proven to be effective in treating depression and restoring mental and emotional well-being, and as a result, physical health as well.

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proposed medication outweigh the risks, and (3) there is no less intrusive alternative, can medication be given to an individual over their objection.

Comparing the decision in Rivers v. Katz and the guardianship law, the Court concluded that they are incompatible. First, a guardian may be granted the power to make medical decisions for an indefinite period of time. As a result, it is possible that at the time the proposed involuntary psychiatric medication or treatment is proposed the individual in question may have regained at least some capacity in order to be able to make a reasoned decision about the risks and benefits of the psychiatric medication and/or ECT. More importantly however, the guardianship statute provides no mechanism to weigh the risks and benefits of the proposed medication or to reach decisions about whether there are less restrictive alternatives than the treatment requested. As mentioned earlier, both of these considerations are required under Rivers v. Katz.

Another controversial topic revolves around a guardian's authority to make decisions regarding life sustaining treatment. Simply put, the enactment of the guardianship law did not alter the legal landscape in this area. A guardian may be provided this daunting authority. However, a guardian may only be granted this power where there is clear and convincing evidence that these were the prior expressed wishes of the Incapacitated Person. Such clear and convincing evidence can be in the form of a prior written document when the person had capacity, such as a health care proxy, living will, or do not resuscitate order. In addition, evidence can also be presented to the court in the form of verbal expressions, such as specific conversations had with the person who is to be deprived of life sustaining treatment. It should be noted, that general perceptions or intuitions regarding the person's wishes on life sustaining treatment, or the wishes of family or the guardian as to what they would choose, will not suffice, no matter how close the third party decision maker is to the infirm individual. Moreover, where a guardian wishes to withhold, or withdraw, such treatment, the guardian must return to court for this specific grant of authority. This is true even if at the time of appointment the guardian was granted the widest swath of authority.

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Mental Health Treatment in Westchester

The VNSW Mental Health Home Care Program provides:

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- On-going assessment of all health needs relevant to the individual's diagnoses.
- Consultative services for the individual whose primary diagnosis is medical/surgical in nature, however, due to difficulty coping with illness, requires mental health intervention.
- Coordinated home care services for non-compliant individuals and those with complex combined mental health/physical needs that present ongoing problems.

Program Features

- Facilitate psychiatric care from in-patient to home & community
- Prevent in-patient psychiatric hospitalization
- Decrease symptoms & improving functional ability
- Improve knowledge base about medications, illness, coping & staying well
- Improve medication compliance
- Access community services

The Big Picture

Visiting Nurse Services in Westchester (VNSW) believes in a holistic, broad approach to the treatment of mental illness, addressing the "whole person's" life circumstances and environment. VNSW fields nurses with advanced psychiatric training, and in some cases, advanced degrees in related fields. The staff provides home visits for assessment, evaluation and development of a treatment plan with interventions related to mental health issues in conjunction with medical/surgical needs. This program meets the total health care requirements of individuals utilizing a case management approach led by a psychiatric nurse specialist. Adjunct services complementing the mental health component include psychiatric social workers, home health aides, medical/surgical nurses and relevant rehabilitation therapies.

The program serves the elderly, adults, adolescents and children.

To receive further information or make a patient referral, contact:

Lisa Sioufas, LCSW-R, ACSW • Mental Health Program Manager
(914) 682-1480, Extension 648 • e-mail: MentalHealth@vns.org

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The Mental and Physical Health Connection: Visiting Nurses Services in Westchester Treats The "Whole Person"

Staff Writer
Mental Health News

Almost 60 years ago, the World Health Organization (WHO) defined health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity."

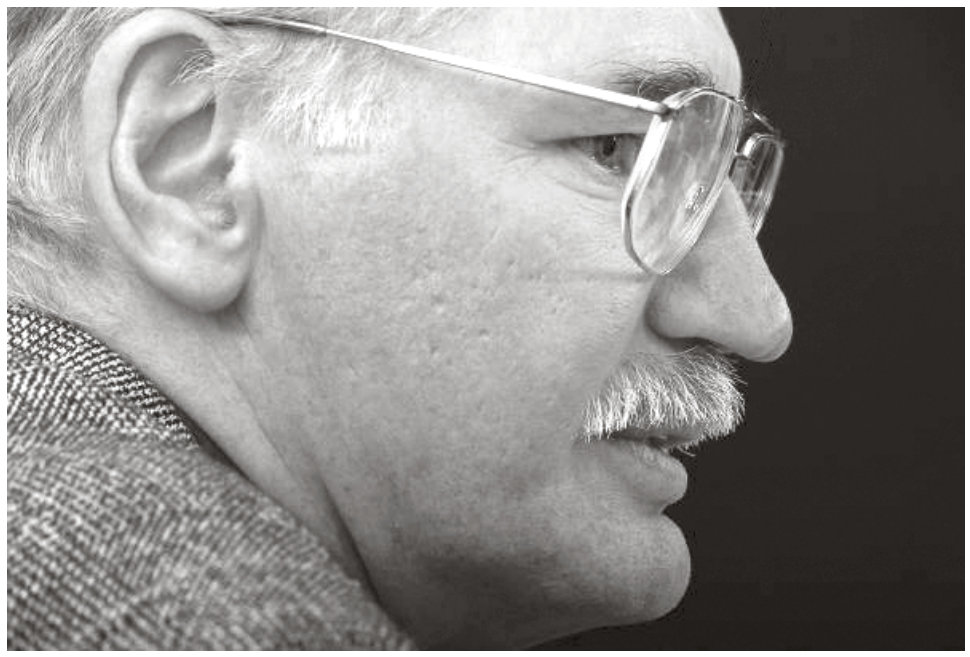
This definition has opened the doors to an increased understanding of the interrelationship between physical and mental health. Mental health problems are real. They affect one's thoughts, body, feelings and behavior. These feelings and behaviors are not just a passing phase, they can be severe enough to seriously interfere with a person's life.

There is now sufficient evidence on the relationship between mind and body. The relationship between physical and mental health is often not recognized. More recently, evidence has emerged about the adverse long-term effect of untreated behavioral disorders. Different psychological reasons can create risks both physical and mental. "The evidence is growing stronger that states of mind can affect physical health. Psychological factors affect the way people experience medical symptoms, even when the mind does not affect the underlying disease process" – Psychology Today, Mind/Body Medicine by Daniel Goleman and Joel Gurin.

Different psychological reasons can create risks that affect cardiac health. They can be classified into three categories: Chronic, Episodic and Acute. Chronic factors can play a role in the build up of artery-blocking plaques. "Increase of blood pressure during mental stress can lead to blood vessel blockage" – Science News, December 3, 2007. Negative emotions can also be associated with cardiac arrhythmias. Chronic long term effects of stress can suppress the immune system.

Depression and other major mental illnesses can have devastating effects on a person's body. Depression can lead to poor health as it often leaves people unmotivated and causes high risk patients to ignore any prevention and treatments. Depression is a risk factor for the development of cardiovascular diseases and stroke.

Mental Health problems can exacerbate or produce physical problems.



Physical symptoms can mask an underlying depression and may present as hypertension, ulcers, allergies, and asthma. Depression can also lead to substance abuse and alcoholism. They are a major co-occurring problem for adults with mental disorders. "Adolescents with a diagnosis of depression or bi-polar disorder have an increased risk of substance abuse and cigarette smoking. With the increase in cocaine abuse, there is also an increased risk of stroke and heart attacks." – Science Daily, April 3, 2007, Pg. 14-16. One in five persons, after a heart attack, will experience depression. It can have significant physical symptoms, such as unexplained aches/pains, decreased energy, increased fatigue and insomnia.

Relatively new attention is being paid to Post Partum Depression. It can affect up to 80% of women. The emotional surges are believed to be from a natural hormone shift that occurs during pregnancy and childbirth. It can happen anytime during the first year after childbirth. Women experience feelings of loss, sadness, tearful episodes. These usually subside within a few weeks. A more severe form of mental illness is Post Partum Psychosis. It is a rare occurrence – 1 or 2 in every 1,000 births. Symptoms can include delusions, hallucinations and/or obsessive thoughts.

A great deal of research has investigated the relationship between stress and physical health. Stress interferes with the body's ability to adapt, thereby increasing the likelihood of illness. Stress may be responsible for raising cholesterol levels and lead to heart disease. High blood pressure during mental stress can lead to blood vessel blockage – Science News, January 11, 2006. People with increased stress are prone to developing asthma, arthritis, diabetes, kidney disease, lung disease and ulcers, to name a few.

Mind/Body Medicine describes a variety of treatments ranging from medications, relaxation and stress reducing techniques, bio-feedback and palliates. These techniques may actually alter the course of the disease itself. They will assist the patient in learning to control muscle tension and decrease the heart rate.

Anxiety is another mental health disorder associated with panic attacks, increase in blood pressure and palpitations. Persons with anxiety have a higher risk of peptic ulcer disease. Eating disorder patients have a fear of gaining weight, an increase in stress and anxiety related to food intake. They may have a reduction of weight to the point of severe malnutrition, cardiac abnormalities and electrolyte imbalance.

Mental disorders are an immense burden in the U. S. Major depression is now the leading cause of disability in the U.S. Schizophrenia, bipolar disorder and obsessive compulsion disorder are ranked among the ten leading causes of disability. These disorders cause such distress and a reduced ability to function in every-day life. People with mental illness suffer debilitating effects, affecting family, relationships and employment. Mind and body are inseparable, and we cannot treat one effectively without treating the other. The choice between good or bad behaviors and habits rests largely on a person's mental state of mind. "The WHO notes that mental health is now recognized as an essential and inseparable part of health" – Cayman News, October 2005, by Kiran Kuman. Especially important is for women to recognize that they are affected twice as often as males by depression, anxiety and eating disorders.

Scientists are working hard to unravel the mystery behind the mind/body connection. The split between mind and body in healthcare has been a problem for years. More recently, evidence has emerged about the long-term medical effects of untreated mental health disorders. These two dynamics now suggest that we combine mental and physical health coverage—essentially financing both on the same basis. This would result in a small added healthcare cost at worst, and quite possibly, a net reduction in total costs.

The main basic point is that it is best to treat the whole person. Treating emotional distress should be an essential part of the health care system. Illness of the mind remains shrouded in fear and misunderstanding. People can be active participants in their own health care and may be able to prevent disease or shorten its course by managing their own psychological states.

Basically, we need to eliminate the distinction between the quality and kinds of services available for physical and mental health. As long as mental illness is seen as existing separately from physical health, then mental health will not receive the attention it deserves.

With its dedicated Mental Health Home Care Program, Visiting Nurse Services in Westchester is working actively toward this objective, emphasizing treatment of the whole person with the agency's core multidisciplinary approach. For details, visit www.vns.org, call (914) 682-1480 Ext. 648 or e-mail MentalHealth@vns.org.

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Activities in Group Work with Children and Adolescents

By Andrew Malekoff, LCSW, CASAC
Executive Director and CEO
North Shore Child and Family Guidance Center

The use of physical, and other, activities in group work is more than a "tool," more than programmed content, more than "canned" exercises, and more than a mechanistic means to an end. Group work scholar Ruth Middleman aptly described the "toolness of program more as putty than a hammer, i.e., as a tool that also changes as it is used." In addition to a wealth of structured resource material (e.g., manuals, games, exercises), there are the activities that grow spontaneously out of the living together that the group does. These are the creative applications, the group member- and group worker-initiated innovations that can be cultivated and brought to life in the group, contributing to a growing sense of groupness and rich history of experience together.

Andrew Malekoff, LCSW, CASAC

Extending the Bonds of Belonging Beyond the Group Itself

A well-conceived activities program in group work can add texture to the group experience, fueling its capacity to transform itself into a unique entity, something new and special that has never existed before. This is the unbreakable, malleable stuff that real life groups are made of, creating "something-ness" from "nothing-ness." In group work with children and youth, physical and other activities can help to promote a sense of competence, belonging, self discovery, invention and creativity; and can help to extend the bonds of belonging beyond the group itself.

In the development of a Children's Mental Health Plan, for example, the New York State Office of Mental Health has formed a Youth Workgroup composed of youth consumers, to contribute to the development of the Plan, along with four complementary adult groups. At statewide forums, one aspect of the youth message has been projected through the use of a video created, in part, by the youth themselves that speaks to critical issues such as the impact of stigma. Many of these youth have become capable advocates, speaking out to large groups in statewide forums. On a one-to-one basis they sell buttons and wristbands that proclaim: Youth Power. The latter process gives them a more intimate opportunity to "sell" their message. Their motto: Nothing about us, without us. Their work together is clearly aimed at extending the bonds of belonging to youth across New York State, adding strength and support to a "youth voice" in matters that affect young people struggling with emotional disturbances.

Cautionary Notes

When using evidence-based activity manuals or other protocols in group work, I suggest that you do not blindly follow the manualized instructions. Please keep the following cautionary notes in mind:
Activities should not be used to keep kids busy and practitioners anxiety-free.

When using curricula (i.e. anger management, conflict resolution) activities should not be curriculum-driven, rather curriculum-guided so as not to minimize opportunities for interaction, mutual aid, and spontaneity.

Have a clear and above board purpose for the use of activities and no hidden agendas (i.e. don't use activities to "get them to talk about their feelings," unless group members understand that it is an activity might promote conversation and expression of emotion, for example).

Be conscious that the outside world might devalue the use of activities with kids, especially when the groups are noisy or messy (i.e. there is a tendency to trivialize as frivolous, anything that is not particularly psychological and anything that looks like good fun).

Following are illustrations of two mental health groups, in two different settings, both using activities to cope with loss and grief.

Rock and Reflective Garden

A group of pre-adolescent boys and girls who lost parents in the attack on the World Trade Center prepared for the ending of their group by decorating stones to be placed in a memorial rock garden. At the same time another group of high school students attending an alternative school for students with serious emotional disturbances approached their principal about planting a tree in the school courtyard to memorialize their friend Geoffrey, a group member who succumbed to a chronic disease.

The kids in the bereavement group sat together around a rectangular table covered with newspaper. In front of each of them was a smooth oval shaped stone, roughly double the size of a portable CD player. They decorated the stones with unique designs of paint and glitter, each one a personal remembrance of their moms or dads. As they decorated, the group worker moved from one to another, admiring and asking them about each one's design. "Mine is painted gold," beamed Mac. "I painted it gold because my dad is like gold to me." Jenny's design was framed by a heart, "because my mom will always be in my heart." On Seth's stone were two intertwined hands, a small one and a larger one that showed "me and my dad were best friends." Victoria painted a fire hat and said, "my dad is my hero." On some stones they painted, "I will miss you," on others, "I will always love you," and on some a combination of both. Many included a patriotic theme. There were lots of stars and stripes. Each one of them touched a chord in the others as they spoke… "he's like gold…she will always be in my heart…he was my best friend…he's my hero…" The room was enveloped in a warm glow.

It was the end of the school year. Planning a memorial for Geoffrey coincided with the end of the group. They organized a fund-raiser that revolved around selling baked goods and homemade candy. They advocated successfully with the school administration for space in the courtyard for what they called a "reflecting garden," that would contain a bench and tree to remember their friend.

After a week or so when the stones were dry, a memorial ceremony that the 9/11 bereavement group planned was held. This was an important ritual for kids whose moms and dads bodies were never recovered or were found only in parts. During one group meeting Alison revealed that her family couldn't decide whether to bury her father in regular-sized casket or a baby casket. She explained, "All they found was his arm." The ceremony was held in the evening. The surviving parents and siblings, many of whom also decorated stones in their groups, participated in the candlelit ceremony. Each one had a chance to place their rock in a spot of their choosing in the rock garden. If they chose to they could say a few words or silently place their stone.

The installation of the bench and tree planting Geoffrey took place on the last week of the school year, a bright and sunny June day. The family of their deceased friend attended. They would later say that they were overcome with the thoughtful and sweet nature of the modest memorial. A touching and tastefully designed four-page booklet that the group designed contained the details for the memorial program. On the top of the front cover was printed in calligraphy, In Loving Memory of Geoffrey B. Underneath was a color illustration of a flower. And beneath the flower and the words, We see your love in every flower that blooms and grows. Several of the group members sang "The Storm is Over." Others wept openly, even the some of the tougher boys, and hugged one another.

see Group Work on page 35

Post Traumatic Stress Disorder

By Lawrence J. Winters, BPS, LMHC
Senior Clinical Group Psychotherapist
and Coordinator of Veterans Treatment
Four Winds Hospital

Until recently in our society, a warrior held on to his identity when he had returned from war. His role remained as one who had and would continue to protect the society in which he lived. The warrior was trained to put his personal fears and needs aside for the others. He was the one called when there was danger. He was the one who would teach society what war was really about. This social role provided an identity for returning soldiers.

During the Vietnam War, however, many civilians did not see returning soldiers as warriors. Because of changing political and social perceptions, returning warriors were all too often seen as trained killers or, at best, misguided souls. As we all know now, this caused a grievous wound to the psyches of our soldiers. To have been asked by your country to risk your life—and to take the lives of others—and not be honored for your sacrifice when you return, is a soul wound.

Today, this is recurring with reference to soldiers returning from the Iraq and Afghanistan Wars.

I recently finished writing a book titled *The Making and Unmaking of a Marine*, which is about my journey from childhood through Vietnam to the present. I'd spent fifteen years working on that book and thirty years writing poems about my war experiences. Since my return from Vietnam, I had been in personal therapy for many years. I attended years of school to become a therapist. I enrolled in more workshops that I can list, from Robert Bly's men's groups to professional conferences concerning PTSD. I even went back to Vietnam in 1994 with a group of health care professionals to deal with my ghosts and to ask for forgiveness from the Vietnamese people.

This is a poem that I wrote shortly after returning from Vietnam in 1970. Listen for the confusion in it and you will begin to understand how many of today's returning soldiers feel.

CONFESSION

I'm ashamed that I may not have
killed anyone in Vietnam;
I'm ashamed that I may have killed someone.

I'm proud that I was a Marine;
I'm embarrassed to tell anyone that
I was in the Marines.

I grew up believing in God and country.
In Vietnam I lost my belief in God and
distrust anything my country told me.

Vietnam was the most beautiful country
I ever saw; vibrant colors, skies
piled with cumulus clouds, beautiful
women with silk black hair;
Vietnam was an ugly, blood-drenched,
sweating inferno where women and children were, at times, weapons themselves.

Vietnam made heroes out of schoolboys;
Vietnam made traitors out of scared boys
who hated what they were told to do
but did it anyway.

I wanted my father to be proud of me for
standing up and fighting for my country;
My father never asked me anything about
the War when I returned.

I missed my girlfriend and married her
as soon as I got home;
I divorced my wife and for years could
not father our child.

Nowhere in all my searching did I find any individual or group that understood what the war had done to me. I searched like a well-trained Marine looking for the enemy. No one seemed to want to know what the war did to my insides.

That is, until recently when I read Ed Tick's book *War and the Soul.* I lay in bed each evening for three weeks reading it. I wept so frequently that I stopped trying to hide it.

Ed Tick's thirty years of working with vets had opened his heart. His expansive scholarship on the topic of the warrior tradition was helping me pull my fragmented soul together. Finding someone who understood the interior of me as a Marine was deeply affirming. All the academic treatises I'd read on PTSD left out the fact that human beings have souls.

In my life of study and learning, I have never thirsted to take in anything as much as the teachings of *War and the Soul*. My eyes and heart opened when I read on page 108, "We have seen that classifying and treating PTSD merely as a stress and anxiety disorder fails to address its deeper dimensions. Moreover, while medication may rebalance biochemical functioning, it cannot heat the inner self. In the standard kind of treatment, the veteran feels pathologized and is expected to "get on with life". He feels encouraged to measure his progress against normative civilian functioning rather than to do what is truly needed, which is to embrace the experience of inner death and seek a new identity and spiritual rebirth. The common therapeutic model, that is, misses the point that PTSD is primarily a moral, spiritual and aesthetic disorder – in effect not a psychological but a soul disorder.

You may hear in this next poem some of the rage from PTSD that had disassembled me after coming home from the war.

AMERICA

"For all of you that live here during the
Vietnam War" I killed for you. You may
not have asked me to, But I killed for you.
I didn't ask to go to Vietnam.
I didn't support the war.

Still I killed for you and for me.
I killed for you, While you paid your
taxes. You watched me kill on TV,
While you were eating cheeseburgers.
I killed for you. While you were
protesting that I was killing for you, I
killed for you. While you were avoiding
the draft, While running off to Canada,
I killed for you.

I killed for you
While you waited in line at the supermarket,
While you were out getting drunk,
When you got your first good job
after college, As you enjoyed free love,
I was killing for you. I have carried pain
for you. Guilt for you. Shame for you.
For all the killing I did for you.
To get on with my life for you.
To be productive for you.
To marry you. To raise children for you.
And most of all to forget for you.

Often at these presentations, I am asked by clinicians questions like, "What tools do you have that I can use when a vet comes into my office and won't open up?" or "How do you deal with the anger that these men carry?" or "How do street drugs play a role in PTSD when you know drugs were a part of the war?" Of course, I put on my clinician's hat and field these questions as best I can, but when I leave, I don't feel like I have gotten my point across. Upon reflection, I think looking for new and unique tools to

see PTSD on page 22

FOUR WINDS HOSPITAL • FALL 2008

OCTOBER 2008

GRAND ROUNDS

Friday, October 3, 2008 • 9:30 – 11:00 am

A Child's View: How to Talk to Children at Any Age

Sarah Klagsbrun, M.D.

Child and Adolescent Psychiatrist in Private Practice, New York City; Assistant Attending in Psychiatry, New York Presbyterian Hospital Weill Medical College

This program will provide practical information and skills to mental health professionals, school personnel, administrators, parents and anyone who spends time with children. At the conclusion of this session, participants will:

- Improve their communication skills with children of any age.
- Understand how to help children handle and express their feelings.

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

1.5 CME Credits Available

Application pending for 1.5 OASAS CASAC/CPP/CPS clock hours

A COMMUNITY SERVICE

Friday, October 10, 2008 • 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.

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.

Register online at www.fourwindshospital.com

OCTOBER 2008

GRAND ROUNDS

Friday • October 24, 2008 • 9:30 – 11:00 am

New York -- The State of Mental Health

Michael F. Hogan, Ph.D.

Commissioner, New York State Office of Mental Health

At the conclusion of this presentation, participates will better understand:

- "Mega trends" in mental health.
- Current issues and challenges in New York State.
- Current priorities for New York's Mental Health Community.

Fee: $15.00 payable to Four Winds Hospital

1.5 CME Credits Available

Application pending for 1.5 OASAS CASAC/CPP/CPS clock hours

OPEN HOUSE

Tuesday • October 28, 2008 • 4:00 – 7:00 pm

Nursing Career Day

Experience Four Winds firsthand during this informal event.

Join a Team that uses a Multi-Disciplinary Approach to Treatment.

Your Voice Will Make A Difference!

Refreshments, Tours, an Opportunity to Meet with Nursing Leadership

Competitive Salaries/Benefits

RSVP by October 20th to 1-800-546-1754 ext. 2413

Albert Einstein College of Medicine designates each 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, physician's assistants, psychologists, nurse practitioners, social workers, mental health providers, EAP's, education professionals, school counselors, RN's and consumers.

Community and Professional Education Programs

NOVEMBER 2008

SPECIAL TRAINING

Thursday • November 13, 2008
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

DECEMBER 2008

SPECIAL EVENT

Friday, December 5, 2008 • 9:30 – 11:30 am

MOZART: The Mind and Music of a Genius

Richard Kogan, M.D.

Director of the Human Sexuality Program, Weill-Cornell Medical Center and New York Presbyterian Hospital; Private Practice, New York City

Wolfgang Amadeus Mozart (1756-1791) is universally acknowledged as the greatest child prodigy and greatest genius in music history. What was the impact of his complex personality on his creative output? Did Mozart suffer from Tourette's Disorder or Asperger's Syndrome? Dr. Richard Kogan, psychiatrist and virtuoso concert pianist, is uniquely qualified to explore these questions. He will illustrate his talk by performing some of Mozart's most glorious music.

This program will enable participants to:

- Recognize the psychological factors that influenced Mozart's artistic development.
- Understand some of the fundamental concepts about creativity.

Fee: $20.00 payable to Four Winds Hospital

2.0 CME Credits Available

This training is provided under New York State Office of Alcoholism and Substance Abuse Services (OASAS) Education and Training Provider Certification Number 0815. Training under a New York State OASAS Provider Certification is acceptable for meeting all or part of the CASAC/CPP/CPS education and training requirements.

Four Winds HOSPITAL

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- **10-13 years old:** focuses on developing social skills, mastering impulse control and promoting healthy communication
- **14-17 years old:** focuses on empowering adolescents through peer support and feedback

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ext. 2413

PTSD from page 19

heal PTSD is not what is really needed. There are an abundance of toolboxes from many modalities that are used to treat PTSD ranging from exposure therapy to standard cognitive behavioral therapy approaches. Attention to this topic is good because it has forced the medical and psychological communities to focus on PTSD and its treatment.

In my opinion, we are missing the target when we look for new tools. In my experience, there is no tool that can put the soul into a box so it can be examined. There is no blueprint for how to treat PTSD that works any better than the caring, listening, and compassionate truthfulness of a clinician. By putting the trauma of war into a diagnostic category, we remove responsibility from our society for having traumatized our soldiers by sending them into war. In addition, PTSD therapeutic tools are nothing more than diagnostic armor working to protect us from the painful, dehumanizing, soul-wounding events our clients report to us. These tools come from the heads of scholars and keep us one step removed from the souls that may be withering before us. Yes, tools are important and are useful, but they insulate us from feelings, which should, in my opinion, be a central source of information on how we work as therapists and healers.

The best tool I know for speaking with a war veteran is to know that one cannot speak to a vet about war if one hasn't listened first. I mean the kind of listening that uses more than the ears. I would call it deep listening; Ed Tick would call it soul listening. It's easy to hear the facts, assess the circumstances, analyze the difficulties and even devise a game plan to help. However, there are few who take the time needed to hear a soldier. If a soldier is going to speak about war, it will be within his or her own time frame, not yours or managed care. Most of what gets said about war is in the punctuated silences. However, if one listens long enough, open up wide enough, one may hear the oblique tenor of war. Mother Teresa understood when she said, "Kind words can be short and easy to speak, but their echoes are truly endless."

Human souls have many forms of communication, and words can only hold so much. Silence, if heard as simply empty moments needing to be filled, only closes the treatment door. Taking time, tolerating silence, waiting, witnessing the presence of another human being in pain, and staying in the room are the skills needed to communicate with a war veteran. It has so much more to do with being present than speaking. You should know that it is an honor if a veteran speaks to you about war, and if it happens, please share with them that you're honored. What I have just said could be summed up by the famous anonymous who said, "When you walk the walk, people listen."

When I returned to Vietnam in 1994, I was visiting a Vietnamese Cemetery. Afterwards, I wrote this poem:

VIETNAM

Cemetery Worker at Viet Cong Memorial

I called to you. "Come here, I have
something for you". You mumbled back.
I called again. You mumble again.
I wave for you to come. You looked away
and spoke clearly. "I no come here".
I wanted to give you money. You who
takes care of my enemy's graves.
But you turned away. Both of us
knowing it could never be enough.

Charles Swindoll, the evangelical Christian pastor said, "Forgiveness is not an elective in the curriculum of life. It is a required course and the exams are always tough to pass."

In 1980 PTSD became a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders or DMS II at that time. This was seen by many health care professionals as making great strides for combat veterans; they would now be eligible for the treatment they had urgently needed since the ending of the Vietnam War five years earlier. Finally, the effects of war trauma on soldiers – which in previous wars had been called "Shell Shock" or "Soldiers Heart" – became legitimized and the VA was held responsible for its treatment.

When declaring PTSD an illness and listing it in the mental health manual for the treatment of individuals, we effectively isolated the problem into the category of mental illness. This, in turn, placed the onus of healing on the patient and the patient's treatment team.

All of this misses the point that war wounds the soul, and soul wounds are not listed in the DSM.

There is a reason that such a large number of Vietnam vets are coming to the VA with PTSD symptoms some 37 years after the war. They have hidden from the society that shamed them for what they had done. With the change in attitude towards our current soldiers or at least the use of politically correct language such as "I don't support the war but I support the troops," these Vietnam vets now have come for help with symptoms that have become a way of life for them and their families.

Another thing we miss when we see PTSD as an individual disorder is the fact that it is an infectious illness. We may treat the individuals with PTSD but ignore that it has spread into their families and their communities where it goes largely untreated. The VA is not responsible for the veterans' families, so who is there to help them?

Unless we accept our responsibility as a society in the healing of PTSD, our veterans will not find peace and nor shall we.

Our social responsibility means seeing and listening to our vets when they come home from war. But when we send our soldiers to isolated VA hospitals, we don't have to sit next to them in our waiting rooms. When we bring our war dead home under the cover of darkness, we won't have to watch. When we put Ipod plugs in, we don't have to listen to our veteran's war stories.

We are also protecting ourselves when we use the word "hero" because we don't have to see the depth of pain in the soldiers we are pinning the medals on. They stand erect, proud to be acknowledged, and later implode at the bar or with family or when they are alone.

What can we do to help heal those who have protected us from the furies of the outside world? I believe that first, we must understand that we can heal our soldiers and our society, that the damage we are confronted with is not insurmountable. Somewhere in our makeup are patterns or instincts left that can guide us towards opening our arms to each other, towards opening our ears to human pain and allowing compassion to return to the social equation.

When Abraham Lincoln said, "With malice toward none, with charity for all, with firmness in the right as God gives us to see the right, let us strive on to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan, to do all which may achieve and cherish a just and lasting peace among ourselves and with all nations," he was pointing the nation towards its obligation to help and heal its returning soldiers and their families. He knew that this would, in turn, heal society.

Our obligation to veterans goes beyond parades, VA hospitals, and military medals. Only when we watch our willingness to help heal our soldiers in their commitment to go to war will we begin to stop their suicides, their relief from pain with addiction, their spilling of rage in domestic violence, and in short, their self destructiveness within our midst. I would like to end with a poem that I wrote and read to the Vietnamese in 1994:

WAR

If a man kills another man,
He must dig two graves –
One in the earth for the dead man,
And one in his heart
For his own spirit,
Or he will not return.

The Mental Health News

New York City Section

Improving Cultural and Linguistic Competence: The Case of Integrated Physical And Mental Health Care

By Denise Reed, MBA, MPH
Elizabeth Siantz, MSW, Ron Turner
and Roberto Lewis-Fernández, MD
Center of Excellence for Cultural Competence
New York State Psychiatric Institute

Health is not possible without mental health, and quality mental health care cannot be achieved without culturally and linguistically relevant services. These are the two principles that guide the work of the Center of Excellence for Cultural Competence at New York State Psychiatric Institute ("the Center"). The impetus for the creation of the Center was the review of the status of mental health in New York State performed by the NYS Standing Committee on Mental Health, Mental Retardation, and Developmental Disabilities. Under the leadership of its Chairman, Hon. State Assemblyman Peter M. Rivera, the committee undertook a comprehensive review of the mental health delivery system in New York State. Not surprisingly, the Committee's report released in 2002, titled Broken Promises, Broken Lives: A Report On the Status of the Mental Health Delivery System in New York State, reached the following conclusion: "The current system of service delivery was not meeting the needs of the citizens of the state. As a result, thousands of mentally ill persons have suffered indignities and abuse, and hundreds of others have succumbed to untimely deaths due to a dysfunctional mental health system."

Top Row: Elizabeth Siantz, Luz Marte, Roberto Lewis Fernandez MD, Stephanie Sosa, PHD, Denise Reed. Bottom Row: Hannah Carliner, Ron Turner, Andel Nicasio

The follow-up work performed by the Subcommittee on Underserved Populations led to the passing of Assembly bill A01612 to create two centers, one at Nathan Kline Institute in Orangeburg, New York and the other at the New York State Psychiatric Institute in Manhattan. Both were funded in November, 2007.

Among the demographic factors that influenced the passing of this bill was the growing proportion of New York residents (and of the US population as a whole) who belong to a racial, ethnic, and linguistic group that is underserved by the health care system. While this population shift is most evident in the state's urban centers, rural communities are equally impacted. A longstanding injustice affecting ethnic, racial, and linguistic underserved groups in New York State (regardless of urban or rural location) is the persisting level of disparity in the care of both physical and mental health. In fact, the gap appears to be widening between non-Latino white Americans and other groups with respect to several indices of health care access, quality, and outcome.

The increasing number of unmet physical health needs of individuals receiving treatment for chronic mental disorders, also defined as serious mental illnesses (SMI), is one byproduct of this demographic shift. As a result of the marked morbidity and mortality associated with physical illness, ethnic/racial and linguistic minority individuals coping with SMI are one of the most vulnerable

see Improving Competence on page 37

Health Integration Activities in the NYC Department of Health and Mental Hygiene

By David A. Rosin, MD
Executive Deputy Commissioner
for Mental Hygiene Services

In recent years, health has come to be recognized more as a state of physical, mental, behavioral and social well-being, and not merely the absence of disease or infirmity. The link between physical and behavioral health has been measured in New York's own population. According to the 2004 New York City Health and Nutrition Examination and Survey (NYC-HANES), on average, New Yorkers who had significant emotional distress were 12% more likely to engage in behaviors (including physical inactivity, binge drinking, smoking, and poor diet) that put them at increased risk for co-morbid medical conditions.

Adults with serious mental illnesses, such as schizophrenia, bipolar disorder and depression, as well as co-occurring serious mental illness and substance use, lose significant years of their life to disability, morbidity, and mortality resulting from a combination of physical and behavioral health factors. Many die prematurely from conditions such as cardiovascular, pulmonary and infectious disease at

David A. Rosin, MD

a much higher rate than individuals who do not have a serious mental illness. People living with serious mental illnesses encounter additional barriers to adequate health care such as system fragmentation and stigma and as a result receive fewer routine preventative services.

The New York City Department of Health and Mental Hygiene's (DOHMH) Division of Mental Hygiene (DMH) through its Bureau of Mental Health and Offices of Health Integration and Mental Hygiene Quality Improvement is engaged in a two-part approach to integrating physical and mental health services. The first focuses on detection and management of depression in primary care settings. The second focuses on addressing the physical health needs of individuals receiving mental hygiene services.

While depression is commonly seen in primary care settings, it is frequently unrecognized by primary care physicians and, even when diagnosed, often results in less than adequate treatment. DOHMH's Depression Initiative aims to better prepare primary care physicians to screen and manage depression through training, technical assistance, and care management support.

To improve the quality of depression and management in primary care, DMH works with local health care providers to promote integrated care.. In one model, depression care managers provide follow-up, outreach and support to individuals who have screened positive for depressive symptoms and are receiving care from their primary care doctor. Individuals receive follow-up phone calls between their regular office visits. During these calls care managers may periodically administer the PHQ-9 depression screen to assess changes or improvement in symptoms, help people adhere to their treatment plan, and encourage self-management goals such as exercise. This information is shared with the treating primary care provider, who may also consult with a psychiatrist as needed. DMH began working to place care managers in selected Federally Qualified Health Centers (FQHCs) in 2007 and is currently evaluating the model.

The DOHMH strategy for integrating physical health care into behavioral health settings includes working with mental hygiene providers through the DMH Quality IMPACT Initiative to conduct continuous quality improvement projects aimed at improving the assessment, monitoring, and care coordination of consumers' physical health issues in mental hygiene treatment programs. In fiscal year (FY) 09 50 participating providers will complete health screening instruments, assess for unmet physical health needs, and establish goals in partnership with individuals to address identified health

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Fountain House Members Improve Mind and Body

By Ruth Parson, MA, Unit Director and Wellness Unit Participants Fountain House

Several years ago Fountain House, the originator of the Clubhouse model of psychiatric rehabilitation, witnessed the statistical rise in morbidity that affects those living with mental illness within our own consumer ranks. We suffered loses to a degree that we could not overlook. After two years working as a wellness committee, we realized that taking such a small step would not sufficiently address all the issues of concern. To remedy this, we have developed a *Wellness Work Unit* that will include: a health food bar and healthy cooking program, a gym, and a personal training program. In addition we are working on building relationships with community clinics, agencies, businesses, and providers to develop articles, information, and workshops on such topics as diabetes, smoking cessation, yoga, and other integrative health modalities.

The oldest and fastest growing part of our program is personal training at our in-house gym. We offer fifteen classes during the week and make our gym available before and after our work day. Our *Berry Xcellent Café* offers a morning and afternoon Health Bar with homemade beverages, soups, and salads. Research and information collection occurs throughout the day providing us with answers to our own questions and those coming from our community members. To help the program inspire a cultural change toward physical and mental health, we offer healthy alternatives at every chance we get. The Wellness unit's also contributes to our social program in a healthy way by offering dancing, biking, spa-ing—always with a healthy slant on the foods we offer.

The question remains, is there a correlation between physical and mental health and how do we know if we are seeing the effects of the interrelationship here at Fountain House? We hear it from each other in the elevator and on the staircase. We observe it when a member decides to come in more regularly to exercise on the treadmill and meet for relaxation exercises in order to stay calm enough to pass her driving test. We see it in the transformation of the person who heads for the gym looking quiet, pale and sluggish who after their workout steps into the rest of their day with animated posture and expression, thanking us for the time and asking for help to learn more about a nutritional issue. It's still a little early for us to call our observations scientific evidence, but the anecdotes abound and interest is increasing beyond our hope in our first year. When we began our work three years ago, very few discussions took place about staying healthy physically and even fewer about the effect it could have on mental health. These days this is a fairly common topic, not only at lunch time but where ever we meet each other. We asked a few people to share their thoughts on the effect of the Wellness unit's work over the last year. Here are some comments:

"The Wellness unit helps me keep my mind directed toward being healthy." "I feel better than when I was working in the Snack Bar. We talk about diabetes a lot in the Wellness Unit and I am now more aware of how much sugar I eat."

"In my old unit, the Snack Bar, we learned about cooking, bussing and working as a cashier. But in the Wellness Unit, we learn how to stay focused about what we eat, how to lose weight and how to make healthy foods and drinks. Since working in the Wellness Unit, I have cut down drastically on the amount of sugar I eat, and I have noticed that I have lost some weight! Sometimes I use the treadmill in the gym, and I do exercises at home, also."

"The Wellness Unit has changed my mind about eating healthier. This unit educates me about eating well, which has had a strong impact on me. The Snack Bar was good in a way, but they served junk food. In the Wellness Unit we try to convince people that health food is better for you and that exercise is good for you, too. When the Snack Bar ended, many people in the House were upset and said that they could never eat health food. But now the same people who said they wouldn't try our smoothies, juices, soups, salads and granola bars are regulars at the juice bar, and love all of our healthy food!"

"The Wellness Unit is about eating healthy. I eat healthier now that the Wellness Unit is here. Our unit is a health and nutrition unit so we want people to be in shape. I've been leading the chair exercises for almost a year. It is important for people to do them. The chair exercises make working out accessible to everyone; chair exercises are easier to do than other exercises, and they are less intimidating. I think people should exercise, eat right and watch their bodies."

"It's the best unit in the house. I don't eat cooked or fresh veggies, but I'll drink the juices! The veggie drinks brought me in. I first thought there wasn't going to be much of anything but it's excellent. The prices are very affordable. I checked out the gym and I started today. The unit is the best thing that's happened in the house since I came in 1974."

"I joined the Wellness Unit because I thought that I might have the chance to use some of my learning and skills from my job as a physician. I found that working on the unit taught me many things about nutrition, exercise and especially food preparation. I've started on a cardio routine for the first time in over a year. I've enjoyed watching how the rest of the House has come around to making use of what we have to offer. This is so thrilling because I believe that this could contribute to improving life expectancy among my fellow members."

"It provides a morning an opportunity to drink a vegetable juice that provides my greens, which I need because I am deficient in iron. I also find the exercise gym vital to my good health. I find especially

see Fountain House on page 36

Improving Access to Health Care for Mental Health Consumers

By Jack Carney, DSW, Senior Director F·E·G·S Citywide & Brooklyn Blended Case Management Programs

Recently published studies have startled mental health professionals with the assertion that persons with serious mental illnesses in the United States can now expect to live, on average, 25 years less than everybody else. The CATIE and the State Mental Health Program Directors studies detail a hierarchy of causative factors. First, they point to the "second generation" or "atypical" neuroleptic medications, which are linked to excessive weight gain and insulin resistance in many of the persons prescribed them. The weight gain and insulin resistance appear to account for the emergence in many persons with serious mental illnesses of a medical condition termed "Metabolic Syndrome" which if left untreated, can lead to the development of Diabetes II and cardio-vascular and other systemic medical conditions.

Finally, other presumably remediable causes include consumers' life style choices, i.e., smoking, lack of exercise, poor nutrition, abuse of intoxicants; their exposure, in shelters and mental health residences, to communicable diseases; and, ultimately, their lack of access to appropriate and effective medical care.

Jack Carney, DSW

I direct the New York City-based case management programs for FEGS, a large mental health and social welfare agency active throughout the City and in Nassau and Suffolk counties. At present, 50 case managers serve 720 clients with serious mental illnesses located in all five boroughs. After discussions with program staff, consumers and the senior vice president of the agency's Behavioral Health division, we decided to develop a pilot training program and case management protocol whose primary objective is to prepare consumers and case managers to work closely together to improve our consumers' access to necessary medical treatment.

We called our initiative the *Integrated Collaborative Case Management Demonstration Project* (ICCM) to reflect our newly balanced emphasis on behavioral and physical health care and the collaboration between consumer, case manager and health care providers that it requires. We anticipate that improved treatment access and coordination will bring with them reduced use by our consumers of emergency room medical care and inpatient hospitalization, and, ultimately, longer and healthier lives.

We launched the Project in September 2007, when a small group of self-selected case managers, consumers and team supervisors of the FEGS City-wide and Brooklyn Blended Case Management Programs began a fourteen hour-long training course designed to prepare them to improve these consumers' access to necessary health care. It was decided to train consumers and case managers together because we assumed that a true collaborative effort between the two will be required to overcome the barriers to health care personified by overtaxed and often intolerant health care providers.

As soon as the training was completed, each of the case managers who participated selected a second consumer who, like those in the first group, was being prescribed one of the atypical anti-psychotic medications or had a chronic physical ailment. The case managers then proceeded to share with this second group the information that they had acquired in the formal training.

The case managers and both sets of consumers then set out to operationalize our ICCM Protocol, which, in summary, involves the following:

- initiation by each consumer's primary care physician (PCP) or psychiatrist of the Metabolic Syndrome Monitoring Protocol;
- review by the PCP or psychiatrist of the Protocol's test results with consumer and case manager, as well as communication of the results to the consumer's other physician;
- referral (s) for recommended treatment.

Our ICCM Demonstration Project concluded in April 2008, when the last of our outcome data from the Project's participants was fully collected. At its conclusion, the final participant cohort was comprised

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Wellness Initiatives for People Living with Mental Illness

By Salene Browne, Glenn Stelzer and Allison Wendell, F·E·G·S Health and Human Services System

According to New York State's Commissioner of Mental Health, Michael Hogan PhD, "There really is no recovery without some overall experience of wellness. There is no wellness without positive mental health. We need integration of care in every place. We have to approach it from a lot of different angles in behavioral health care settings to address emerging health problems." Dr. Hogan served on the committee which published the 2006 "Morbidity and Mortality in People with Serious Mental Illness" report by the National Association of State Mental Health Program Directors (NASMPHD). The report found that people with mental illness die 25 years earlier than the general population, largely due to treatable medical conditions caused by smoking, obesity and inadequate access to medical care.

F·E·G·S Residential Services highly values the wellness of its tenants and places a strong emphasis on the influence that physical health has over an individual's emotional well-being. As part of the Urban Institute of Behavioral Health (UIBH)/OMH Wellness Self-Management Initiative, F·E·G·S has trained it residential staff to help all tenants maintain the lifestyle habits that are an integral part of maintaining good mental health, such as abstaining from alcohol and street drugs, maintaining a balanced and healthful diet, and exercising daily.

Salene Browne, Glenn Stelzer, and Allison Wendell

Gabrielle, 25, is a resident of Tanya Towers Apartment Program, one of the numerous housing programs offered by F·E·G·S for people who are living with a mental illness. Tanya Towers is a specialized building that houses persons who are deaf while they may have other disabilities. In March 2008, Gabrielle began attending newly formed Wellness and Nutrition groups provided at the residence by trained staff to address her health, as well as, emotional issues.

Before she joined the group, Gabrielle was agitated and impulsive; she didn't have much appetite and had trouble sleeping. The group offered her the education and support necessary to better manage her life. The group helped her commit to avoiding unhealthy foods and beverages, and learn how to identify any physical and mental task that was too intensive and a potential trigger for angry and impulsive actions. Gabrielle reports that since joining the Wellness group she is happier at home and on her job, she feels better and has not gotten in trouble for aggressive behavior. Her appetite is better and she understands the need for good nutrition and healthy foods. Even her sleep has improved. At 25 she is developing healthy habits that can help her stay well both mentally and physically.

In order to achieve this goal, F·E·G·S conducts groups like Gabrielle's at all of its residential programs. F·E·G·S's Burnside Community Residence, for instance, offers a full compliment of Wellness Self-Management groups to aid residents in improving their overall well-being and move toward healthier, more independent and happier lives. The weekly groups offered are: New Consumer Orientation; Fitness Lab; Stress Reduction; "Eating for Life"; Symptom Management; Peer Support, which includes sessions on smoking cessation; Paths to Recovery; and Medication Management. The groups are having success with the Eli Lilly's *Solutions for Wellness* and *Team Solutions* workbook materials which allow group participants to identify the issues they struggle with in their lives and in doing so make the first step toward resolving them. One participant said, "The book taught me how to get around obstacles and gave me a better understanding on how to deal with every day life."

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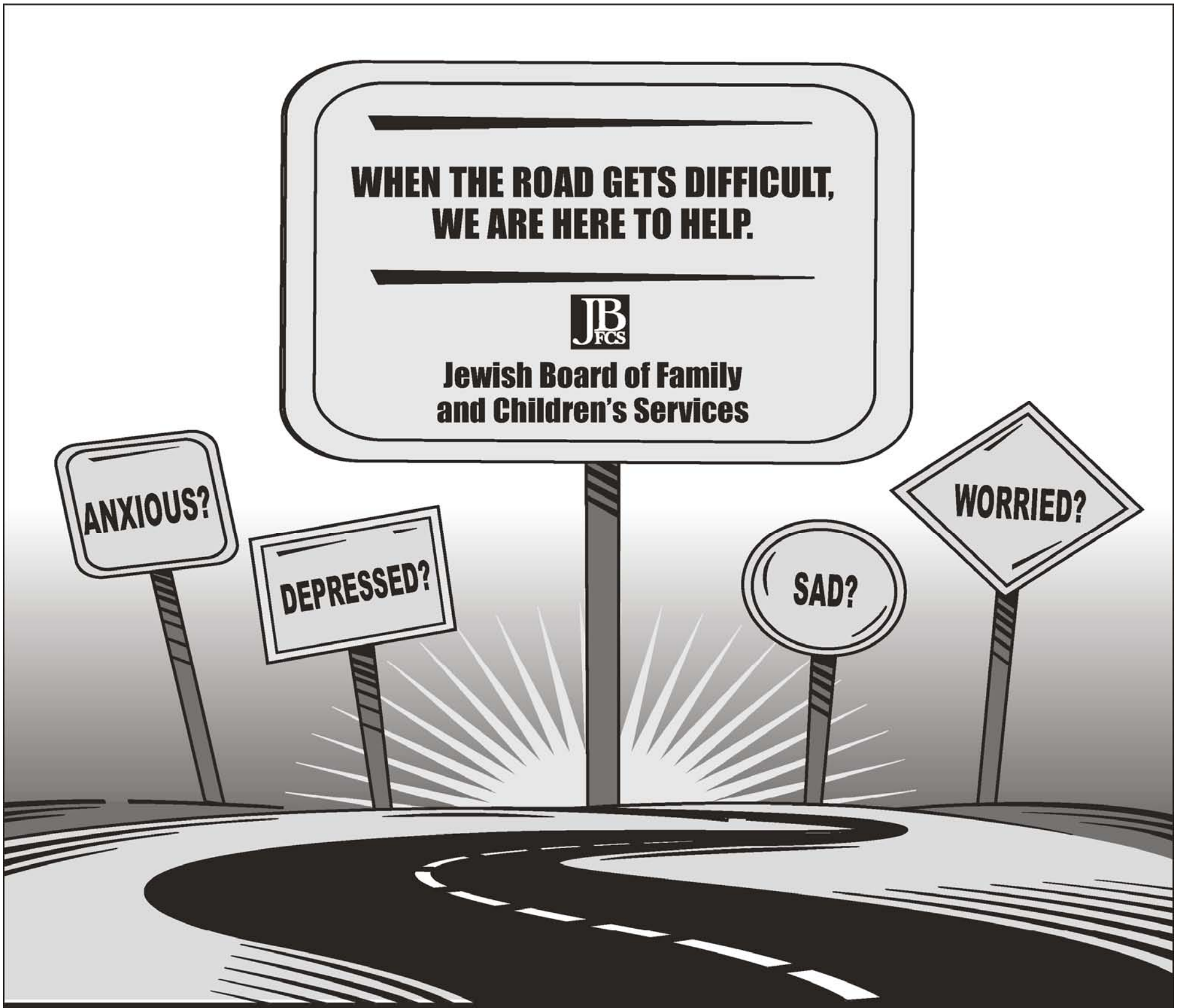

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Addressing a Risky Business: The Interplay Between Medical and Psychiatric Disorders

By Richard J. Gersh, MD
Director of Psychiatric Services
and I. Bruce Gordon, MD, MBA
Medical Director, Jewish Board
of Family and Children's Services

Richard J. Gersh, MD

I. Bruce Gordon, MD, MBA

Prior to the last decade, the interface between medical and psychiatric disorders was largely discussed as medical conditions that are risk factors for behavioral problems. More recently, however, we are focusing on the ways in which psychiatric conditions are risk factors for medical (physical) disorders.

It still bears reminding ourselves of common medical conditions – and common medical treatments – that can produce a clinical picture that mimics a psychiatric disorder. For example, hyperthyroidism – an overactive thyroid gland – will often cause an individual to complain of feeling anxious, jittery, having trouble sleeping, and losing weight, which may look like an anxiety disorder, if the underlying medical condition is not recognized.

An underactive thyroid gland – hypothyroidism – will present a clinical picture of feeling tired, sluggish, confused, and gaining weight, which might be mistaken for depression. In each instance, it would be a mistake to treat the behavioral phenomena, when the underlying thyroid disorder should more properly be addressed.

Similarly, fluctuating blood sugar levels – seen in diabetes mellitus and hypoglycemia – can produce periods of confusion, anxiety, personality changes, and mood swings. Older treatments for hypertension, such as alpha-methyldopa, were notorious for causing depressive symptoms. Steroids, used to treat a variety of disorders, are associated with mood swings and psychosis.

More recently, Retin-A, a powerful acne medicine, has been associated with cases of clinical depression. Pancreatic cancer, which is often undetected until it is advanced, is associated with symptoms of depression, which may be the first signs of the cancer. Disorders that involve brain structures, such as HIV infections, strokes, brain tumors, head injuries, and seizure disorders, commonly produce changes in mood, personality, cognitive functioning, perceptions and behavior.

From these examples, we see how important it is to consider the patient's medical status when assessing a suspected psychiatric condition. Ideally, all possible medical conditions – such as those mentioned above – would be tested for or ruled out before any psychiatric treatment would be considered. It is not unusual for a thorough psychiatric evaluation to reveal a medical problem that has been unrecognized by primary care practitioners. In practice, however, it is often difficult to maintain this standard, and psychiatrists generally limit a medical work-up to the most likely problems that must be assessed.

The Medical Side of Psychiatric Illness

Of growing importance, in more recent years, are the medical aspects of psychiatric illness. Since the introduction of modern psychiatric medications in the 1950's, we have recognized various medical complications that could result from their use. We referred to these consequences as "side effects" or "adverse events," such as sedation, muscle stiffness, tremors, dry mouth, dizziness, constipation, and others.

These side effects can generally be well managed by adjusting the dose of medications, changing medications, or adding another medication that reduces the side effect. Some psychiatric medications require periodic blood tests to monitor possible toxic effects on liver functioning, kidneys, thyroid, blood cell production, and other normal physiology, that might go unnoticed without these special tests.

Presently, and for the foreseeable future, we are turning our attention to a set of medical problems that we underappreciated for many years. It is common for individuals with a psychiatric condition, taking psychiatric medication, to gain a significant amount of weight. In the past, we attributed this to an improvement in appetite as psychiatric symptoms resolved. Now we can more closely associate weight gain with particular medications, notably antipsychotic medications, although others can produce some increase, as well.

More thorough investigation has revealed that these medications can also cause elevations of blood sugar – which can progress to diabetes mellitus – elevated blood pressure, and elevated triglycerides and cholesterol. These issues contribute to an overall increase in risk factors for cardiovascular disease, which can result in heart attacks, strokes, and death. This constellation of risk factors has become known as the "metabolic syndrome," and is of concern throughout the general population, for all ages, beyond the psychiatric community.

While it now seems clear that some psychiatric medications increase the risk of certain medical problems, we have also recognized that individuals with a chronic psychiatric condition are at risk for medical complications, independent of treatment.

On average, individuals with chronic schizophrenia have a twenty percent shorter lifespan than people without psychiatric illness. Individuals with chronic psychiatric illness – including schizophrenia and bipolar disorder – are at greater risk of developing many serious medical conditions, such as cardiovascular disease, diabetes, pulmonary conditions, and cancer. We do not yet understand if this is a consequence of poor self-care, neglect, exposure to other risk factors, or some physiologic or genetic connection between physical and mental illness.

Additionally, the above factors, involving the interface of medical and psychiatric disorders, occur in children as well as adults. This raises questions about potential effects on development and long term consequences.

A Response to Health Risks

At the Jewish Board of Family and Children's Services, a high priority project is developing programs to assist clients in managing both medical and psychiatric issues. Solutions will address a broad range of services for clients of all ages with diverse needs and support systems. New programs will reach our residential and community-based services as well as our day treatment programs and clinics.

Two new initiatives have already started in our residential programs. In cooperation with the Institute for Community Living (ICL), JBFCS is participating in a grant funded by the New York State Health Foundation to advance best practices in diabetes management.

A new curriculum was developed to assist adults with chronic mental illness in identifying and dealing with issues of obesity, elevated blood sugar, and both type I and type II diabetes.

In our children's residential programs, an intensive education initiative focuses on obese clients with pre-diabetes, type I and type II diabetes. Exercise and weight loss programs and reward systems are in progress and they are proving effective. In a short period of time, children have achieved significant weight loss, and we are planning new modules to help our clients continue their progress.

Our adult continuing day treatment programs are incorporating components of established "wellness" programs to promote healthy living, in general, and minimize the risky medical effects of illness and medication, specifically. We are considering ways to make the monitoring of weight, blood pressure, blood sugar control, and cholesterol status part of our routine care, even in clinic patients.

Increasingly, the care of individuals with mental health problems also requires a consideration of physical health issues, and demands new efforts to intervene in effective ways. JBFCS will continue to respond to this interplay of needs.

New Horizons for NYC Homeless Veterans: Institute for Community Living Assumes Operation of Borden Avenue Veterans Residence in Long Island City

Staff Writer
Mental Health News

The Institute for Community Living (ICL) recently assumed operation of Borden Avenue Veterans' Residence (BAVR), the only shelter exclusively for homeless veterans in New York City.

"Our veterans deserve the best New York City has to offer," said Robert V. Hess, Commissioner of the New York City Department of Homeless Services. "Based on its expertise and management strategy, the Institute for Community Living team will continue the level of care Homeless veterans have come to expect at Borden."

July 1 marks the beginning of the transition phase for BAVR. A team of 85 full-time employees, including two social worker/recovery specialists, two recreation specialists and an entitlements counselor, will utilize individualized planning, vocational training, substance abuse counseling and employment opportunities to assist a projected 600 to 700 veterans each year to return to independent housing. Additionally, residents of BAVR will be linked to the continuum of ICL's services, as well as to those of the federal Department of Veterans Affairs, DHS and Project TORCH (The Outreach and Rehabilitation Center for Homeless Veterans).

Dr. Peter Campanelli

"Working with veterans is an honor for us, and we thank the Department of Homeless Services for this opportunity," says Dr. Peter Campanelli, CEO and President, ICL. "Through our experience gained in other shelters, we will implement evidence-based practices -- approaches that achieve results-- and will incorporate the new shelter wellness module, developed by the Urban Institute for Behavioral Health of NYC."

Borden Avenue Veterans' Residence services will include:

- Individualized treatment plans for rehabilitation and recovery, including onsite mental health services from ICL's Guidance Center of Brooklyn; onsite medical care by ICL's clinic HealthCare Choices; and self-care skills focusing on wellness management and community re-entry
- Peer support and counseling, an essential component of ICL's program, helps veterans feel empowered and know that they are not alone. Veterans will be connected with colleagues who share common interests or life experiences and have successfully met similar challenges; they will receive information about community resources, develop problem-solving strategies and build social skills
- Support and opportunities for socialization and recreation
- Service coordination and advocacy to find permanent housing placement in VA housing, affordable or supportive housing, publicly-funded supportive housing, Section 8 housing or even a shared living arrangement with another client
- Vocational training and employment services, including training to become a Peer Counselor at BAVR, at one of ICL's 84 other programs and/or non-profits around the city, job training for people with disabilities and employment with ICL's subsidiary Phoenix Maintenance
- Access to support and resources in the community, facilitated by ICL, Community Advisory Boards and the Borden Avenue Good Neighbor Plan

The Institute for Community Living serves over 8,000 disabled adults, children and families each year. This New York-based 21-year-old nonprofit offers an array of services including residential options for adults and children providing housing stability with a unique family reunification program as an alternative to foster care; mental health and healthcare clinics offering evidence-based treatment and best practice approaches; assertive community outreach; and case management services to individuals with mental illness, mental retardation and/or developmental disabilities. ICL's programs are located in Brooklyn, Manhattan, the Bronx, Queens and Montgomery County, Pennsylvania.

Dr. Jeanie Tse Named President-Elect of the AAPA - NY Chapter and Brooklyn Museum and ICL Team Up to Change Public Perception of MR/DD

Staff Writer
Mental Health News

Dr. Jeanie Tse Named President Elect of the AAPA - NY Chapter

Dr. Jeanie Tse has recently been named president-elect of the NY Chapter of the American Association of Psychiatric Administrators (AAPA), an educational, networking and support resource for psychiatrists working in administration and management. The honor reflects her innovative work as Director of Integrated Health at the Institute for Community Living (ICL), a non-profit mental health agency that serves over 8,000 individuals with psychiatric disabilities, mental retardation and/or developmental disabilities.

On her new role, Dr. Tse says, *"Our goal is to build community and capacity among psychiatrists who have chosen to work in the public sector by providing education and networking opportunities. I hope to expand the visibility of the AAPA and to better address the needs of child and adolescent psychiatrists among our membership. It's a real privilege to be working with some of New York's foremost public psychiatry leaders in the AAPA."*

Dr. Tse certainly fits into that category. As Director of Integrated Health at ICL, Dr. Tse serves as medical coordinator of the Diabetes Co-morbidity Initiative, a groundbreaking coalition of NYC behavioral health agencies improving the way the system works with people with serious mental illness and co-existing Type 2 Diabetes. As part of this Initiative, she co-authored the Diabetes Self-Management and Healthy Living Workbooks, the central tools of the program. This project introduces a new way of *approaching* and *making* lifestyle changes to address diabetes and other co-occurring medical disorders.

The AAPA promotes the professional development of psychiatrists at all levels of expertise, who practice in sites of varying complexity and represent various sectors – public, private and academic. Dr. Tse's work reflects the breadth of its reach. She provides psychiatric care in ICL's MICA (Mental Illness/Chemical Abuse) day treatment program, child and family clinics and school-based mental health programs. She also maintains an academic appointment as Public Psychiatry Fellow at Columbia University and has published research on the effectiveness of cognitive behavioral therapy and social skills training in disruptive behavior and autism spectrum disorders at McGill University.

The product of her experience, which includes working at many sites and with different populations, is the potential for her to bridge the gap between academic psychiatry and the clinical reality of disadvantaged communities. Through the network of the AAPA, Dr. Tse's leadership will mutually benefit her vision, her colleagues in the field and those who receive services for mental illness, substance abuse disorders and developmental disabilities.

New York State of Mind:
Collaborative Works by Artists with Mental Retardation and/or Developmental Disabilities Help to Change The Public's Perception of MR/DD

The impact of New York City is striking on its inhabitants – artists and non-artists alike. In a recent Brooklyn Museum exhibition, New York State of Mind, artists with mental retardation and severe visual impairment have used inspiration from the city for their works in clay, paint and photography. New York State of Mind ran from August 14 through August 31 and was an offshoot of a four-year collaboration between Brooklyn Museum and Institute for Community Living (ICL), a not-for-profit agency specializing in services to people with mental illness, mental retardation and/or developmental disabilities (MR/DD).

The exhibition will featured art in three mediums. Visual impairment heightens the importance of touch. Works in Clay resulted from touching select bronze pieces from the Museum's collection. The artists used wire armature to capture self-expression. Clay was applied to complete the sculptures. Works in Photography and Works in Paint reflect the artists search for "elements that inspire," including light, seasonal changes and life in the city.

In an ongoing effort to better integrate individuals with MR/DD into their communities, as well as bring a unique experience of the arts back into their lives, ICL residents attended monthly trips to Brooklyn Museum for guided tours focused on specific themes inspired by the museum's special exhibits and permanent collection. The resulting exhibition, New York State of Mind, will help to change the general public's perception of individuals with MR/DD from that of those who need care to those who are strong and capable..

Exploring Creative Approaches to Improve Health and Wellness

By Marie Sabatino, Training Specialist
Center for Rehabilitation and Recovery
Coalition of Behavioral Health Agencies

It is widely recognized that a strong connection between physical health and mental health exists. But where do we go from here? What creative approaches can health care providers explore for improving general health and mental wellness to enhance recovery?

With a growing shift toward recovery-oriented person-centered care, and a lack of integrated services to help people recover from physical and mental health needs, it is reasonable to consider the role of the creative arts in facilitating healing for people with co-occurring physical and mental health conditions. While formal art therapy programs incorporate models of counseling and psychotherapy, engaging in the creative arts with less clinical emphasis offers promise as a more self-directed intervention to healing.

Often underutilized as an approach to fostering health and wellness, the freedom and self-determination associated with expressing oneself through the arts has been found to engender feelings of empowerment and autonomy, improve sense of well-being and quality of life, and increase motivation toward adopting healthy behaviors (Kilroy et al., 2007). Research conducted by the Arts for Health team of Manchester Metropolitan University in England by Kilroy and colleagues found that engaging individuals in creative expression through culture and the arts had a profound effect on well-being by increasing an individual's capacity to make healthy changes in lifestyle. The Manchester study measured general health, anxiety and depression, well-being, and work and life attitudes across six different art projects involving 104 participants. Outcomes in all domains of health, including somatic symptoms, improved significantly following engagement with creative arts. Providing outlets for creative self-expression enabled individuals to share their thoughts, feelings and ideas in non-conventional ways, to discover their unique abilities, talents, passions and dreams, and to move beyond the exclusive role of patient. This study demonstrated that engaging the whole of the person in the creative arts yielded opportunities for change, personal growth and a greater sense of meaning in life.

Marie Sabatino

Responsive to these themes, the Coalition of Behavioral Health Agencies' Center for Rehabilitation and Recovery, New York City's primary education and training entity for mental health providers, is introducing a training module on leadership development to include information on the use of narrative as an essential tool for communication directed toward change. The art of forming narratives or storytelling will be used as one approach to help providers improve interpersonal skills, identify common values, challenge perspectives and stimulate meaningful changes that promote hope, empowerment and a greater sense of purpose among both givers and receivers of care.

Professionally, I have used the creative arts, though storytelling, as an intervention when working with individuals with co-occurring disorders of mental health disabilities and HIV. In collaboration with *The Moth Outreach Program*, an organization which conducts storytelling workshops with underserved groups in New York City, participants who actively engaged in personal storytelling were able to "find" their voice, develop empathy, identify with one another's pain, deepen relationships and build social supports among group members. Upon completion of the workshop, members were invited to perform their stories at cultural venues in the city which contributed towards their integration as active members in the community.

I also understand the first-hand benefits of using creative self-expression to promote healing. During a particularly difficult period while recovering from a health condition, writing about my physical pain and emotional distress served as a catalyst for transformation. The creative process functioned as a distraction from physical symptoms, provided an outlet for deep, reflective thinking, allowed me to redirect intense emotions toward healing, and helped to shift my perspective from loss of meaning to purpose and value in life.

Engaging in the creative process can help people develop insights, organize their thinking, and find relief from events which cause distress or pain, all of which have critical implications for physical health and mental wellness. Because individuals have different interests, strengths, desires and dreams, a variety of creative options are needed. Creative and artistic activities ranging from singing and dancing, painting and drawing, to storytelling and drama, may be of interest. These activities can inspire self-directed action toward healthy living and recovery.

For resources about arts and healing programs, please go to: www.nea.gov/resources/accessibility/rlists/artsnhealthresources.html or www.manhattanarts.com/resources.

To learn more about the Center's trainings please visit our website: www.coalitionny.org/the_center/ for future updates.

Healing From Within

By Dr. Brenda Shoshanna

Dr. Brenda Shoshanna

The connection between our mind, body and spirit has been documented widely. When we feel balanced, loved and connected, the immune system is stronger and the body finds its own health. Heartbreak, loss, anger and other forms of stress inevitably take a toll, not only on our personal lives, but on our physical health.

As we tense up to fight our personal problems, our body tenses as well and begins to block the natural healing energies that would otherwise flow. Beyond that, the way we handle our illness can compound this situation. Modern medicine is based upon the notion of battle. We battle germs and fight for life. As soon as we feel pain or discomfort, we immediately try to stop it from happening and look for some way to soothe what we are going through. We feel we must change our illness or problems, overpower them with our expertise. This orientation leads to increasing stress and a never ending battle with all that impinges upon us. However, often, after one illness or problem is conquered, another arises. There is little room for ease of mind. When we include a psychological and spiritual component to healing many changes can take place.

To begin, let us look at illness itself. Illness often comes when we feel defeated or overly exhausted. The illness may be the only way they can give themselves permission to stop, rest, and make much needed changes in our lives. Each illness has it's own story. When someone is in physical pain and suddenly understands what is troubling them personally, what needs to be done in their life, or how they may have to grow, they often let go, and it is not unusual for physical problems to subside. For full healing to take place it may be essential to make changes in one's total life.

When illness comes, it is useful to ease up and begin to look within. This does not preclude also having fine medical care. It simply includes taking a broader attitude not only towards our illness. One step in healing from within includes a meditative state of mind, or mindfulness practice, where we are taught to stop, pay attention and respect all that comes to us. It is as if we were re-focusing a camera, receiving our experience through a different lens. For example, usually there is a deep sense that pain is bad, and must be removed at any cost. As we begin healing from within we see that pain is not bad. Pain arises from lack of balance and contains much information. It brings many messages along with it. When we see our pain as a messenger and learn how to respect and listen to it, healing begins in all kinds of ways.

The first step is to learn how to see pain as an ally and to "dialogue" with it. This requires a complete turn around. Instead of tensing up and gearing for battle, we learn how to pause and look for the lesson we have to learn. When we do this we find the pain often comes holding a gift in its hands. Usually we feel like victims and expect the doctor or psychologist to take control of our illness and make us well. This attitude itself is part of the disease. When we take this attitude we are relinquishing our part in the illness, denying our inherent ability to understand and correct our lack of balance and what our illness is saying to us.

Most of the time we are reluctant to notice the quality of our lives, moment by moment. We are all experts at brushing things under the carpet. Then the carpet begins to roll up at the corners, and we feel we are coming unglued. During illness the body is rebelling. It is demanding that we pay attention to all that has been unattended. We may have been pushing ourselves for too long. Now our body is fed up. Stop and listen to me, it pleads.

We could have been looking and listening all along, but we are not taught to stop, pay attention to and respect what we are feeling. In the time of pain and sadness it is of the utmost urgency to learn how to reconnect with our own inner understanding and source of strength. When we learn how to listen and how to reply, an entirely new life begins. Then pain and illness become an opportunity for vital change.

Learning To Listen

We usually listen only to part of ourselves. The rest is rejected. But no matter what we are rejecting, soon or later we must come up against it and face it straight on. Rejecting something never makes it go away. In fact, it will come back time and again, just for you to accept it. Everything needs to be loved and

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What is the Metabolic Syndrome and What Can You Do About It?

By Richard H. McCarthy, MD, CM, PhD
Research Psychiatrist

A number of psychiatric medications are associated with the metabolic syndrome. The medications most typically related to this syndrome are the so called Atypical Antipsychotics, the newest class of medication available to psychiatry. While called antipsychotic, these medications are also used to treat an ever increasing range of difficulties including the symptoms of mania and depression of Bipolar Disorder.

In medicine, the term syndromes implies a collection of signs (things that the physician finds on exam or through tests) and symptoms (things that are observable or that the patient reports) that often occur together, such that the presence of one element of the syndrome will lead the physician to look for other elements of the syndrome. It is very important to note that a syndrome is not the same as a specific disease. A disease is a specific problem and different diseases or underlying problems can give rise to similar syndromes. Most psychiatric illnesses are really syndromes, where many different pathological processes can lead to the problems being observed. For example, depression can be caused by a wide variety of medical illnesses and an even larger number of drugs, both medications prescribed by physicians and drugs of abuse . The presence of the syndrome of depression will lead us to look for these and

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other potential causes before we look for treatments. Another problem with "Syndromes" is that they are often defined differently by different people; as a result there are many Metabolic Syndromes depending on which definition is being used. In spite of the variation in definitions, individuals with a metabolic syndrome have more than twice to three times the risk of a significant cardiovascular problem and have twice the risk of all causes of mortality.

While there are many metabolic syndromes, there tends to be general agreement about many of the components of the problem. These include issues related to weight, blood sugar and diabetes, how the body handles fats, including cholesterol and triglycerides, and blood pressure. You no doubt recognize these as many of the factors that are important in maintaining good physical health in general and good heart health in particular, and they are just that. Obesity is now calculated in a different way than was once the case. A general index called the Body Mass Index is used. It is based on weight and height and is the same for men and women. It is a bit complicated but can be done on line at www.nhlbisupport.com/bmi/. The surprise about BMI is how thin you have to be to be normal. The average male American is 5"10 inches tall, and is said to be overweight at more than 173 pounds and obese if he is more than 209 pounds. The average female is 5" 5' tall and is said to be overweight at more than 149 pounds and obese if she is more than 180 pounds. For those individuals that do not have access to the internet, an easy way to determine if you are obese is to look at your belt size. For men obesity starts at 40 inches and at 35 inches for women. Unfortunately, weight and waist size are the only real symptom of metabolic syndrome. All of the rest of the components that go into metabolic syndrome are signs, which mean that they must be discovered by the doctor. So, if you are obese or have a larger waist than you should, you need to see a physician for a couple of blood tests.

When you see your physician you want to make sure that, in addition to finding out your blood pressure, you also want at least 2 blood tests to determining how your body manages sugars and fats. You want your blood pressure to be less than 130/85, your blood sugar (glucose) to be less than 100, your triglycerides to be less than 150, and your so-called good cholesterol (HDL) to be more than 40 for men and more than 50 for women. The American Heart Association and the National Heart, Lung, and Blood Institute say that you have the metabolic syndrome if you have a large waist and any 2 of these other problems. Triglycerides are made by the body when we eat fats, alcohol and carbohydrates. We can lower them by eating less of these substances. We can also lower our triglyceride levels by increasing our aerobic exercise. Over the counter products such as fish oil, large doses of the vitamin niacin, and statins, medications prescribed by doctors, can reduce triglyceride levels. Before you add in the over the counter products, talk with your physician. Cholesterol is more complicated. It is also made by the body and comes from the diet. Avoiding many of the same foods that will elevate triglycerides will also help keep cholesterol under control. Interestingly, exercise for 30 minutes a day will also help to increase the good cholesterol. Blood sugar is also related to the diet, but the best thing to lower this is to lose weight. Obesity in and of itself will raise blood sugar.

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Heart Attacks: Signs, Symptoms, and Risk Factors

By Colm James McCarthy
Emergency Medical Technician

Heart Attacks, called myocardial infarctions by physicians, are one of the leading causes of death and disability in our country. They occur more frequent in males but lead to death more often when they happen in females. Heart attacks occur when the blood supply to the heart is interrupted. While it may seem odd to think that an organ that is filled with blood may need more, that is exactly what happens. The heart is a unique muscle within the body. It is constantly working and it needs both oxygen and energy to do this work. These nutrients are delivered to the heart by an intricate series of blood vessels that extensively penetrate the heart muscle. When these blood vessels are blocked or closed off, the heart muscle is deprived of nutrients and oxygen and heart cells die. If large areas of the heart die, then the heart will not be able to work and the patient will not survive. Occasionally heart attacks are silent, that is they occur with no pain. More often there is a very distinctive pain that occurs, called angina. This is the most prominent symptom of a heart attack.

Colm James McCarthy

The initial sign of a heart attack is usually shortness of breath. The shortness of breath is either closely related to a squeezing pressure that develops into pain in the center of the chest. This can last for several minutes and is often confused with indigestion. As the pain increases, it will often move, typically migrating to one or both arms, back, neck, jaw, or stomach regions. This is called referred pain. These symptoms are usually followed closely by cold sweating, nausea, and vomiting. Typically, men have the more classical symptoms of chest-centered pain and women have the pain in the arms and jaw. A characteristic feature of most forms of angina is that it increases with exercise (when the heart needs to work hard and needs oxygen) and decreases with rest (when less heart work is necessary). Do not be fooled by the fact that the pain comes and goes with exercise and rest. A serious problem is taking place within the heart. This is a true medical emergency and attempts to "walk the pain off" or "push through the pain" are more likely to lead to death than they will lead to recovery. The patient should sit and rest and 911 should be called immediately. Be prepared to do CPR. If you do not know CPR attempt to find someone who does. If you or someone you know has a preexisting heart condition, be aware of what medications are being taken, specific information about that condition, and have the medication with you at all times.

All forms of heart attack are due to a restriction of the blood flow in the heart. There is a special kind of heart attack where the blood vessels go into spasm and close off. Called Prinzmetal's Angina, it is not so well understood and can happen at rest as well as during exercise. Most other heart attacks are due to blockages that occur in arteries in the heart that are too narrow. Arteries become narrow over age with the build up of a fatty substance called plaque. This process is called atherosclerosis and it not only narrows the blood vessels, it weakens them as well. If these plaques break up or if a small blood clot occurs, the blood vessel can become blocked and a heart attack ensues.

Those factors that worsen atherosclerosis will make heart attacks more likely. Some of these factors are outside of our control, such as age (usually over 65), being a male, or having a family history of early death due to heart attacks. However, the most important factors that lead to heart disease are within our control, at least partially. These include smoking, high cholesterol, high blood pressure, physical inactivity, obesity, and high blood sugar or diabetes. Alert readers will see that the metabolic syndrome includes many of these factors. The single most important thing to do to reduce the risk of heart attacks is to quit smoking. The second is the control and prevention of diabetes. After that exercise, a healthy diet, losing weight and control of blood pressure will all reduce your risk for a heart attack as well as other diseases.

A Priority from page 9

Even though there are well-tested forms of family support that address the mental health needs of family members and result in substantial delays in nursing home placements, little has been invested in putting these supports in place.

Housing for people with co-occurring serious mental and physical disorders is also a critical need. Many people end up in nursing homes just because mental health housing programs and other supportive housing programs just don't have the capacity to deal with serious physical health concerns. It is easy enough to conceptualize appropriate housing, but close to impossible for the mental health and health systems to work together to do it.

Mental Health In Primary Care

Most people with mental and/or substance use disorders go to primary care physicians for health care or even for mental health care. Unfortunately most of these physicians are not trained to identify or to treat mental illness. As a result, according to the National Co-Morbidity Replication survey, primary care physicians provide "minimally adequate mental health care" only 13.8% of the time. And their ability to identify mental illness is so poor in general that upwards of 70% of older adults who commit suicide have seen their primary care physicians within 30 days, some even on the same day.

The answer is not referral to mental health professionals because so many people do not follow through on referrals. And if they did, we would rapidly run out of mental health professionals to refer them to. There is simply no alternative to continued widespread reliance on primary care physicians to provide treatment for mental illness. How to prepare them to do this continues to be a serious problem. "Training" sounds like the right solution, but often doesn't work, except under particular conditions. However, screening tools are available to help physicians identify potential problems, and several collaborative treatment models in which physical and mental health providers work together at the same site have been well-tested. There also needs to be increased use of tele-psychiatry both for consultation and for treatment.

Conclusion

All of the above are compelling reasons for focusing mental health and health policy on the inter-relationship of health and mental health. But we will need to work hard to make the case compelling not just to those of us in the health and mental health professions, but to public officials, who need to adopt new policies stressing integration of care.

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Wellness Initiatives from page 25

The health and wellness groups provided by F·E·G·S have had a tremendous impact on its clients. A wellness management group at the Simon Community Residence started in September 2007 with ten consumers of whom five moved to independent living, three moved to an apartment treatment program, one moved to an SRO, and one moved independently to her own apartment. A resident at Burnside stated that the groups have helped her "learn to be responsible and patient." Another resident, who had experienced multiple long-term psychiatric hospitalizations, poor attendance at her day treatment program, and difficulties at the residence, has been attending many of the groups offered. She is very active in her participation in the fitness and "eating for life" group and her disposition at the day treatment program has improved dramatically. She is focused on improving skills in self-medication and maintaining her psychiatric stability. She says that she feels that she looks better and feels better because of her participation in the groups.

Having a focus on health combined with using a structured Wellness Self Management curriculum (we use both the OMH curriculum and Eli Lilly's) has benefited so many clients. There are many examples of residents who are now more careful about abstaining from alcohol and drugs, have become motivated by the material, staff and the success of peers, and are moving on to more independent living and moving on in their recovery. A horticulture group at the Kingsbridge CR/SRO is a creative example of engaging residents who were not going out during the day and giving them something to take care of. The residents get a hands-on connection with nature and they realize they have an effect on something else that is living. David has been participating in The Horticultural Therapy Group since its inception, and states that he has been feeling more relaxed and it also gives him a "sense of purpose". David has also been able to reconnect with his family members and his estranged grandson who has since become a part of his life. David was also accepted into the Supported Apartment Program.

In recognizing the impact maintaining and improving consumer's physical health has on their overall well-being, F·E·G·S is better positioned to help clients achieve self-sufficiency and feel fulfilled in their lives. One group participant said that the wellness group "was very educational. It helped me with my mental illness. I learned skills which will help me to move to my own apartment…It is good to know that even though you have a mental illness, you can still do stuff." By encouraging clients to make healthy life choices and to control what they can in their lives, F·E·G·S each day is helping individuals realize their true potential and, with the support of staff and peers, develop viable ways to achieve it.

Salene Browne is Director of the Simon Community Residence, Glenn Stelzer is Director of the Tanya Towers Apartment Program, and Allison Wendell is Director of the Burnside Community Residence of F·E·G·S Health and Human Services System.

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additional key members of the Latino mental health community in personal meetings to discuss the future of the publication. The proposed theme for the next issue of *Salud Mental* will be: "Bilingual Service Providers and Consumers of Mental Health Services: Facing the Challenges". For more information contact *Salud Mental* at mhnmail@aol.com.

Photo (Front: L to R): Michael Stoller, Executive Director, Human Services Council of New York City; Suzanne M.L. Colin, Ph.D., President, Association Hispanic Mental Health Professionals; David A. Rosin, MD, Deputy Commissioner of Mental Hygiene Services of the NYC Department of Health and Mental Hygiene; Dr. Rosa Gil, President of Comunilife; Michael B. Friedman, LMSW, Chairman of the Geriatric Mental Health Alliance of New York; Arlene González-Sánchez, Commissioner of the Nassau County Department of Mental Health, Chemical Dependency and Developmental Disabilities; (Rear: L to R) Ira H. Minot, LMSW, Executive Director, Mental Health News Education, Inc.; Peter C. Campanelli, PsyD, President and CEO of the Institute for Community Living; Leo Leiderman, PsyD, Director of Latino Treatment Services at Saint Vincent Catholic Medical Center in Westchester; Carmen Collado, LCSW, Director of Immigrant and Latino Services and Director of Public Policy and Government Relations at JBFCS; and Paul Levine, LCSW, Executive Vice President and CEO of JBFC.

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accepted, including our illness and pain. The best way is to make friends with the pain. Fighting intensifies it. If we can relax into it for a little while and explore it, many possibilities arise. When we let go, and allow ourselves to speak to the pain, and to listen to what it has to say, incredible changes can happen.

To do this, we simply close our eyes, stop fighting, and ask our pain what it is saying to us, what does it need from us right now? Then we become very quiet and listen deeply. An answer may not come right away. Patience is needed. This attitude is called making friends with the pain. Answers come in different ways. Some hear answers within. Others see images, some have dreams. We learn to be open to all that comes and in this openness, we learn. As we do this process over and over, fear diminishes and we begin to hear.

For example, if we are sad for too long and have not done enough crying, our bodies may begin to cry for us through the illness we are going through. If we feel that life is meaningless, our bodies can start to express this by shriveling up and dying. If we have held onto difficult attitudes, our bodies will bear the burden of them. Persistent negative attitudes become wounds upon our entire selves.

We must look at the basic attitudes we live with and ask ourselves if they are conducive to our health, or do they contain the very seeds of pain?

Some live with deep fear. They believe life is full of defeat. Other do not allow themselves too much beauty or pleasure. They drive themselves relentlessly. Is it any wonder they become ill?

In order to heal from within, it is essential to handle these long standing patterns, to change them to attitudes and patterns that are productive of well-being. Health comes with learning to say "yes" to all of our experience, in being willing to experience it just as it is. Wellness emerges out of the balance and harmony of all parts of ourselves.

When we are well, we feel whole, accepting and in harmony with ourselves and the entire world we live in. Like a fresh water stream flowing, this state of being brings continual refreshment and healing day by day.

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Screening for Soldiers from page 6

homecoming starts fading. And with their families by their side, they hear about benefits and programs outlined (and potentially ignored) at briefings during demobilization.

At two months, there are briefings on anger management, substance abuse, compulsive behaviors, financial management and other topics. Army studies have found that these issues occur at about those times. Again, spouses and families are invited along and the National Guard pays for the hotel for this session.

At the 90-day interval the Soldiers return to regular drilling status and report to their Armory for medical checks and additional briefings.

Integrative Healing: Linking Emotional and Physical Wellness to Recovery

By Joseph Galasso, PsyD
Meadowview Psychiatric Hospital

Recovery from mental illness is a complex process marked by ebbs and flows of wellness and relapse. Furthermore, it involves the interaction of many internal (i.e., physical and psychological) and external (i.e., housing and family) systems. Our past two articles have focused primarily on how external factors (i.e., housing and employment) can impact one's ability to recover from a psychiatric illness. This article's primary objective is somewhat different, as it focuses chiefly on the interconnectedness of one's own physical and emotional life and how these two internal factors impact recovery. In this article, I will focus on three factors related to the interrelationship of physical and emotional wellness in the process of recovery from mental illness. These three factors include: (a) Mind-Body Connectivity; (b) Psychological Symptomatology and Physical Health; and (c) Connecting Your Mind to Your Body.

Mind-Body Connectivity: How Your Feelings Affect Your Health. The connection between Mind and Body has been established through empirical examination (see Ray, 2003; Pally, 1998) by many different scientific communities (i.e., psychological, biological, and medical). As such, the medical and social service communities have begun to reinforce the need to strike a firm partnership when treating people with mental illness.

According to Ray (2003), both what we think and believe can have a significant impact on our overall health. The reverse is true as well, because our physical functioning and health will also impact our emotional functioning. When considering people with mental illness, the benefits of integrating mind-body treatments are integral, given that people with mental illness are at a higher risk for developing significant physical health problems. As such, physical health and interventions which promote positive physical wellness should be considered as an integral aspect of one's personal recovery plan, treatment plan, and daily life.

Joseph Galasso, PsyD

Psychological Symptomatology and Physical Health. Research has found the link between depressive disorders, anxiety disorders, and physical health to be the most prevalent. In fact, the World Federation of Mental Health conducted the *Mind-Body Connection Survey* in 2007 and their findings emphasized how being aware of physical and emotional well-being, or lack thereof, can influence the rate at which one can recover from a depressive episode.

For people who have suffered from depression or anxiety in the past, or are predisposed to feeling sad or nervous, a positive focus on our physical health can help to provide the barrier necessary for preventing an occurrence (or reoccurrence). This is true for several reasons, including: (a) we become aware of our bodies and are better able to notice subtle differences in mood or physical states before having a full-blown episode of depression or anxiety, (b) physical wellness can promote improved cognitive functioning, helping us to make better/less self-destructive decisions, (c) we may notice increased self-esteem (i.e., how we feel about ourselves) and self-efficacy (i.e., our perception of how much control we can exert over our situation), (d) we can strengthen our immune system, (e) we can moderate the negative side effects of medication, and (f) we can all benefit from the natural anti-depressant effects of exercise.

Steps to living well. While the concept of Mind and Body may seem straightforward, the real challenge appears when it is time to implement this in our own lives. To make it easier, we can recognize that our success lies in balance. If we are truly balanced, we should notice that we have a calm mind and a strong body.

Treatment compliance. Remaining disciplined within the confines of your treatment is extremely important. This can include keeping regular doctor's appointments, taking medication, and attending a treatment program. Also, by meeting with your doctor regularly and receiving education about your condition, you are more likely to recognize when symptoms are increasing or subsiding.

Furthermore, meeting with your treatment providers allows you the opportunity to discuss other factors that influence recovery, including sleep and nutrition management. Having a healthy diet can influence how well your immune system functions, how you are able to manage co-occurring medical issues (i.e., diabetes), and how you feel about yourself. The same is true for sleep. Not maintaining an adequate sleep schedule (i.e., approximately 8 hours per night) can influence how clearly you can think, mood states, and physical wellness.

Physical activity & exercise. Exercise is essential to recovery. By caring for your physical self you can increase the effectiveness of medical intervention. This is particularly true of depressive illnesses and anxiety. While not recognized as a cure for depression and anxiety, a growing body of research has indicated that when used in conjunction with therapy and medication, exercise has had great success in reducing symptomatology (see Babyak et al., 2000 & Johnsgard, 2004).

Stress reduction. The ability to reduce stress can be the key to keeping yourself emotionally balanced. For some, however, the ability to reduce stress can be a very challenging process. One such way, is to become comfortable expressing your feelings. Learning how to express your feelings in appropriate ways eases stress, reduces anxiety, and combats depression. It can also help us to gain assertiveness skills, which in turn, help us to advocate in our treatment and gain a sense of empowerment with whom we are and where we are in our recovery.

The positive and successful incorporation of mental and physical wellness into your daily life, and into your recovery can help you to feel better and do better. Recovery requires growth on many levels. In this case, being able to recognize how your physical state effects your emotional state (and vice versa) will facilitate the process by increasing your ability to remain resilient and to empower you to become a more active participant in your own treatment and recovery.

This article was written using the information disseminated through the Family Education Group. The FEG is designed for individuals who have a family member or loved one struggling with a mental illness. We meet the second Wednesday of every month. For more information about the Family Education Group or Meadowview Hospital, please contact Meghan Farrell at (201) 319-3660.

Group Work from page 17

Now some time has passed. Surrounding the rock garden are benches. In the highschool reflecting garden sits a bench bearing Geoffrey's name and small tree with its first leaves. Sacred places created by caring group members. Places that they will return to for just a look or to sit for awhile and remember. Two special places for young people to remember someone dear and to recall their time together as a group.

Conclusion

Activity manuals and curriculum guides, when used thoughtfully have great value in addressing mental health issues through group work. Of equal or greater value are the activities that come out of the life of the group itself. These include holiday celebrations (e.g. when there has a been a loss in the family a carefully planned celebration in the group can include a time to reminisce); games (e.g. making up their own games can tap into kids' creativity and give them a chance to address issues along the cooperation-competition continuum); bringing "stuff" in (e.g. more than just show-and-tell, what kids bring in to the group, for example, as a remembrance of a deceased parent has deep meaning and can aid in the grief process); role playing (e.g. creating scenarios and "directing" the action is empowering, providing group members with greater control than they may be accustomed to); poetry, art, music, and dance (e.g. to provide alternative means of expression); and photography (e.g. in one group teenage moms, with the aid of a professional photographer they photographed their babies, developed the film, and created albums to reinforce their attachment, their bonds with their babies). These are but a few ideas that I offer to encourage you to be creative and never discount the interests, inventiveness, and creativity of your group members.

Next time a colleague asks you, "Do you have any activities books?" Give them what you have. But first, have a conversation and encourage them to look to their groups for activities too.

Mental Health News
Upcoming Theme and Deadline Calendar

Winter 2009 Issue:
"Understanding & Treating Posttraumatic Stress Disorder"
Deadline: November 1, 2008

Spring 2009 Issue:
"Follow-up Care After Psychiatric Hospitalization"
Deadline: February 1, 2009

Summer 2009 Issue:
"Recovery and The Consumer Movement"
Deadline: May 1, 2009

Fall 2009 Issue:
"Understanding and Treating Families in Crisis"
Deadline: August 1, 2009

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of nine case managers, nine consumers who had completed the formal training and thirteen who had been recruited at the formal training's conclusion.

Training evaluation data was collected from case manager and consumer participants at the outset of the training program, at its conclusion and after each training session; from the second group of consumer participants when they joined the Project; and from all participants at the three- and six-months marks of the Demonstration Project. The intent was to determine the effectiveness of each of the seven training sessions – which the data did substantiate – and, more importantly, the impact of the training on the learning of the participants over the course of the next six months. Indeed, the case managers who completed the training pronounced themselves "empowered" and "well-informed;" and one of our consumers characterized the training's objective as teaching consumers and case managers to "ask questions and get answers."

Our conclusions: that our training model proved effective; more specifically, that our consumers could learn both in the classroom and as they put what they had learned into practice; and that our case managers could teach the consumers in traditional case management fashion, viz., "side by side" as they carried out the traditional case management functions of linking to and monitoring of requisite services.

Access to Medical Care: Project outcome data at the Project's conclusion indicated improved consumer access to health care. Specifically:

- nineteen of the twenty-two consumers who completed the Project had primary care physicians at the Project's conclusion, and all twenty-two consumers were seeing psychiatrists regularly;
- Metabolic Syndrome risk factors had been identified in sixteen consumer participants, and remedies to address the risk factors had been ordered by their physicians;
- fifteen reported being diagnosed with chronic physical ailments, with all fifteen also reporting ongoing treatment coordinated by a primary care physician;
- eighteen consumer participants expressed satisfaction with the quality of their medical care, and nineteen reported improved access to medical care.

However, several key treatment and systems issues surfaced as our Demonstration phase came to a close that we had not anticipated.

(1) We find ourselves more aware of the acute vulnerability of those of our clients who have been diagnosed with chronic medical ailments. Further, we believe we have identified key variables which heighten their risk of premature death, viz., a diagnosed chronic medical illness, a clear indication of biological vulnerability; age – particularly as they approach or enter their 50's; active or history of substance abuse, particularly alcohol and crack cocaine. We suspect that gender might represent another risk factor, particularly for males, although the 2006 study conducted by the National Association of State Mental Health Program Directors found no correlation between increased risk and gender.

We are convinced of these individuals' need to be connected to primary care physicians and were quite successful in achieving this with our Demonstration Project consumer cohort. Yet, we are troubled that the principal treatment venue for our consumers is hospital clinics with their rotating medical residents and the potential for disruption of care continuity which that represents.

(2) While our decision to pursue initiation of the Metabolic Syndrome Monitoring Protocol for our consumers was on target, we did not conceptualize it as a crucial preventative measure, which it should prove to be, and more apt in application for those of our clients who have yet to be diagnosed with chronic medical illnesses. Accordingly, when we expand ICCM and proceed to train our thirty-five remaining case managers and combined cohorts of seventy consumers, half of the consumers selected will have diagnosed chronic physical ailments and half will not. Efforts will be made to connect all seventy to PCPs, and to monitor their medical progress over the course of twelve months. However, the initiation of the Metabolic Syndrome Monitoring Protocol will be pursued primarily for those consumers without diagnosed chronic ailments. Our objectives will be two-fold: to forestall in the members of this consumer cohort the development of chronic ailments and to mitigate their risk of premature death.

(3) We plan to expand our ICCM model program-wide and, while doing so, to conduct a comparison study with case managers and consumers from the agency's Nassau-Suffolk case management programs. (FEGS employs approximately 150 case managers who work with close to 2000 clients residing in all five boroughs of New York City and Nassau and Suffolk counties.)

Training will commence in September, 2008, and will continue in three two-month training cycles, each consisting of eight two-hour training sessions, until all thirty-five case managers and their accompanying consumers are trained. We estimate that this process will take seven months and should be completed by no later than March, 2009. As each training cycle is completed, an additional consumer cohort will be recruited for *in vivo* training by their case managers. In sum, we will replicate, with only minor adjustments, what we believe to be a proven and effective training model.

Since our ultimate objective is to develop a "best practices" paradigm that can eventually be adopted agency-wide and possibly state-wide by other case management programs and adapted to meet the needs of their consumers, we will continue collecting outcome data to determine the effectiveness of our training approach in preparing case managers and consumers to work collaboratively to improve consumers' access to health care and prolong their lives. Outcome data from both the New York City and Nassau-Suffolk study participants will be collected over a twelve month long period to determine how effective we have been in achieving these goals and, whether, in the process, we have achieved any cost savings by reducing consumers' medical emergency room visits and hospitalizations.

Please note that much of the foregoing article was first published on MI-Watch.org. For further information or continued discussion, feel free to contact the author at Jacarney@fegs.org.

Health Integration from page 23

care needs. Participating mental hygiene providers will also focus on a particular area of need for their program (metabolic disorders, smoking, obesity, infectious disease, or inadequate dental care).

In addition, DMH's FY 2008 geriatric mental health initiative funded by the New York City Council supported nine programs that worked to integrate health and mental health services for the people they serve. Efforts in these programs have incorporated medical screenings that focus on various potential problem areas: breast cancer, colon cancer, cardiovascular health, etc. as well as providing mental health outreach in primary care offices for seniors.

DMH is partnering with the Department's Bureau of Tobacco Control to pilot smoking cessation projects at two community-based clubhouse programs. In response to high smoking prevalence among individuals with psychiatric diagnoses – 75% percent compared to 22% in the general population – participating programs will deliver smoking cessation awareness training and treatment to clubhouse members and staff and will implement a smoke-free facility policy. A full-time certified Tobacco Treatment Specialist in each clubhouse will provide and supervise cessation services, supported by technical assistance from Department staff. An important component of the program is outreach to consumers' treating primary care providers and psychiatrists, both to offer education about best treatment practices and to ensure proper care coordination.

The burden of behavioral health problems has historically been underestimated because it has failed to adequately reflect concomitant physical health problems. Mental illness increases risk for communicable and non-communicable diseases and contributes to unintentional and intentional injury. Conversely, many physical health conditions increase the risk for mental illness. These often-overlooked co-morbidities impede help-seeking, diagnosis, and treatment. DMH, through its ongoing efforts, is working to improve how physical health needs are addressed in mental hygiene service settings, and how mental health needs are addressed in primary care settings. Early identification and treatment of all health problems, including addressing unmet physical and behavioral health needs, can have a drastic effect on the quality and length of a person's life.

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Guardians from page 13

Conclusion

Article 81 has provided great relief to those who are incapacitated, those who care for and love them, as well as the courts in that its flexible nature allows the incapacitated individual to retain as much freedom as possible while still allowing for assistance in the areas that are needed. However, when it comes to psychiatric treatment and care, an individual approach is required.

This approach must take into account the specific facts at the time in question. This individual process is required because of the unique situation that psychiatric illness presents. Symptoms vary wildly from person to person, even within the same diagnosis. The effects that any particular symptom of mental illness may have on one's capacity to make decisions regarding medication also varies from person to person. Additionally, the side effect profile that psychiatric medications present is equally diverse. Hence, nothing less than an individual approach will suffice.

Likewise, because of the seriousness and the permanency of a decision to withhold, or withdraw, life sustaining treatment that power can only be granted where there is specific proof that this is what the Incapacitated Person would have wanted were they capable of making the decision for themselves.

Metabolic Syndrome from page 33

The metabolic syndrome is a real problem. While psychiatric medications may make it worse, it can be improved by simple things like a good diet, weight loss, and exercise. While these are simple they are not necessarily easy. Knowing how to lose weight and doing it are two very different things. In a future column we will discuss this more. In the mean time, you can help yourself by watching your diet, increasing exercise, and avoiding the one thing that will make the metabolic syndrome worse than anything else, smoking.

Fountain House from page 24

the cardio-vascular machines to be the most potent and most helpful of my exercise regimen. I get anxiety attacks very often; since I've been exercising I go home free of anxiety attacks. There is definitely a correlation between exercise, the morning juice, and a healthier body. This has definitely helped my mind. I find keeping up physically helps me be more productive and enjoy life to a greater extent. In short, healthy diet, vigorous exercise, meaningful work, and prayer have created, for me, the environment of a healthy person."

Improving Competence from page 23

underserved populations in New York State. Even without taking into account the effect of SMI, African American and Latino communities are at higher risk of obesity, diabetes, hypertension, and other adverse physical conditions than non-Latino white communities. Across all ethnic/racial and linguistic groups, the presence of SMI worsens the risk of inadequate detection of physical health problems in mental health settings, frequently the predominant source of general health care for the SMI community. However, when their illness is detected, ethnically and linguistically underserved groups with SMI experience a lower likelihood of receiving guideline-concordant care. This increases the already-elevated risk of adverse outcomes, resulting in higher rates of disability and premature death among African Americans and Latinos in New York State relative to white New Yorkers. Since people with SMI die on average 25 years earlier than the general population, it is clear that chronic mental illness compounds already existing racial/ethnic disparities, resulting in a true health crisis among ethnically, racially, and linguistically underserved persons with SMI.

Although shifting demographics have contributed to increasing health disparities throughout all of New York, census estimates indicate that Northern Manhattan has one of the highest concentrations of ethnically/racially and linguistically underserved individuals in the state. Approximately 72% of residents in Washington Heights and Inwood are of Latino origin and 20% are African American; over 90% of the Latino community are first-generation migrants, frequently with limited English fluency. In Harlem, 67% of community members are African American –including a substantial community of African and Haitian immigrants -- 20% are Latino, and 3% Asian. These demographics have created challenges for delivering culturally and linguistically competent care in Northern Manhattan. This region also has one of the highest concentrations of poverty in the City, which contributes to the disparity between need and service capacity.

As a result of the high number of immigrants residing in Northern Manhattan, inattention to language and cultural factors constitutes a serious barrier to the delivery of adequate mental and physical health care to persons who are monolingual in Spanish, French, or Haitian Creole. Health care providers and mental health advocates who are committed to a paradigm of cultural and linguistic competence try to convey to patients and family members that they are not alone. This cultural engagement is an opportunity to build solidarity and a sense of community with stigmatized individuals and families experiencing mental illness. The challenge is to ensure that this message of hope transcends cultural and linguistic barriers and creates an environment that is truly conducive to recovery and that addresses both physical and mental wellbeing.

The Center is committed to the integration of mental health and physical health care for illnesses such as heart disease, hypertension, diabetes, and other obesity-related conditions that frequently co-occur with mental illness. In order to address this integration in a culturally competent way, it is critical to explore culturally adaptable models of service integration and public health promotion so that consumers, families, and providers can work together to transcend cultural and linguistic barriers and empower diverse consumers to make healthy choices. In order to develop such a model, the Center is engaging in a five-phase community outreach project centered in Northern Manhattan that will develop culturally competent, person-centered best practices for delivering physical health care to SMI patients. This project is being conducted in collaboration with diverse community stakeholders, including consumers, family members, care providers, faith-based leaders, and community residents. We have started this work with the community surrounding our base at the New York State Psychiatric Institute in Northern Manhattan, and will then expand from there into a statewide initiative.

The five-phase project will start to address the gaps in the physical health care of underserved patients with SMI by outreaching to several mental health clinics in our surrounding neighborhood, including consumers, staff members, and other stakeholders. The first phase of the project is a program needs assessment, involving an initial evaluation of 6 mental health clinics across Northern Manhattan. The goals of this phase are to engage community stakeholders, explore existing programs related to physical health care, and start to develop alternative models for integrated physical and mental health services. During the second phase we will work with the programs, clinics, and community members to collaboratively choose interventions to enhance culturally competent management of physical health problems in a way that addresses patients' needs. Jointly with all stakeholders, we will then conduct the third phase, which consists of a more thorough baseline evaluation of each clinic. We will assess information on cultural competence of existing services, detection/ management of physical health problems, patient engagement, self-management of lifestyle choices that affect health --such as diet, exercise, and smoking-- and patient outcomes. During the fourth phase the research team will assist each mental health clinic to implement the intervention they have chosen. Finally, the fifth phase consists of a post-intervention assessment, which will be used to assess the intervention's impact and sustainability. During all five phases the Center research team will employ a mix of qualitative and quantitative research methods, which have become the standard methodology for studies of this sort. A mix of surveys, participant observation, individual interviews, and focus groups will be used.

Throughout the whole research process the Center will engage consumers and their families, providers, and other key helpers (such as their faith-based community) through person-centered approaches that employ self-management models. We also recognize the importance of strengthening support networks in order to help the person through his/her recovery process. Ultimately, the Center's goal is to work together with the person and his/her recovery team to develop a sustainable programmatic infrastructure that embeds culturally competent best practices for physical health care into his/her existing network of mental health services.

The staff of the Center of Excellence for Cultural Competence at New York State Psychiatric Institute also contributed to the publishing of this article.

The Diabetes Initiative from page 1

Early experience with the Diabetes Self-Management Workbook

The Workbook was recently piloted across several programs at ICL, The Bridge, F.E.G.S. and William F. Ryan Community Health Center. About 200 consumers with mental illness and diabetes volunteered to participate in trying out the Workbook, some in a diabetes group and some during individual sessions, according to their preference. Staff used motivational enhancement techniques to develop interest in participation.

Le'Nise Watson-Hudson, Director of Nursing at ICL, recalls one individual at ICL's Milestone Residence on the campus of Creedmoor Psychiatric Center in Queens, who was challenged with high A1c levels, blood pressure and cholesterol. Previously, this person avoided all groups and did not want to talk about his diabetes. Staff respected his decision while still extending invitations to the weekly diabetes group. One week, a group was held for participating consumers who were working on monitoring their blood glucose levels through finger sticks. Chinese food from the "diet" menu was ordered and served as a reward. Intrigued that a favorite food could be served in the context of a diabetes group, the individual attended. Gradually, this person not only became "a regular" at the weekly diabetes group, but noticeable changes in attitude and behavior became apparent. Moreover, the positive changes he made produced immediate results: his A1c level (i.e. his blood glucose) was slowly but consistently dropping to a normal range.

A Case Manager for F.E.G.S. in Nassau County says that a consumer shared with her for the first time that he had diabetes when the Workbook was introduced at their program. Case managers are the "glue" in the mental health services system and are responsible for referring and motivating consumers to access health care services. They also help consumers to develop self-management skills and knowledge. When this F.E.G.S. Case Manager learned of her client's diagnosis, she immediately linked him to a nurse who contacted his primary care provider and coordinated care. He asked questions about diabetes, and they used the Workbook together to look for answers. He began to take small steps toward improving his eating and physical activity. He tried limiting sweets and "portion sizes," and was surprised that he could feel full with less food. He also began doing push-ups. He started using his glucometer, which had never before been taken out of its box, to measure his blood glucose. He reports that his mood has improved since he began making these changes, and shares diabetes-related news with his Case Manager each time they meet.

Preliminary results of data analysis show positive trends in the proportion of consumers reporting that they talk to their primary care providers about diabetes, ask about their A1c level and regularly check blood glucose. A significant change was found in the proportion of people indicating that they take their medications as prescribed. There was also an increase in the number of people reporting that they had useful ways of managing stress in their lives.

The initial experience with the Diabetes Self-Management Workbook is encouraging, and ICL and the DCI partner agencies hope to make an even bigger impact with the enhanced DCI Toolkit. Consumers can beat the diabetes crisis, working with the people that support them towards self-management and full recovery—physical, mental and spiritual.

More information about diabetes is available at: The American Diabetes Association: www.diabetes.org and The Joslin Diabetes Center: www.joslin.org.

Rosemarie Sultana-Cordero, LMHC, Diabetes Co-morbidity Initiative Clinical Coordinator, at the Institute for Community Living. Jeanie Tse, MD, is a Psychiatrist and Director of Integrated Health at the Institute for Community Living. Andrew Cleek, PsyD, is Director of the Urban Institute for Behavioral Health.

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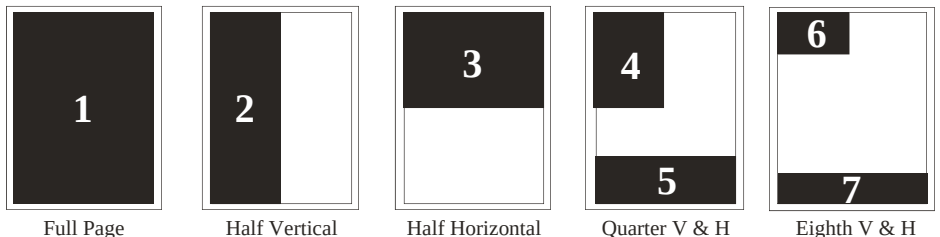

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