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FALL 2009 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 11 NO. 4

NYS OMH Engaged in Mental Health Services Restructuring

By Gary Weiskopf, MPA
Project Director, Mental Health
Financial Restructuring Project
NYS Office of Mental Health

New York State is engaged in a multi-year initiative to restructure the way the State delivers and reimburses publicly supported mental health services. Over the past 50 years, New York's public mental health system evolved from one dominated by large State psychiatric hospitals serving tens of thousands to a highly dispersed system of non-profit organizations, county mental hygiene departments, and state and private hospitals. There are now more than 2,500 mental health programs in New York State. These programs provide Medicaid and non-Medicaid funded mental health outpatient (clinic, CDT, Day Treatment, PROS), emergency, residential, community support, vocational and inpatient care services to 688,000 individuals annually.

As this change was occurring, New York, like many states, expanded Medicaid funded mental health services. Today, Medicaid pays approximately 50 percent of the more than $6 billion annual cost of public mental health services in New York State. However, the distribution of funding for this system has not adjusted to reflect changes in our service delivery system. As a result we have a system where:

Gary Weiskopf, MPA

1. Approximately half of the public mental health dollars finance mental health hospitalization while the vast majority of people with mental illnesses need outpatient services;

2. Reimbursement for mental health services is complex and inequitable. "Short term" Medicaid initiatives like "Comprehensive Outpatient Programs" (COPs), a Medicaid payment rate add-on for clinics and selected other outpatient providers, have become permanent solutions;

3. Research shows that the onset of serious mental illness occurs in early adolescence, yet identification and treatment are often delayed for years;

4. In some areas of the State, there is insufficient access to specialized services (e,g., case management, vocational services, children's waiver) that assist individuals in meeting life roles;

5. The financing system does not incentivize recovery/resiliency, success in school and/or employment, and other desirable outcomes;

6. Many consumers experience a system plagued by fragmentation, poor communication, poor coordination, and a lack of accountability.

7. There is poor integration between mental health/substance abuse/physical health care. As a result, individuals with emotional disturbance/mental illness often have unaddressed debilitating health conditions (e.g., obesity, diabetes);

8. There is insufficient data to demonstrate the effectiveness of service outcomes; and

9. Other systems serving children and adults (i.e., schools, criminal/juvenile justice, social services and emergency rooms)

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OMH's Mental Health Services Restructuring: A Commentary

By Phillip A. Saperia
Executive Director
The Coalition of
Behavioral Health Agencies

The Coalition of Behavioral Health Agencies has been gratified to be an active participant in the stakeholder process established and nurtured by the New York State Office of Mental Health (SOMH). For close to five years, we have maintained that restructuring of clinic reimbursement and attendant program design is long overdue. In fact, we have seen the closing of large numbers of Article 31 outpatient clinics in the New York City area, a consequence of the gross imbalance between the costs of running clinics and the inadequate Medicaid and other reimbursements for services. The closing of clinics is threatening the fabric of community care, the continuity of service delivery, especially for hospital discharges, and to the welfare of consumers who have depended on them for stability and predictability of care.

Phillip A. Saperia

Properly alarmed, The Coalition, in 2005 convened a workgroup of its providers and hired a team of consultants. Members engaged in a long process of review, analysis of clinic operating data and consideration of alternative models of service delivery. The Coalition produced a conceptual framework for reimbursement and clinic reform that was presented to the newly appointed NY State Office of Mental Health's (SOMH) Commissioner Michael Hogan at a meeting in his first week in New York. We are mindful still of his auspicious response: "I know that clinics are the portal to the mental health system."

Now we have been engaged for two years in an intense and meaningful SOMH/DOH process that is heading down the road towards major reform, scheduled to begin in January, 2010, a scant five months away. We have seen considerable accomplishments: 1) a pool of dollars established to cover those people who are not covered by insurance (the uninsured); 2) the measured phase-out of a Medicaid rate add-on called COPs, the previous mechanism for covering these people; 3) a new reimbursement mechanism that will be compliant with federal HIPAA law, guaranteeing confidentiality to consumers of service; 4) a broadened range and flexibility of services for recipients (although recent rumors about last minute unilateral changes in procedures by State authorities may belie this accomplishment); 5) increasing the base Medicaid rate (although, the exact rate and the rate for supplemental services is still in discussion and providers await the outcome of the deliberations before assessing the impact on community clinic service delivery); and 6) regulatory changes that are designed to promote more integration of care, both within behavioral health and with primary care (although the sector is still unsure how these services will be reimbursed).

The work has been intense and SOMH must be applauded for all its hard work. So too do the stakeholders deserve plaudits for determined participation that has required data collection and analysis, many meetings within each group, uncountable trips to Albany, conference calls and webinars. Many good results may be observed.

Yet there remain a variety of unaddressed issues on which the future of New

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From the Publisher
The Economy's Impact on People and Community Services

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

As we all watched on TV and felt first hand when we pay our monthly bills, we have been in the midst of an economic meltdown not seen since the Depression of the 1930's. The Stock Market tanked, the housing market crashed, foreclosures reached all time highs, and many people lost their homes and life savings. In addition, there is rampant unemployment, businesses large and small are downsizing, people have lost their medical insurance, and many are having difficulty affording basic necessities.

I can't think of a worse situation for everyday people who are suddenly being thrown into their own personal or family crisis due to the down-turn in the economy. To suddenly lose one's job, home, and life savings is a horrible thing to go through. I know, because I lost all of these things during my illness. I can't help but also be deeply concerned about the economy's impact on people with mental illness and other disabilities, and for the vital community services that provide vital services to them on a daily basis.

During my battle with depression, I had to take advantage of numerous treatment and support services that make up the mental health system of care, including: in-patient and out-patient hospital services, community day-treatment programs, entitlement advocacy programs, supportive housing agencies, vocational programs, and consumer clubhouse and drop-in centers. During my illness I was living in the Metro-NY area where I was fortunate to have access to all of these services. However, such a menu of service providers may not exist in every community, especially in more rural areas where it is not uncommon to have one mental health center that addresses all or some of these services under one roof.

Some may ask why so many different services are really needed to help someone get well? I can honestly tell you that they are not only needed but can be the difference between life and death for someone who has suddenly fallen ill to a serious mental illness. It is hard to describe unless you've been there yourself.

Ira H. Minot, LMSW

The sudden onset of a serious depression or other emotional disorder can grab hold of a person's life much like an avalanche grabs hold of the side of a mountain. At the very beginning of the event it may appear as only a minor disruption, but as it progresses it destroys everything in its path.

Based on my own personal experience, I have always believed that mental illness, and caring for someone with one, is not an exact science. There are so many differences in the symptoms each person might have—even with the same diagnosis. Similarly, the same medication may help some people and not others. Often, a mix of medications may be necessary to find the right chemistry that will help a person feel better. This may take weeks or months of trial and error to find the right medication(s) that work.

The reason that a community of treatment and support services are such a lifeline to people who develop a mental illness is the extreme free-falling nature of the experience for many. Much like a skydiver jumping out of a plane you are in a free-fall with your symptoms hoping that your chute will open for a smooth and safe landing. Unfortunately that's not always the case. For an adult (as I was) the experience is even more unnerving because you are responsible for providing for yourself and your family. As your illness emerges, your symptoms interfere with your daily life—so much so that in some cases that you are unable to function at work. There isn't always that much leeway given to you to get back on track, and managing the normally simple responsibilities of your life can come crashing down on you quite suddenly in only a few days or weeks. You may then have to be admitted to a psychiatric hospital as I was, and when you come out you may feel a bit better, but the world you once knew may not be the same. In my case, I had lost my job and felt a great embarrassment and humiliation—unable to explain my condition to my employer, friends and family. Thus, this first breakdown triggered a series of unexpected changes in my life beginning with the collapse of my ability to support myself on a daily basis. That only added to the emotional distress of my illness that took over ten years to struggle through. If it were not for all the services that I previously mentioned I would not have survived. I had lost everything, and was forced to fall into that safety-net. Thank heaven it was there to catch me.

Community mental health organizations and other disability and support services are feeling the squeeze that the economy has placed on them. State and local governments are in a terrible crisis and most are unable to meet budgets that fund essential services to communities everywhere. The nonprofit sector is reeling. Some organizations are losing their entire budgets and are being forced to close, while others are having to let staff members go, while trying to provide the same or increasing service demands with an even smaller workforce. This may have a serious impact on people with mental illness who rely on these services and the people who deliver them. Unfortunately, there have always been cracks in the mental health care system that caused some people to not get the care that they needed. It is likely that we will begin to see even larger cracks in our community services network as a result of the struggling economy. How will this effect the most vulnerable people in our society? Will the safety-net remain in place?

We all have basic needs for food, shelter, friends and family, a sense of worth and wellbeing (that comes about by having a meaningful life), and a positive and nurturing feeling that we are part of a supportive community in which we live. When I recently moved from the Metro-NY area to a somewhat rural part of Northeast Pennsylvania, I found I had left behind a sense of community that I had developed over the years I lived in supportive housing in New York following my illness. They say you don't appreciate the things you have until you lose them. It may sound trivial, but little things that I came to enjoy where I used to live are harder to find now. Things like having a cup of coffee at the deli down the block and seeing familiar faces just outside my door on a daily basis had become a part of who I was at that time in my life. Moving to a new location, means having to develop an entirely new social network that may not equal the one you had.

It may be difficult to measure the impact today's economy is having on everyday people, some of whom are being uprooted from their familiar surroundings due to losing their job or their home. Many are being forced to move when their home goes into foreclosure, and many who have recently lost their jobs may take whatever job they can find—even if it means moving to another location far from where they now live. For a single person it is certainly traumatic, but when families are uprooted it may have far deeper psychological consequences for parents and their young children. This is also true where a parent has to travel a long distance to a new job, or has to relocate to another city in order to work and provide for their families. This can certainly put a strain on families and can be a huge emotional hardship for the parent forced to live away from home for long periods of time.

Let's hope that the economic recession will be over soon and that local and state government can stem the tide of budget cuts to the nonprofit sector. Too much is at stake in an already stressed system of care. Perhaps in meeting dwindling budgets, organizations will find ways to be more cost effective while still delivering the highest level of care to their clients. This will be a real challenge and something we will continue to follow here at *Mental Health News*.

Good luck in your recovery, never give up, and don't be afraid to ask for help.
Have a wonderful fall season !

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Staying in Balance: Helping Nonprofits Manage Stress in an Uncertain Economy

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

As the economy began to cool down, business at New York City nonprofit organizations began to heat up. In June of 2009, more than 375,000 New York City residents were unemployed, increasing NYC's unemployment rate to 9.5% - the highest level in over 10 years (New York State Department of Labor, 2009). Losing a job can be life-changing, and financial strain can be overwhelming, especially if you find yourself in need of social services for the first time.

In the past year, emotional stress stemming from the economic downturn has driven more and more New Yorkers to seek assistance from local nonprofit organizations. Increases in service demands place additional stress on the frontline staff members who deliver these essential services. As New Yorkers find themselves increasingly unable to make ends meet, our city's nonprofits are stretching their resources to meet the demand.

In response to the growing need for these services, the Mental Health Association of New York City (MHA of NYC), with support from The New York Community Trust, has developed a groundbreaking new program to promote emotional wellness and organizational health during the economic crisis.

Giselle Stolper

Staying in Balance: Managing Stress in an Uncertain Economy provides key safety-net organizations with a tool-kit and training for managing the stress associated with economic loss.

Staying in Balance is designed to meet the needs of individuals and families whose economic stability has been threatened to the point that they must seek assistance from a safety-net organization, and the needs of the front-line staff members whose own economic situation may mirror that of their clients.

For staff members, the *Staying in Balance* training will focus on:

- Reducing Stress in the Workplace: Day-to-Day Tips for Supervisors
- Reducing Personal Stress: Helping Yourself, Helping Your Clients – A training for front-line workers
- Managing Challenging Client Behavior: Resources for Clients in Serious Emotional Distress

Client material will promote coping skills by offering stress reduction tips, information on navigating the social service system, and resources to help clients overcome barriers imposed by the economic crisis.

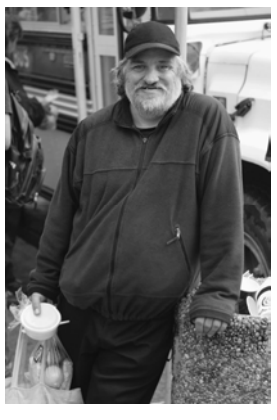
Staying in Balance has been funded by the New York Community Trust to provide emotional support to eight New York-based organizations that deliver critical services to the neediest of New Yorkers, including: The Bridge Fund; Legal Services NY; NY Financial Network Action Consortium; City Meals-on-Wheels; Cancer Care; City Harvest; Food Bank of NYC; and United Neighborhood Houses.

Staying in Balance will prepare these organizations to distinguish between normal emotional responses to difficult times and responses that demand professional attention. Through this project, MHA of NYC will provide these organizations with tailored trainings and materials to identify when and how to refer emotionally fragile clients to 1-800-LifeNet, New York City's primary 24/7 mental health crisis, information and referral hotline or 1-800-273-TALK, the National Suicide Prevention Lifeline.

Following 9/11 and again after Hurricane Katrina, MHA of NYC was a first port-of-call for those on the frontlines of disaster response delivery. Through lessons learned from years of post-disaster work, MHA of NYC has crafted a public health approach that builds community resilience and engages and prepares a wide range of human service providers impacted by crisis or disaster. *Staying in Balance* is one way in which MHA of NYC is responding to the emotional needs of those experiencing the financial crisis.

The *Staying in Balance* training and toolkit will be made available to wider audiences of social service providers, clergy, educators, government agencies and private sector employees in the coming months. ***Staying in Balance*** resources will be available online on the MHA of NYC website (www.mhaofnyc.org) in the fall of 2009.

Organizations interested in receiving the Staying in Balance training, should contact Kathryn M. Salisbury PhD, Director of Program Innovation and Community Partnerships at the MHA-NYC at Ksalisbury@mhaofnyc.org



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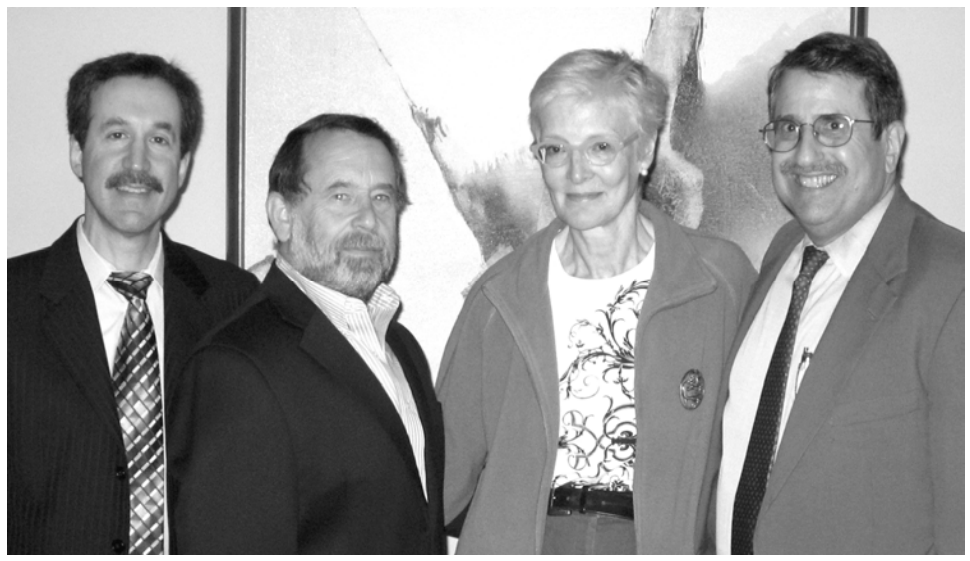
MENTAL HEALTH NEWSDESK

Mitchell Presents 20th Annual Maniscalco Lecture at Saint Joseph's

Staff Writer
Mental Health News

Grant Mitchell, MD, Commissioner of the Westchester County Department of Community Mental Health presented the Twentieth Annual *Anthony Maniscalco, MD Lecture in Public Psychiatry* to the Department of Psychiatry of Saint Joseph's Medical Center in Yonkers, New York. The lecture was created in honor of Dr. Maniscalco who had been the Director of the Department of Psychiatry from 1970 until 1980, a period during which many of the full range of mental health services currently available at Saint Joseph's were established. Steven Friedman, M.P.H., a former Westchester Commissioner who had presented the first Maniscalco Lecture, was present for this year's address.

Dr. Barry B. Perlman, Director of the Department of Psychiatry, introduced this year's lecturer. Dr. Mitchell has been Commissioner since 2007. Prior to that he served as the Chief of Behavioral Health at Northern Westchester Hospital Center and Chair, Department of Psychiatry at Sound Shore Health System. He is the CEO of Prime Care, a multidisciplinary behavioral health group practice and was the founder of Virtual Briefcase-Psych, a behavioral software company.



Grant Mitchell, MD, Commissioner, Westchester County Department of Mental Health, Steven Friedman, MPH, former Commissioner, Nancy Maniscalco, daughter of Anthony Maniscalco for whom lecture is named, and Barry B. Perlman, MD, Director, Department of Psychiatry at Saint Joseph's Medical Center

Dr. Mitchell's topic was "Mental Health in the New Environment" and he utilized the presentation to lay out his vision for his Department in the areas of leadership, services delivery, and policy making. Programmatically, he spoke about the county's initiatives which, among others, include: (1) a new person-centered care coordination program for individuals with historically poor outcomes and high costs; (2) mental health collaboration teams which place a care manager with police units with the goals of early intervention with individuals a risk for decompensation; (3) advocating for flexibility in utilizing Medicaid funds; (4) seeking to rationalize use of resources in the children's mental health system in relation to housing, emergency and transitional services; and (5) pioneering a county based Autism Advisory Committee. Dr. Mitchell described his department's quantitative, outcomes oriented approach to each of the domains being focused on.

The Department of Psychiatry at Saint Joseph's Medical Center, which serves the community of Yonkers, New York and contiguous communities, includes a wide array of outpatient and inpatient mental health services as well as substance use disorder treatment programs.

New Family-Focused Model of Depression Care Needed To Minimize Risks and Problems for Parents With Depression and Their Children

By National Research Council and Institute of Medicine

Health and social service professionals who care for adults with depression should not only tackle their clients' physical and mental health, but also detect and prevent possible spillover effects on their children, says a new report from the National Research Council and Institute of Medicine. To achieve this new family-focused model of depression care, federal and state agencies, nonprofits, and the private sector will have to experiment with nontraditional ways of organizing, paying for, and delivering services, said the committee that wrote the report.

Depression affects roughly 7.5 million parents (about one in five) in the United States annually, and about 15.6 million children under 18 live with an adult who has had major depression in the past year, the report notes. Effective tools and strategies exist to treat and prevent depression, but only one-third of adult sufferers get treatment. Although many factors affect children's development, parental depression can increase the chances for health, emotional, and behavioral problems in children. The report does not suggest that every parent with depression will inadvertently or deliberately cause harm to their children, but rather that parental depression increases the risks for spillover consequences during critical periods of child and adolescent development.

"To break the vicious circle of depression, we need to refocus our view of this illness through a broader lens that sees the whole family, not just the individual with depression," said committee chair and psychiatrist Mary Jane England, President, Regis College, Weston, Mass. "Our report describes a new vision for depression care that would provide comprehensive services not just to adults, but to their children as well. It will take significant policy changes to make this vision a reality, but the benefits warrant the effort."

Endeavors to increase the family focus on depression should aim to remove barriers that inhibit more coordinated care across organizations and among service providers. Children and adults are treated by separate health care providers who too often do not look at the whole family, and many health and social services are disconnected. Few programs and health care providers routinely ask patients with depression if they have children and if their depression has affected their family members. Health plans are not geared to pay for services delivered in nontraditional settings.

Fathers and mothers may benefit from counseling to improve their parenting and coping skills, and children may need treatment for emotional, behavioral, or physical problems. Services need to be available in a range of locations that include not just obstetrics-gynecology and pediatric clinics, but also Head Start facilities, schools, prisons, other community locations, and even people's homes, the report says. This means that clinicians must gain experience in delivering services in a variety of settings. States should revise policies that prohibit services outside of clinical settings. Federal agencies should establish a national program to improve the abilities of primary care providers, mental health professionals, and those who treat substance abuse to identify, treat, and prevent depression and lessen its effects on children of all ages.

Public and private health insurance plans should support access to screening, treatment, and supportive services. The Centers for Medicare and Medicaid Services (CMS) could extend Medicaid services provided to new mothers to two years after birth, which includes a critical period of early childhood development, the report says. CMS could reimburse primary care providers for mental health services and cover preventive services for children at risk of developing health problems, rather than covering only treatment. Private health plans could pay for parental depression screening and treatment, and support the implementation of effective models of depression care in a range of settings.

Lack of insurance coverage is not the only reason that two-thirds of people with depression do not get treatment. Public and private groups also need to tackle the insufficient numbers of care providers and facilities, difficulties that low-income individuals in particular confront in traveling to service providers, and the stigma associated with mental illness.

Given the variation in health and social services across states, broad experimentation with service strategies will be needed. Governors of each state should convene a task force of state and local agencies to coordinate efforts and to design and implement an array of programs involving multiple organizations and settings. State officials should document their activities and results so that they can learn from one another.

MENTAL HEALTH NEWSDESK

Schizophrenia and Bipolar Disorder Share Genetic Roots

By The National Institute of Mental Health (NIMH)

A trio of genome-wide studies -- collectively the largest to date -- have pinpointed a vast array of genetic variation that cumulatively may account for at least one third of the genetic risk for schizophrenia. One of the studies traced schizophrenia and in part, to the same chromosomal neighborhoods. "These new results recommend a fresh look at our diagnostic categories," said Thomas R. Insel, M.D., director of the National Institute of Mental Health (NIMH), part of the National Institutes of Health. "If some of the same genetic risks underlie schizophrenia and bipolar disorder, perhaps these disorders originate from some common vulnerability in brain development."

Three schizophrenia genetics research consortia, each funded in part by NIMH, report separately on their genome-wide association studies online July 1, 2009, in the journal Nature. However, the SGENE, International Schizophrenia (ISC) and Molecular Genetics of Schizophrenia (MGS) consortia shared their results - making possible meta-analyses of a combined sample totaling 8,014 cases and 19,090 controls.

All three studies implicate an area of Chromosome 6 (6p22.1), which is known to harbor genes involved in immunity and controlling how and when genes turn on and off. This hotspot of association might help to explain how environmental factors affect risk for schizophrenia. For example, there are hints of autoimmune involvement in schizophrenia, such as evidence that offspring of mothers with influenza while pregnant have a higher risk of developing the illness.

"Our study was unique in employing a new way of detecting the molecular signatures of genetic variations with very small effects on potential schizophrenia risk," explained Pamela Sklar, M.D., Ph.D., of Harvard University and the Stanley Center for Psychiatric Research, who co-led the ISC team with Harvard's Shaun Purcell, Ph.D. "Individually, these common variants' effects do not all rise to statistical significance, but cumulatively they play a major role, accounting for at least one third -- and probably much more -- of disease risk," said Purcell.

Among sites showing the strongest associations with schizophrenia was a suspect area on Chromosome 22 and more than 450 variations in the suspect area on Chromosome 6. Statistical simulations confirmed that the findings could not have been accounted for by a handful of common gene variants with large effect or just rare variants. This involvement of many common gene variants suggests that schizophrenia in different people might ultimately be traceable to distinct disease processes, say the researchers.

"There was substantial overlap in the genetic risk for schizophrenia and bipolar disorder that was specific to mental disorders," added Sklar. "We saw no association between the suspect gene variants and half a dozen common non-psychiatric disorders."

Still, most of the genetic contribution to schizophrenia, which is estimated to be at least 70 percent heritable, remains unknown. "Until this discovery, we could

see Genetic Roots on page 40

NYS Researchers to Test Approaches to Alter Course of Schizophrenia

Staff Writer
Mental Health News

Michael F. Hogan, Ph.D., Commissioner of the New York State Office of Mental Health (OMH), today announced that researchers in New York State will head the two independent teams selected by the National Institute of Mental Health (NIMH) to develop and test new therapeutic strategies for treating people experiencing a first episode of the psychotic symptoms of schizophrenia. The Recovery After an Initial Schizophrenia Episode (RAISE) project is based on the premise that early intervention with optimized treatments and services can alter the course of the illness and reduce disability while increasing recovery. The research teams will be headed by:

- Jeffrey A. Lieberman, M.D., Lawrence E. Kolb Professor and Chairman, Department of Psychiatry, Columbia University College of Physicians and Surgeons; Director, New York State Psychiatric Institute; and Director, Lieber Center for Schizophrenia Research. Dr. Lieberman will lead a team of researchers from the University of Maryland, Dartmouth College, University of California Los Angeles (UCLA), Duke University, University of North Carolina Chapel Hill, University of California Davis, and Harvard University Beth Israel Deaconess Medical Center.

- John M. Kane, M.D., Chairman, Department of Psychiatry at The Zucker Hillside Hospital of the North Shore-Long Island Jewish Health System and Professor of Psychiatry, Neurology and Neuroscience and the Dr. E. Richard Feinberg Chair in Schizophrenia Research at the Albert Einstein College of Medicine. Dr. Kane will lead a team of researchers from SUNY Downstate Medical School, Dartmouth College, University of North Carolina, Weill Cornell Medical College, Yale University and the University of Calgary.

Commissioner Hogan said, "All New Yorkers can be proud that both teams involved in this intensive effort to forestall the disability associated with schizophrenia will be led by researchers in New York State. New approaches to the treatment of schizophrenia will be tested, emphasizing aggressive interventions as early as possible. These new approaches are aimed at helping people and their families to live with the illness and successfully transition to adult life. The Office of Mental Health intends to use the findings of these projects to help transform the care for all New Yorkers with serious mental illness."

Dr. Lieberman said, "This award will enable researchers to demonstrate how a strategically timed intervention at the onset of symptoms can prevent the debilitating effects of one of humankind's most devastating and costly mental disorders."

Dr. Kane said, "We are very pleased to have this opportunity to work with colleagues, families and individuals with schizophrenia to develop and test a comprehensive early treatment program that can not only alter the course of this potentially devastating illness, but also change the way that it is perceived."

"This new initiative will help us determine whether intervention that is started early, incorporates diverse treatment and rehabilitation approaches, and is sustained over time, can make it possible for more people with schizophrenia to return successfully to work and school," said NIMH Director Thomas R. Insel, M.D. "Moreover, the interventions being tested will be designed from the outset to be readily adopted in real world health care settings and quickly put into place."

"Depending on the study's outcome, RAISE could help set the stage for a paradigm shift in the way schizophrenia is treated in the United States," said Robert Heinssen, Ph.D., acting director of the NIMH division of Services and Intervention Research and project officer for RAISE. "The ultimate goal of the initiative is to eliminate the chronic form of schizophrenia that is so costly and devastating to the individual, family members, and society as a whole. This Recovery Act-supported project will hire and help train many mental health researchers and care providers for a project that is likely to help some of our most vulnerable citizens lead more productive and satisfying lives."

Affecting just over one percent of the adult population, schizophrenia is often thought of as the most serious and intractable mental illness. Schizophrenia often strikes in the college or early adult years, and although many experience a substantial recovery, many others experience substantial and lifelong disability. People with schizophrenia often do not receive

see Schizophrenia on page 40

In The Mental Health News Spotlight

Prominent Leaders Elected to Key Positions on Newspaper Board

Peter Beitchman, DSW

Barry B. Perlman, MD

Peg E. Moran, LMSW

Alan Trager, LCSW

Staff Writer
Mental Health News

Behind every successful non-profit organization is a Board of Directors that is made up of dedicated men and women. These prominent individuals, who hold key positions at their own organizations, volunteer their time and energy to serve on another organization's Board to assist the organization in key areas of its mission and overall operation.

Mental Health News Education, Inc. (MHNE), the organization that publishes *Mental Health News* and *Autism Spectrum News* is extremely fortunate to have a Board of Directors which is made up of many of the mental health and autism community's most prominent leaders.

At its recent June meeting, the Board of MHNE recognized its outgoing Chairman and Co-Chairwoman, elected a new slate of Officers who will lead the organization in the coming years, and bestowed additional honors to two members who have recently left the Board after many years of dedicated service. In this multi-page review, we have the pleasure of introducing you to the MHNE Board's newly elected officers and to also pay tribute to board members who have given many years of service to the organization.

Chairman: Dr. Peter Beitchman

Dr. Peter Beitchman who joined the MHNE Board in 2006 and was the organization's immediate past Treasurer, has worked and advocated within New York's mental health system for the past 42 years. He is Executive Director of The Bridge, Inc., a comprehensive multi-service agency for men and women with serious mental illness located in New York City. Before becoming Executive Director of The Bridge in 2000, Dr. Beitchman served as the agency's Deputy Director for 17 years. Prior to The Bridge, Dr. Beitchman held a number of key public mental health policy positions in the New York City Department of Mental Health, Mental Retardation and Alcoholism Services, the New York State Assembly and the Coalition of Voluntary Mental Health Agencies, the advocacy and technical assistance organization that represents New York City's nonprofit mental health sector.

Dr. Beitchman received a Doctorate in Social Welfare from the City University of New York and has a Masters degree in Social Work from Hunter College School of Social Work.

According to Dr. Beitchman, "*Mental Health News* and *Autism Spectrum News* have filled a void that very much needed to be filled to keep both the professional and lay communities informed on critical issues in their respective fields. These publications have set a gold standard in reporting and informing. In assuming the role of Chairman of the Board, so impressively filled by Dr. Alan Siskind and Dr. Peter Campanelli, I look forward to working with the board and our extraordinary executive staff of Ira and David Minot, to maintain the excellence of our publications and to address the emerging needs and interests of our readers. In this regard I urge readers to share your suggestions and thoughts about our publications." *(more about Dr. Beitchman's background and The Bridge later in this article)*

Vice-Chairman: Barry B. Perlman, MD

Barry B. Perlman, MD, a founding member of the MHNE Board, is a graduate of the Yale University School of Medicine, and completed his residency in psychiatry at Mount Sinai Hospital in New York City. He is Board Certified in Psychiatry by the ABPN. Since 1981 he has been the Director of the Department. of Psychiatry at Saint Joseph's Medical Center in Yonkers, New York. He is a Clinical Associate Professor of Psychiatry at New York Medical College. He is the Legislative Chair of the New York State Psychiatric Association of which he is a past president. He served as Chair of the New York State Mental Health Services Council and as a member of the State Hospital Review and Planning Council. He is currently the Vice-Chair of the Council on Advocacy and Government Relations of the American Psychiatric Association. He has published both academic and general articles in the field of public policy and psychiatry.

"Dr. Perlman is someone I can always call with a question and know that I will get a thoughtful and well informed answer. His extraordinary knowledge of psychiatry and his fair and balanced views on the politics of mental health care has been a continual source of learning and inspiration to me," stated Ira Minot, LMSW, Executive Director.

Secretary: Peg E. Moran

Peg Moran, LMSW, a founding member of the MHNE Board, has been with F·E·G·S Health and Human Services System since 2005, and is presently the Senior Vice President of Residential and Housing Services. F·E·G·S is one of the largest housing providers in New York City and Long Island with over 1200 beds representing a range of housing options for people with mental illness, developmental disabilities and other needs.

Prior to coming to F·E·G·S Peg served as Vice President for Behavioral Health Services at St. Vincent Catholic Medical Centers, Associate Hospital Director for Psychiatry at Mount Sinai Medical Center and Vice President for Network Development at Four Winds Hospital. She served with the New York State Office of Mental Health as Director of State Operations and Deputy Regional Director. She also served at the New York State Office of Mental Retardation and Developmental Disabilities and the Association for Retarded Citizens. She has previously served on the Board of Directors for Mental Health Association of New York State and Putnam Family and Community Services, and held an academic appointment at New York Medical College. She is currently on the Advisory Board of the Supportive Housing Network of New York, and works with the Urban Institute for Behavioral Health, the New York State Association for Community Living, the Coalition of Behavioral Health Agencies, the New York City Coalition of the Continuum of Care, and the Geriatric Mental Health Alliance.

Peg stated, "*Mental Health News* brings a unique, powerful message as a best practice disseminator and connector for consumers, families and providers. It has been a privilege to be part of this collaborative venture since its early beginnings in Westchester County and experience its growth and expansion under the leadership of the newspaper's founder, Ira Minot. Congratulations Ira on MHN's 10th Anniversary!"

Treasurer: Alan Trager, LCSW

Alan Trager, a founding member of the MHNE Board, is Chief Executive Officer

See Newspaper Board on page 9

In The Mental Health News Spotlight

Newspaper Board Members Recognized for Years of Service

Peter Campanelli, PsyD and Janet Segal, LMSW

Jonas Waizer, PhD

Leo Leiderman, PsyD

Newspaper Board from page 8

of Westchester Jewish Community Services (WJCS), a diverse, nonprofit human service agency in Westchester County New York, where he has worked since 1976. Among the many positions and accomplishments during his tenure at WJCS, Mr. Trager gained national recognition for the creation and development of the Child Sexual Abuse Treatment Center, which has developed into the Treatment Center for Trauma and Abuse, a model program in the New York metropolitan area. He served as an adjunct Associate Professor at New York University Graduate School of Social Work for 15 years and is a member of the training faculty at Fordham University since 1985. He has written for a variety of publications and has been the recipient of a number of professional awards, including the Leonard Rohmer Award for Professional Achievement and the NASW Social Worker of the Year (Westchester). Mr. Trager received his Masters Degree from Columbia University and bachelors degree from Binghamton University.

"As we celebrate the 10th Anniversary of the launch of *Mental Health News* we have seen this organization become an important part of the fabric of the mental health community and I look forward to continuing part of the team that supports Ira and David Minot as we continue to contribute to that quilt and grow as an organization."

Outgoing Chair and Vice Chair Honored

Dr. Peter Campanelli joined the MHNE Board in 2004 and has served as Chairman of the Board for the past three years. Janet Segal is a founding member of the MHNE board, and has served as Co-Chairwoman since the organization began. Both were presented with leadership awards in recognition of their many years of service to MHNE at the organization's recent June meeting.

Peter C. Campanelli, PsyD

Dr. Peter Campanelli is the President and Chief Executive Officer of the Institute for Community Living, a not-for-profit agency he founded in 1986 which provides rehabilitation, housing, vocational and support services to over 8000 serious mentally and/or developmentally disabled New Yorkers.

Dr. Campanelli is a licensed Clinical Psychologist in both New York and New Jersey and is the recipient of numerous local and national awards including the Peterson Prize awarded by the Graduate School of Applied and Professional Psychology of Rutgers University, two Gold Awards from the American Psychiatric Association, as well as various congressional and legislative awards. Dr. Campanelli previously served as Chief of Service of the Community Residential Service for South Beach Psychiatric Center, a New York State psychiatric hospital. He has served on the faculty of Pace University, Rutgers University and Metropolitan College of New York within their graduate training programs.

Dr. Campanelli has been the Chair of the Board of Directors of the Association of Community Living, Inc. a statewide residential group of providers consisting of over 120 residential providers and has served as Chairman of the Board of Directors of the Coalition of Behavioral Health Agencies, an organization which is comprised of the majority of mental health care providers in New York City. He currently serves on the Coalition's Executive Committee. In addition, Peter is Co-chairman of the Governance Committee of the Human Services Council of New York City.

Janet Z. Segal, LMSW

Over the past thirty years, Janet Segal's innovative and steady advocacy for people in need of mental health treatment has had a strong impact on the quality of mental health services throughout the tri-state area. In 1979, Janet joined the staff of Four Winds Hospital located in Katonah, New York. Then a 35-bed facility, she served as the Director of Social Work, eventually becoming a member of the senior management team as they grew the hospital to 175 beds. During this time she assumed responsibility for program development, treatment initiatives and marketing strategies, eventually becoming Chief Operating Officer.

She worked to improve services to patients and to strengthen training and coordination among clinical staff. As part of this effort, she began a Group Therapy Training Program for nurses and mental health workers to make them an integral part of the treatment program. To help people in crisis, she instituted an around-the-clock admissions policy at Four Winds, putting herself and the admissions staff on call, 24/7. Responding to the challenges of managed care, she helped to establish three partial hospitalization programs for children, adolescents and adults so that patients could continue their treatment.

Janet's community outreach efforts to clinics, agencies, emergency rooms, schools, and residential treatment centers, has forged a new path, enabling referents to participate in their patient's treatment through communication with Four Winds clinical staff. This collaboration had great benefit to patients.

A graduate of Bard College, Janet had originally pursued a career in music as an instructor of piano and composition at Bard and then as Assistant Director of Recorded Music at Radio Station WQXR in New York City. After her marriage, and while raising three children, she returned to school where she earned a Masters Degree in Pastoral Counseling at Iona College and a Masters Degree in Social Work at Fordham University.

As Executive Vice President of Four Winds Hospital, Janet continues her focus on advocacy for people with mental illness and outreach to the community. She is also the President of the Four Winds Hospital Foundation. She serves on the Boards of the National Council on Alcoholism and Drug Dependence and the Community Counseling Center of Westchester. With the participation of local clergy, she has started spiritual meetings at Four Winds that incorporates music and explores the benefits of spirituality for people with mental illness. She has reached out to the veteran community through the various county offices and the Veteran's Administration and is currently working with the Red Cross of Westchester, in collaboration with Four Winds colleagues, to establish support groups for veterans and their families. Janet believes collaboration, partnerships and communication are at the heart of effective mental health treatment.

Waizer and Leiderman Retire From Board After Years of Service

At MHNE's June meeting, Dr. Jonas Waizer and Dr. Leo Leiderman, were recognized for their many years of service to the organization. Each brought their expertise in mental health care to improve the scope and reach of MHNE's educational publications. In recent years, Dr. Waizer was instrumental in helping MHNE develop *Autism Spectrum News*. Dr. Leiderman, a leader in the Latino

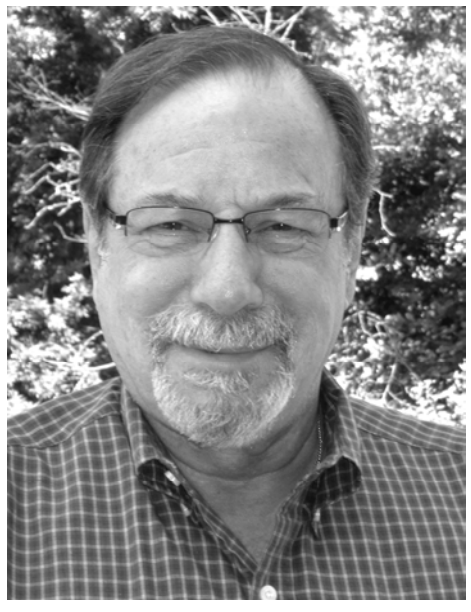
see Newspaper Board on page 40

An Organization's Multi-dimensional Response to the Economy

By Harvey I. Newman
Chief Executive Officer
Wellspring

When I reflect on the impact of the economy on mental health services, I find it impossible to describe the effect beyond the organization that I manage in Bethlehem, Connecticut. Wellspring is a nonprofit multi-service mental health organization that serves children, adolescents, young adults and adults, and their families. Services provided by Wellspring and the highly regarded Arch Bridge School include a community-based outpatient psychotherapy practice for children and adults, an educational program for ages 6 to 21, and a set of age specific residential/congregate care programs for ages 5 to young adult (we are licensed to 65). Wellspring is a small organization with a capacity of 41 residents and 51 special education students and, at any one time, serves about 200 individuals and families through our outpatient practice. Since we work with a small operational reserve and no endowment, we are very concerned about the effect of the economy on our organization.

This fiscal year, 2009, was the most financially volatile we have experienced in 12 years. Although the fiscal trend was the same as every year, the valleys were deeper and the peaks were higher. Since



Harvey I. Newman

we predominately serve children, our fiscal year is structured around the school year, with census low in summer, rising from the fall to the spring, then plummeting at the end of June. Financially, we always spend nine months chasing the first three months. The calendar year 2008 (last six months of FY 08 and the first six months of FY 09) was the worst we have experienced in more than 10 years—probably the worst in our 32 year history. It represented a seven percent deficit, more than three quarters of the loss in cash. Then, suddenly in January, referrals picked up and for the first five months of 2009 we experienced the second highest census in 12 years.

So, what was the impact of the economy on Wellspring? Did families feel that our services were a luxury during these difficult times, and then realize it was a need? Was the change in our fiscal fortune due to the economy – a situation beyond our control? Or, did we make brilliant management decisions that turned our fortunes around? As the CEO, I still do not know the answers to these and other pertinent questions about our current and recent past. Regardless of the cause, we needed to act.

In several different ways, Wellspring reaffirmed its commitment to mission, to intensity of clinical practice, and to quality of services. We cut back, but not at the expense of programs and staff integral to the accomplishment of the mission. This was important because as a mission driven organization, how we meet our mental health purposes is as important as balancing a budget. We have a clinical philosophy that was developed over 32 years ago which has had significant success, along with clinical practices that set us apart from many other mental health serving organizations. Next, we looked at the three streams of funding used to support Wellspring -- private payment (including reimbursement by insurance companies to families), government payment (including per diem and contract methods of payment) and philanthropy (a modest 3% of our income). As a result of this analysis, we decided that we needed to market to each target source of income.

Also, expenses needed to be controlled. In fact, expenses were the only financial aspect of the organization we could control. Over the 20 months between October 2008 and May 2009, we eliminated four positions, just below 4% of our employee count. We eliminated the positions of COO, one of two admissions coordinators, a discharge planning Social Worker, and an assistant to the Director of External Affairs. The reductions of personnel had little, if any, effect on direct clinical services. Non-personnel expenses were reduced within each program by the line staff. Even though income was reduced in 2008 because of lower census, expenses also were lowered through staff cuts and non-program reductions. In this period, we created a position for a marketing director to assist in increasing our census and our philanthropic visibility and asked some clinical managers to develop more functional direct relationships with referrals sources.

At the same time, we looked at ways to lower non-program expenses. We refinanced mortgages, renegotiated leases, stopped advertising to fill vacant positions

see Response on page 36

See the film, BOY, INTERRUPTED on HBO

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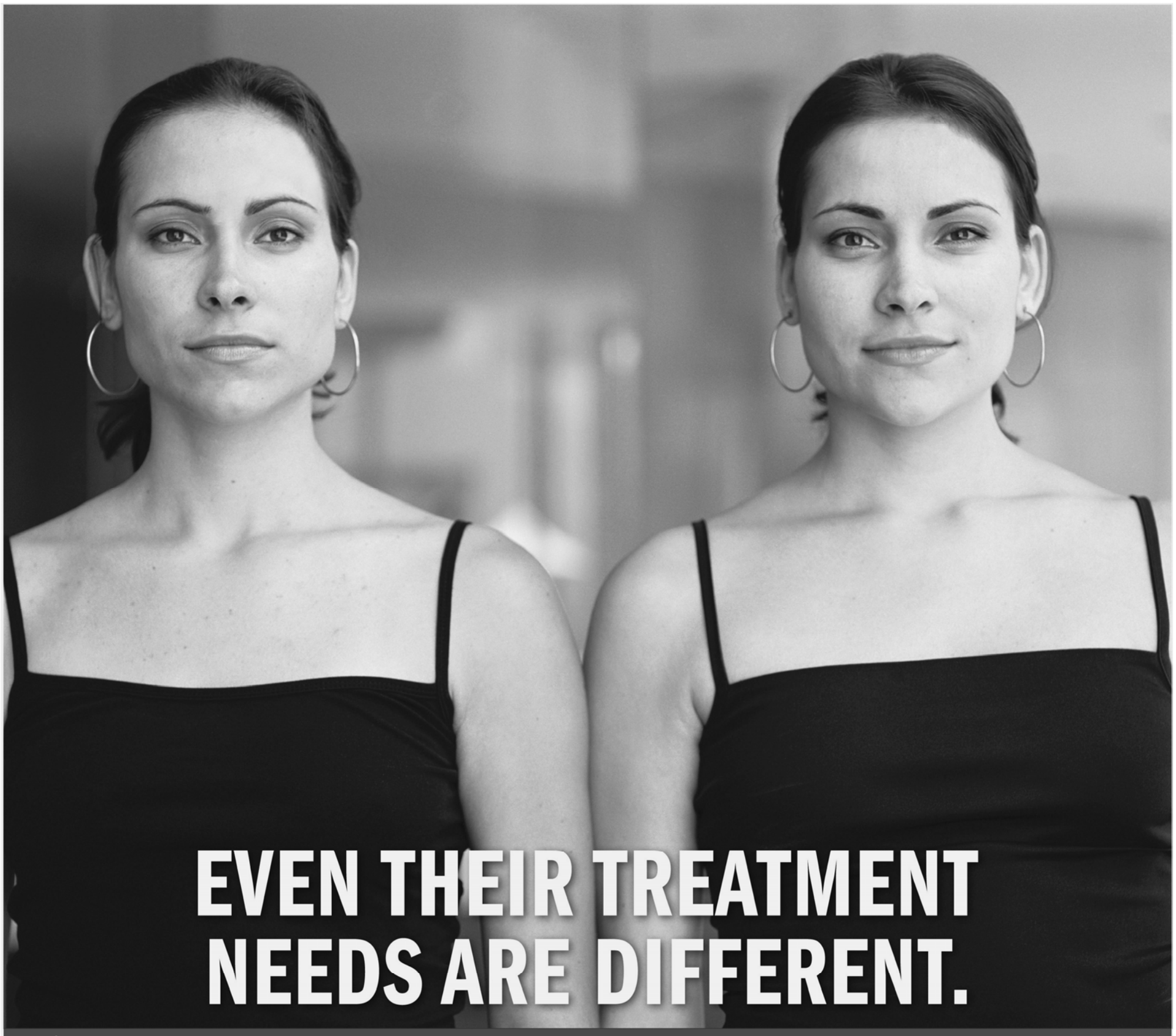

EVEN THEIR TREATMENT NEEDS ARE DIFFERENT.

Photograph is for illustrative purposes only. Persons depicted are models, not actual patients.

1 in 4 adults suffer from a diagnosable mental disorder in any given year.[1]

Open access is especially important in the treatment of mental disorders because the response to therapy can vary greatly from individual to individual and from one medication to the next. Restrictions in the form of prior authorizations and preferred lists may have the unintended consequences of jeopardizing patient health while failing to reduce costs.

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1. National Institute of Mental Health. Available at: http://www.nimh.nih.gov/healthinformation/statisticsmenu.cfm. Accessed March 24, 2008.

D6-K0198H March 2008

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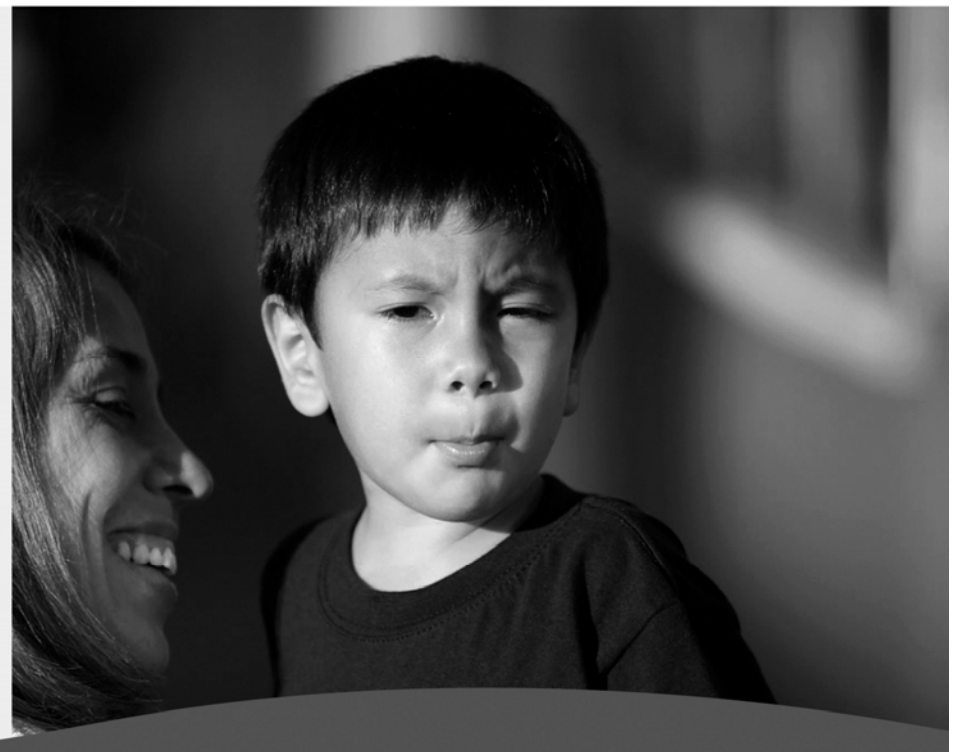

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of NYU Post-Graduate Medical School, the NYU Institute of Community Health and Research, the NYU School of Medicine Department of Psychiatry, Bellevue Hospital Center, World Psychiatric Association, American Public Health Association, NYS Assembly Committee on Addictions and Gambling, New York State Assembly Mental Health Committee, New York State Office of Mental Health, New York City Department of Health and Mental Hygiene, American Association for Psychosocial Rehabilitation, World Federation of Mental Health, National Alliance on Mental Illness, National Society of Hispanic Psychiatry, the Hispanic Federation Mental Health Consortium, the Association of Hispanic Mental Health Professionals, National Latino Behavioral Health Association, The New York State Office of Mental Health Nathan Kline Institute Center of Excellence in Cultural Competence.
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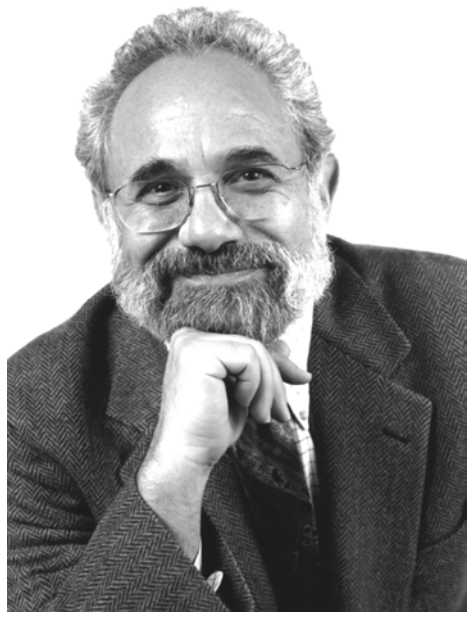
POINT OF VIEW

We Need a Sound Bite for Mental Health: Please Send Suggestions

By Michael B. Friedman, LMSW

As health policy reform is unfolding, it has become clearer and clearer that mental health is not much on the minds of health policy makers in Washington—despite the best efforts of national mental health advocacy organizations. The Bazelon Center, Mental Health America, NAMI, the National Council of Community Behavioral Health Organizations, and others have each developed an agenda of mental health issues that should be addressed as part of health policy reform (fortunately with lots of overlap), but they haven't gotten much traction.

The problem, it seems to me, is that the mental health community hasn't come up with a few sound bites that resonate with the American people and their elected representatives.



Michael B. Friedman, LMSW

> "Universal health coverage"—everyone gets that, and it is the driving goal of health policy reform even though, I would argue, the driving goal really should be to improve the health of Americans. Health care should be understood as a means, not as an end in itself.

> "Contain health care costs"—everyone gets that, too. We have all experienced first hand or heard stories about people who can't afford the health care they need or have even been wiped out by health care costs. And it is striking, to say the least, that the U.S. spends double per capita what the highest rated health care system in the world spends and is ranked only 37th in the world.

> "Improve quality of care"—everyone gets that, too, because we all have personal knowledge of someone who has gotten just awful care. It is entirely believable and horrifying that 100,000 people or thereabouts die from medical mistakes in hospitals each year.

So these three sound bites—health coverage for all, contain costs, and improve quality—work in the political arena. But what about mental health?

"There is no health without mental health". Many of us have quoted the Surgeon General's line confident that it is persuasive. But I'm afraid that while it's true, most people don't get it. And, come to think of it, what does it mean? What's the policy goal? It's not clear.

The most effective sound bite for mental health over the past couple of decades has probably been the call for "parity". It has a strong moral ring to it and also calls for a policy that at least seems clear and—presumably—won't cost any additional money. Even so it took nearly 20 years to win that issue, and—as Dr. Michael Hogan, Commissioner of the NYS Office of Mental Health has been asking —what's next? Been there, done that. What's "beyond parity?" Implementing parity? Yes, that needs to happen, but it's just not a compelling policy issue.

The most popular contender for a new central theme, it seems to me, is "Integrate physical and mental health." It's a one-liner that covers a lot of territory. We need to focus on the health needs of people with serious and persistent mental illness, who—we now believe—die 25 years younger than the general population, largely because of unattended health problems. We need to focus as well on the mental and substance use disorders of people who are not identified when they get primary health care, a very serious failure since 70% of those who complete suicide have seen their primary care provider within 30 days of taking their own lives. Not to mention the unnecessary suffering of people with untreated depression and so forth. We also need to focus on the mental health needs of people with co-occurring mental and chronic physical illnesses; they are at high risk for disability and premature death, and their medical costs are far higher than people without mental illnesses. In addition, we need to focus on the behavioral health problems of people in, or at risk of needing, long-term care. Federal and state governments have made long-term care reform (aka reduced Medicaid expenditures on long-term care) a major goal; but, as we have argued elsewhere, it can't happen fully without dealing with behavioral health issues.

So, as a sound bite "integrate health and mental health" covers a lot of important ground. But it also leaves out a lot that's important. As Richard Franks and Sherry Glied point out in their book, *Better But Not Well*, one of the critical mental health policy issues at the moment is whether we should pursue mental health "mainstreaming" or mental health "exceptionalism." By "mainstreaming" they mean embedding mental health services more and more in the health system. By "exceptionalism" they mean continuing to provide services—especially for people with long-term psychiatric disabilities—outside of the health system in a special mental health system. Their answer—clearly correct—is that we need to do both—more integration of mental health in the health system and continued expansion of a broad range of treatment, rehabilitation, support, and residential services for people with long-term psychiatric disabilities. The sound bite "integrate health and mental health" just doesn't capture that complexity, I'm afraid.

And, frankly, I don't think the idea speaks to most of the American people, who still don't get what mental health is about, still don't believe it's all that important, and for whom the idea of integration is very abstract and hard to grasp.

There are some other fundamental organizing principles for mental health policy. Good ideas, but do they work as politically persuasive sound bites?

> "Recovery oriented": It strikes me that people who don't speak jargon but do speak ordinary English would be astounded to think that mental health care now is not recovery oriented and would be bewildered by what recovery oriented care might be as distinct from ordinary treatment.

> "Patient-centered": Again, in ordinary English it doesn't make a lot of sense to call for patient-centered care. What are we doing now if we're not centered on the care of our patients?

> "Mental health home": I'm very taken by the recent suggestion to think about mental health needs via an analogy to the increasingly popular concept of a medical home. But, how many people know what a "medical home" is, let alone get the analogy between it and the provision of a comprehensive array of services for people with serious mental illnesses? A home? Isn't that either where you live or an institution you go to when you can't live at home?

So I think the search for a sound bite needs to continue. Preferably we need one that has a clear meaning in ordinary English. (For example, I would not use the term "behavioral health." No one outside of our field knows what that means.) In addition, the sound bite should implicitly contain a broad agenda including:

- Coverage of behavioral health care in all benefits packages
- Continued incremental improvement of community supports for people with long-term psychiatric disabilities
- Expansion of, and improved access to, mental health and substance use services for the 50% of us who will experience mental and/or substance use problems in our lifetimes
- Pursuit of new opportunities for early intervention and prevention
- Preparation for major demographic changes—the growth of aging and minority populations
- Quality improvement
- Integration of health and behavioral health services in primary, specialty, and long-term care
- Inclusion of mental health in the drive to improve information technology
- Workforce expansion and enhanced competence
- Enhanced research and translation of research into practice.

As I assume is apparent, I haven't a glimmer what the mental health sound bite should be. So, I am issuing this invitation:

PLEASE SEND ME SUGGESTIONS
Email me at center@mhaofnyc.org

I'll publish the promising ones
in my next column.

Michael B. Friedman, LMSW is the Director of the Center for Policy, Advocacy, and Education of the Mental Health Association of New York City. The opinions in this essay are his own and do not necessarily represent the positions of the Mental Health Association.

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The NYSPA Report

Outpatient Mental Health Clinic Reimbursement Reform: The NYSPA Perspective

By Seth P. Stein, Esq.
Executive Director and General Counsel, NYS Psychiatric Association

The New York State Office of Mental Health (OMH) has embarked upon a far-ranging project to reform outpatient mental health clinic programs and the Medicaid reimbursement methodology which supports them. A particular target of this reform process is the elimination of the COPs add-on. COPs (short for "Comprehensive Outpatient Programs") was implemented in the early 1990s as an add-on to the Medicaid rate paid to clinics for providing outpatient care and treatment to patients covered by Medicaid. In order to receive COPs payments, clinics were required to see patients referred upon discharge from inpatient psychiatric services or emergency departments within five working days. Many of the issues discussed in this article may appear arcane or irrelevant to the care and treatment of patients with mental illness. However, the reform of the clinic reimbursement methodology ultimately comes down the simple issue of how much money will clinics receive for treatment of patients and, as is always the case, adequate funding is an essential prerequisite to continued access to appropriate care and treatment.

All OMH licensed outpatient clinics receive the same base rate for treatment of Medicaid patients, but only certain clinics receive the additional COPs add-on or additional payment. The COPs payment varies widely from clinic to clinic because the COPs payment was itself merely a device to translate local assistance monies provided to certain clinics by the state and localities (the various counties and NYC) to enhance their funding for uncompensated and undercompensated care. Essentially, the COPs add-on was calculated by dividing the local assistance dollars by the Medicaid units of service. The state devised this approach for one reason only – to access federal Medicaid dollars to reduce the cost of local assistance. By converting local assistance funding for which there was no federal Medicaid participation into a Medicaid rate add-on, the state was able to draw down federal Medicaid matching dollars – the federal government provided 50% of the COPs add-on rate.

During the final years of the most recent Bush administration, concerns arose that the Medicaid division of the US Department of Health and Human Services would take issue with the methodology used to determine the COPs add-on. Federal Medicaid rules require that reimbursement methodologies established by state Medicaid program to set payment rates reflect reasonable costs incurred and most important, pay the same amount for similar services provided by similar providers. There was fear that the COPs add-on would be rejected by the federal government and that the state would have to repay hundred of millions of dollars. However, we are uncertain whether this issue of federal regulatory compliance is

Seth P. Stein, Esq.

at the same level of concern for the Obama administration.

It is correct that the COPs payment methodology system has resulted in significant and unjustified differences in the Medicaid reimbursement for identical services often provided by clinics only miles apart. The problem is that eliminating COPs payments will undoubtedly result in significant reimbursement swings with some clinics receiving far more Medicaid reimbursement than they currently receive (or even need to cover their costs) and other clinics will face a dramatic drop in reimbursement that threatens their financial viability. Although the new methodology will be phased in over several years, many clinics may not survive the phase-in period and services to patients may be jeopardized. We are concerned about the financial viability and survival of individual clinics because of significant reductions in reimbursement. Contingency plans need to be developed now to prevent an adverse impact on patients' access to treatment.

Apart from the direct financial impact, NYSPA has also suggested taking into consideration factors such as the patient's prior history of hospitalization, recent discharge from an inpatient psychiatric facility or the acuity of the patient's mental illness. NYSPA recommended that OMH provide enhanced reimbursement to clinics to ensure proper aftercare following an inpatient psychiatric hospitalization. The primary cause of re-hospitalization is the failure of patients to maintain outpatient follow-up and continue to take their medication. Avoiding unnecessary re-hospitalization is both cost effective and good care. Thus, we recommended that the new reimbursement system provide enhanced reimbursement for outpatient treatment following hospital discharge. Another target of enhanced funding should be the care and treatment of patients with serious and persistent mental illness and children with serious emotional disturbance. OMH has estimated that at any one time there are approximately 50,000 patients with serious and persistent mental illness receiving services in this state. This cohort is not stable and persons move in and out of this core group all the time. However, it is this group that typically utilizes a disproportionate share of services dollars. Targeting funding with incentives to meet the needs of this population will also ensure that limited resources go to those with the greatest need.

OMH responded to suggestions that funding be targeted for special populations that it was unable to confirm from the financial data available to OMH that treatment of these patients is more costly or time consuming. However, the typical financial data available to OMH from clinics was never intended to assess this type of cost data. Second, and more important, the prioritization of limited monies for the highest risk and most potentially costly patients is entirely appropriate and reasonable. OMH has already agreed to recognize the higher costs incurred by clinics operated by counties in this state because these clinics typically have significant forensic responsibilities in the court system. Clinic reorganization at this time incorporates no element to replace the COPs requirements for expedited intake for patients referred upon discharge from inpatient services or emergency rooms. We believe that treatment of patients discharged from psychiatric hospitals and patients with serious and persistent mental illness (and children with serious emotional disturbances) should also be recognized as a priority for funding.

OMH has proposed several new services targeted for patients whose needs require enhanced services. The new services include off site outreach and engagement, crisis intervention, and complex care management. The inclusion of these new services is a positive step to adding new tools to address the needs of patients with significant clinical needs. However, there is a potential financial trade-off in adding these new services. Because OMH is working with a fixed pool of funds, dollars used to pay for these new services will inevitably reduce funding for essential services such as psychotherapy and medication management. Care needs to be taken to ensure that new services are not funded at the expense of core services.

NYSPA also recommended a change in the role of psychiatrists in clinics. Under current Medicaid rules, psychiatrists are compelled to divert a significant portion of their time from patient care to paperwork. Under current rules, every patient's treatment plan must be signed off on by a psychiatrist even when the psychiatrist

see NYSPA Perspective on page 38

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THE MENTAL HEALTH LAWYER

Our Economy's Effect on New York State's Mental Health Budget

By Carolyn R. Wolf, Douglas K. Stern, and Eric Broutman, Esqs.
Abrams, Fensterman, Fensterman, Eisman, Greenberg, Formato & Einiger, LLP

One can hardly turn on a television or listen to the radio without coming across some discussion of our present economic times. Terms like financial tsunami and economic disaster are cavalierly bandied about as ways of describing where our economy presently stands. With unemployment rates reaching levels not seen in the past 30 years our present circumstance has been compared to by experts and pundits alike, and arguably rightfully so, that horrific span of time in American history, the Great Depression. Naturally, with such a difficult economic climate State and Local Governments have felt the pinch with severely reduced tax revenue. In New York, where State law mandates that the Governor and Legislature produce a balanced budget, less money coming into the system means less money going out. Programs are cut, salaries are, at best, stagnated, and planned improvements are either put on hold or completely disregarded.

As those in the mental health community are all too aware, when government seeks to cut its overall expenditures cuts in mental health spending are likely among the first items on the chopping block. In the past two fiscal budgets, while funding for mental health services were certainly cut, advocates and Legislatures with an understanding of the need for appropriate services have preserved critical programs.

This article will discuss some components of New York State's Budget over the past two years as it relates to spending on mental health programs and what the anticipated effect of these cuts can be. In addition, this article will highlight some of the achievements that were previously mentioned.

New York State Budget Spending Over the Past Two Years

New York by far exceeds the rest of the country in terms of mental health spending on a per capita basis. However, that lead has slimmed significantly in the past 30 years. In 1981, New York expended $69 per person on mental health treatment, exceeding the national average by 155%. By 1997, while New York had increased its per person spending, the ratio dropped by half to 88% greater than the national average. Indeed, over the past 10 years mental health spending has remained idle in the State. It is with this background in mind that we look to the present cuts in spending over the past two fiscal years.

In the 2008 and 2009 budgets, reductions in spending on mental health services totaled approximately $240 million.

Carolyn R. Wolf, Esq

Many of these cuts were realized by deferring or outright cancelling previously approved projects that had not yet begun. Adopting this posture with respect to the construction, maintenance, and rehabilitation of state facilities, most notably psychiatric facilities, is where a large portion of these savings took place. As an example, 450 beds were eliminated from State run psychiatric facilities. Significant reductions were also exercised in the area of aid by the State to community based mental health programs.

Specifically in the 2009 Budget, nearly half of the savings achieved that year were at the expense of State workers who were forced to do without a cost of living adjustment to their salaries. The Medicaid reimbursement rates for psychiatric care to hospitals were also appreciably reduced. This reduction will most certainly have the effect of reducing the length of in-patient hospitalizations possibly against better clinical judgment.

Despite what appears to be an otherwise bleak outlook, these cuts must be considered in light of the fact that all State agencies were called upon to reduce spending, reduce salaries, and eliminate programs. With that in mind, mental health advocates, and likeminded members of the New York State Legislature achieved fairly significant successes in terms of limiting, and more specifically, targeting spending cuts to those programs deemed of least importance.

Mental health advocates, such as the New York State Mental Health Association, have fiercely argued that if cuts were necessary, the first place where reductions should take place is spending on Sex Offender Programs. One can argue the relative merit, or lack thereof, of the civil confinement and treatment of sex offenders on a separate basis. However, the fact that these programs, not to mention these individuals, are indiscriminately lumped together with those suffering from a mental illness has been a thorn in the side of the mental health community for some time. Nevertheless, because this is the political reality presented, mental health advocates worked hard to garner cuts in sex offender programs so as to alleviate the pressure on programs that deal strictly with people with mental illness. Those efforts were rewarded in the most recent Budget by forcing cuts in programs designated for the civil confinement of sexual offenders, thereby limiting the spending cuts necessary for other core mental health programs.

While cost of living adjustments to mental health worker's salaries were deferred in the 2009 Budget they were maintained the previous year, which was a rather significant success in 2008 for mental health advocates and consumers of services alike. Also in the 2008 budget, increases in spending were achieved for housing services, children's services, and co-occurring disorders. Successes, in the 2009 Budget were markedly more modest; resigned to ensuring that funding continued at similar levels for already enacted programs, such as supported housing. In light of the worsening economic picture this year as opposed to last, forestalling reductions in a program's funding must be considered an accomplishment.

The Effects of These Cuts On People with Mental Illness

The direct impact of these spending cuts will be sweeping. A reduction in the number of beds available at State run facilities, which are almost exclusively long-term care options, means one of two things; either patients will languish in acute care facilities where they are unable to receive the long-term care they require, or, because these patients are unable to obtain a bed at a long-term care facility, acute care hospitals will seek to discharge patients into the community before they are psychiatrically capable of handling that environment. This will lead to vulnerable individuals being taken advantage of, or worse, suffering physical harm.

Reductions in funding for Medicaid will no doubt affect inpatient care. A reduction in Medicaid dollars will cause a shortening of days available for inpatient care and the premature discharge of these patient. In turn, this leads to patients being placed in harms way because they are left to survive in an environment they are not yet clinically capable of dealing with. Another affect of premature discharge is the exacerbation of the already pervasive problem of the "revolving door" of psychiatric care. In essence, patients leaving

see Budget on page 39

Carolyn Reinach Wolf, Esq
and Douglas K. Stern, Esq of

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The Economics of Recovery: Demystifying Government Work Incentives

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

Joanne is diagnosed with Schizophrenia. She receives $761/Mo. in Social Security Disability Income (SSI), $200/Mo. in Food Stamps, she has her own one bedroom apartment thru Supported Housing (Section 8), Medicaid and a half-fare bus pass.

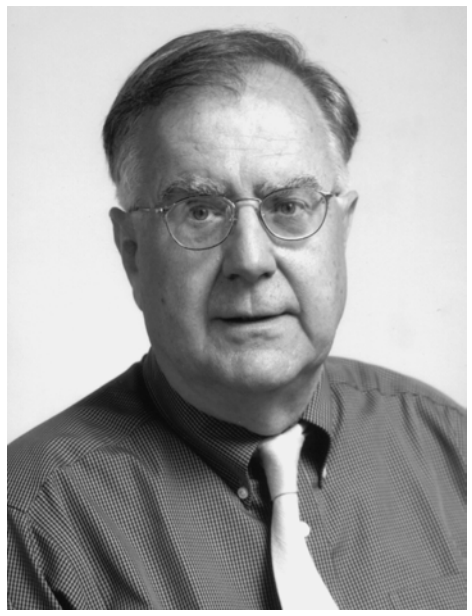
She applied for a part-time cashiers' position at A&P across town, she'll earn eight dollars an hour and work seven hours on Saturdays.

Joanne and her Caseworker are estimating her monthly budget. They're shocked to learn the work-related expenses come to $77/Mo. – that's about one-third of her estimated gross salary of $224/Mo. But, if Joanne brings her own sandwich and water from home, she estimates she could cut her expenses by $20/Mo.

However, the earnings penalties from three of Joanne's' Government Benefit Programs; disability income, housing & food are substantial; they total $233/Mo. Together with her $77/Mo. in work related expenses, they wipe away any financial reason for her to return to work.

Her Caseworker then remembers SSAs' **Red Book** that said if a person on SSI applied for various work incentives, like Ticket-To-Work and Pass Plan, they could return to self-sustaining work. They clicked on ssa.gov/work incentives.

Joanne consults SSAs' **Ticket-To-Work** Booklet, (05-10060), and learns that the only benefit for her to enroll would be to avoid triggering a disability review, (CDR) if she ever makes over the $700/Mo. Substantial Gainful Activity (SGA). The Ticket To Work will not solve her problem of how to keep more of her $224/Mo. gross salary.



Donald M. Fitch, MS

She then explores SSAs' **Pass Plan** (05-11017), and learns this is a savings plan. This won't help her either because there is no money left over for her to save.

Her Caseworker has heard **1619(b)** will let her earn over forty thousand dollars a year and enable her to keep her Medicaid. But, this won't help Joanne, her problem is much smaller. Same story with the **Medicaid Buy-In**; she can only dream of making more than $19,000/Yr.

After reviewing the various **Impairment Related Work Expenses** (IRWE's), only "transportation"; consisting of an unreimbursed medically prescribed car service might apply. But, it still wouldn't solve her problem of helping her keep more of her salary.

The $2,400 **Work Opportunity Tax Credit** would only help her employer, not her. And, she knows A&P wouldn't go for a **Subsidy**.

Out of the eight work incentives, only one; HUDs' **Earned Income Disallowance** would actually help Joanne. If she could save the $67/Mo. Section 8 rent deduction for the first year ($33/Mo. for the 2nd) – she could reduce her total Government deductions to $166. However, these deductions and, the $77/Mo. in work related expenses, a total of $243/Mo., would still result in a net monthly loss for Joanne of nineteen dollars.

Joanne and her Caseworker conclude these work incentives don't address her basic financial needs and decide not to pursue employment.

In spite of the hundreds of billions of dollars spent in the United States for the recovery and rehabilitation of persons with disabilities; health care, housing, education/VR, community supports, job supports and more, **we are unable to help more than one-half of one percent achieve self-sustaining employment (SSA, 2007 Annual Statistical Report; tables 43 and 53).**

When you examine the fine print of SSA's work incentives, you find they don't apply to ninety-nine percent of SSI Recipients.

This failure affects every one of the over twelve million persons with physical and mental disabilities in the U.S.; it is a waste of their lives and talents an enormous loss to the economy, an unnecessary burden to the taxpayer and drain on the Social Security Trust Fund.

America cannot afford to continue this colossal waste of life and resources. It is time for change. It is time to act. We don't need another study, SSA has already provided the data.

Whatever the solution is for achieving self-sufficiency, it will require leadership and bi-partisan coordination. History has demonstrated it won't be solved by SSA and the Academics.

We envision a series of public-private partnerships, with business persons leading the way. These pilot studies could include a variety of scenarios: (1) European-style integrated on-site employer-caregiver programs; (2) Incentivized work-study programs based on ability/performance & a waiver of Government earnings penalties; (3) Parity return-to-work regulations for SSI & SSDI populations; and (4) Outsource transition-to-work programs from SSA/VR to DOL & OMH, Manpower and Goodwill Industries.

In light of this evidence, we submitted testimony last June recommending that the Ways & Means Committee postpone reauthorization of WIPA & PABSS until a thorough review of the Economics of Recovery can be conducted for both SSI & DI recipients.

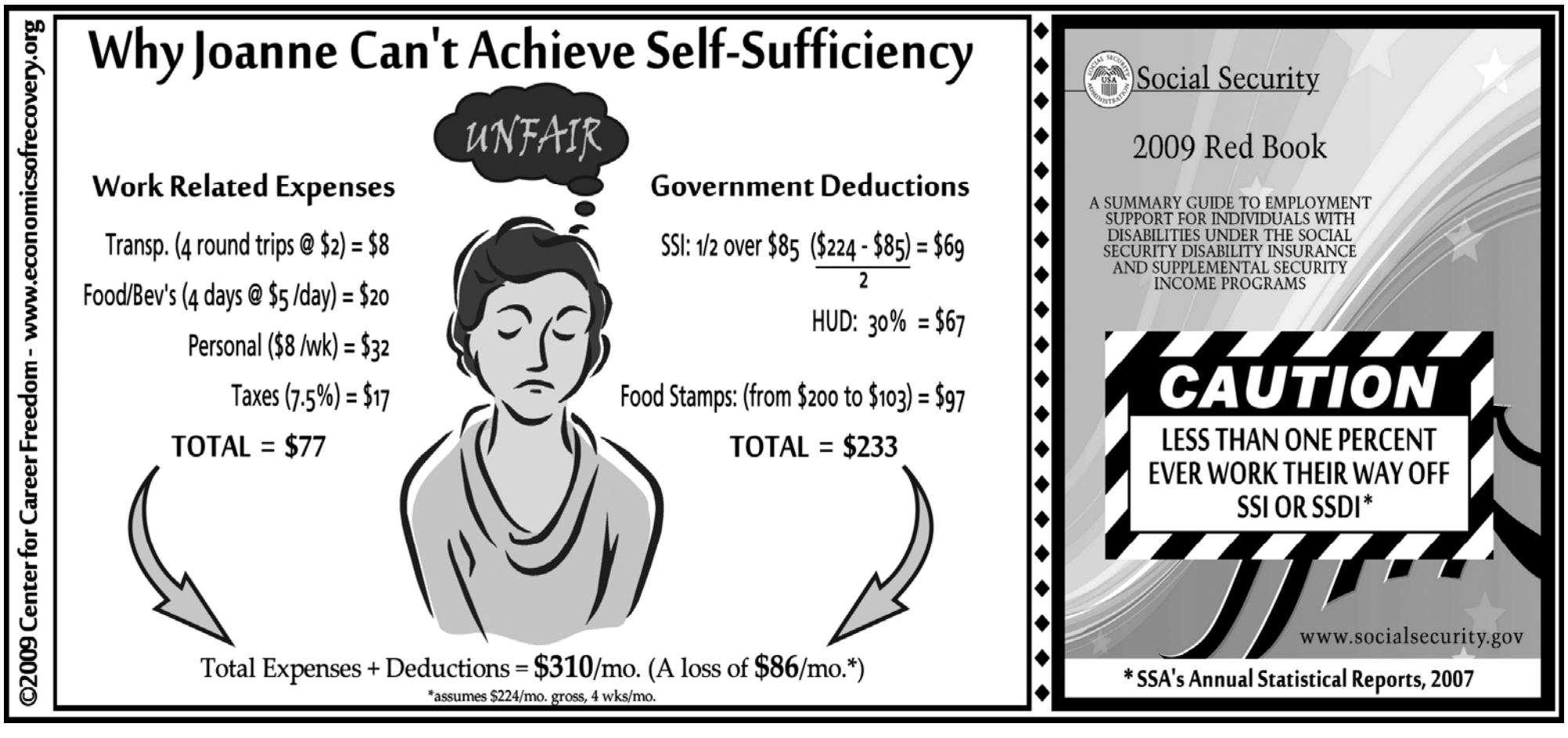
SSA's testimony to the House Ways & Means Subcommittee on the reauthorization of work incentives would have us believe their work incentives would be effective in returning recipients to self-sufficient work, if only more people knew about them. They talk of Demonstrations & Studies that will prove their effectiveness in years to come if the Committee will only be patient. SSA's requests to the Committee are the same in 1999 and 2009; "give us more time and money".

The promise of hope is that for each one percent we help get off Government Benefits, they will contribute over three **billion** dollars to SSA's Trust Fund (GAO).

These facts present a unique historical opportunity to correct this injustice by helping millions of persons with disabilities become self-sufficient.

Please help by making self-sufficiency a part of your 2009 agenda. To read the full report, go to: www.economicsofrecovery.org/employmentoutcomes.

Thank you.



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The Economy's Impact on Vocational Services

By Susan Briskin, MCAT, DTR
Psychosocial Rehabilitation Department
New York Presbyterian Hospital
Westchester Division

Traditionally, behavioral health patients have been referred for vocational counseling because their illness has formed a barrier to obtaining and maintaining employment. Patients may have presented with ambivalence about entering the work force, or fears that their treatment may interfere with the scheduling demands of a regular job. Along with the downturn in the economy, however, there has been a shift in patient's issues and needs. More often we are seeing patients who have a substantial work history and are eager to work again.

Identity issues are different. Instead of dealing with the maturation from dependence to independence, people who have lost their jobs have usually already developed a mature work identity, and are struggling with its loss, as well as other losses including income, structured time, socialization and purpose. In addition to the nuts and bolts of vocational counseling such as updating a resume and assisting with job search strategies, as therapists we also try to support patients in this mourning process. The reality of the current recession is also forcing patients to learn acceptance,

Susan Briskin, MCAT, DTR

perhaps by taking a lower paying, lower prestige and often less interesting job. Throughout this process, we encourage patients to re-evaluate their life style choices, spending habits and ways in which they allocate their free time.

Now more than ever, patients are encouraged to learn and incorporate stress management techniques into their daily lives. When people are searching for a job, experiencing financial pressure, depression and anxiety, they can easily feel like they don't deserve to engage in enjoyable leisure activities. We continually remind patients that there are plenty of low-cost ways to relax and spend quality time with people they care about, which in and of itself can be a powerful stress booster.

Volunteer work is also useful, often providing the same depth of experience as a paying job, but without the income. Volunteer work can also provide a current reference to a prospective employer, as well as a sign of initiative and motivation, and valuable ties to the community.

Also vitally important right now are practices of good follow-through in the job search strategy. As anyone looking for work knows, this is made more difficult by companies utilizing internet sites for advertising positions (e.g., monster.com, Linkin.com, etc.) No longer can applicants forge a phone relationship with a voice from Human Resources or the department of hiring, as sending resumes into the ether of the internet has become the norm. As always, however, using and expanding one's personal network is essential and in fact, 85% of people find their jobs through a personal contact. Letting friends, family, acquaintances and former colleagues know you are on a job search is a very important technique as well as a way to avoid social isolation. Simply continuing to ask the questions, "Do you know of any job openings?" or "Do you know anyone who might know of any openings?" can make a big difference in urging personal contacts to pass your name along to someone else who just may be hiring. While many of these may sound like very basic techniques, learning to market oneself is a real challenge for people struggling with depression and feelings of shame.

A period of unemployment can also present an opportunity to evaluate a career change and re-tool one's skills sets. Especially for older job candidates, this is often the time to update things like computer skills and presentation style. There are free or low-cost skill development classes in every area, and learning or improving on skills like these results in a feeling of mastery, as well as the ability to offer a prospective employer all that much more.

Until the economy turns around, the needs of the behavioral health patients we serve will undoubtedly be affected by the changing work climate. This recession is uncharted territory for all of us, and it is important to remember to try to learn as we go, get advice from people we trust, and as always, help each other. I am certain that the vocational therapists and the rest of the staff at New York-Presbyterian Hospital will continue to find strategies to meet this challenge and support our community, whatever the future brings.

A Peer Run Service Provider that is Making a Difference

By Steve Miccio, Executive Director
PEOPLe, Inc.

Projects to Empower and Organize the Psychiatrically Labeled, (PEOPLe, Inc.) is a Peer Run organization that was founded in 1990. What started as a Drop-In Center and advocacy organization has now become an organization that continues to advocate and provide peer services that attempt to make a difference in terms of improved quality of life outcomes for the people we serve. We currently provide an array of services in 5 counties in New York that include but are not limited to: Peer Advocacy, Supported Housing, Adult Home Advocacy, Representative Payee services, Warm Line Services, Emergency Room Advocacy Services, Drop-In/Social Connection Center, HUD Housing, Peer Support Groups, Nights Out Activities, In-Home Peer Companion Services, Peer Services in Clinics, Hospital Diversion Services, Peers on ACT Teams, Peer Advocacy Training, Consulting Services, Transformation Education/ Implementation, Wellness/Recovery Education, Research Partners, Suicide Intervention Training, Systems Advocacy, and Specialized Contractual Services

PEOPLe, Inc. has grown in size and grown in its mission to advocate for and with people in our community. As we have worked over the years we have had the opportunity to share our stories and

Steve Miccio

hear many personal stories concerning the different levels of care delivered in several counties and different parts of the state and country. When The Presidents New Freedom Commission Report on Mental Health, Achieving the Promise: Transforming Mental Health Care in America was published in 2003, it confirmed what so many people knew in that the mental health system is "broken". The report talks about how fragmented the mental health service system is and that many services do not necessarily support recovery.

Prior to that report PEOPLe, Inc. had embarked on a local mission to move beyond advocacy and begin to design and deliver peer services that "made sense" and focused on recovery of the people we served. One of the first new services we offered was employing Peer Advocates in a hospital emergency room. The concept focused on having the peers assist people in navigating the often traumatic process of being screened and/or admitted or discharged to/from the hospital. Having advocates directly in the ER serves to improve the level of compassionate care that people deserve and it expedites the process. This has been successful over the past eight years and we are now working with two hospitals, one rural and one urban, employing peers in emergency departments.

We then developed a hospital diversion house that serves Ulster and Orange Counties called The Rose House. It's a hospital diversion model whereby people in crisis or heading towards crisis can seek temporary residential care. People can stay from one to five nights in a warm, friendly, safe and supportive home-like environment where peers teach optional recovery and relapse prevention skills. The goal of the house is to help people not just avoid hospitalization, but learn ways to break the cycle of going from home to crisis to the hospital. People that have stayed at the house have sometimes had long histories of cycling though hospitals and often the house serves to break the learned helplessness if people are open to trying new things. In addition to the Peer Companions offering tools for recovery they are trained to listen to people intently and compassionately. The Rose House is staffed 24 hours a day and offers additional tools that can remind people that they are "people first." The additional tools consist of professional musical instruments, art equipment, exercise equipment, video games, books, movies, self-help tapes/CD's/Videos, computer access and other amenities as people request. These tools help one to become distracted from the traditional acute care approach that often focuses on "symptoms" and crisis rather than wellness, recovery and hope.

The Rose House also offers In-Home Peer Companion services to people that would like supports in one's own home. Appointments are made to arrange visits to people that request support in one's home rather than stay at The Rose House. The visits offer an empathetic ear, peer support and the same wellness tools that are offered in the Rose House. This service has also helped people avoid utilization of hospitals and more importantly how to focus on a more successful lifestyle.

A third service that grew out of the Rose House was a warm line service. People can call the Rose House and receive

see Providers on page 36

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Are Psychiatric Disorders Over-diagnosed in Children? Are Medicines Over-prescribed? 13 Myths & Facts

By Kevin T. Kalikow, MD
Author of "Your Child in the Balance: An Insider's Guide for Parents to the Psychiatric Medicine Dilemma"

Headlines scream that too many kids are taking Ritalin or Adderall or whatever the latest ADHD medicine du jour is. TV's talking heads complain that we're drugging our kids with Prozac, Zoloft and other "dangerous drugs." But your child's teacher recommends your child be "evaluated" — a code word that tells you to consider medicine. And mental health professionals tout medicine's benefits. What's a parent to do?

Parents are understandably confused and frustrated. Are these medicines over-prescribed? If I consent to medicine, will my child become a statistic? If I don't, am I withholding needed treatment?

Let's trash the myths and examine the facts.

Kevin T. Kalikow, MD

Myth #1 Children do not suffer with psychiatric disorders.

Fact: While we like to think of childhood as a simple time, a bastion of happiness, it is not for all children. Research has shown that about 20% of children and adolescents have a psychiatric disorder and about half of these have a disorder which disables them.

Myth #2 Psychiatrists invent psychiatric disorders at the drop of a hat.

Fact: Psychiatric disorders are based on years of research and much debate. Even with all the research, are these disorders evolving concepts? Absolutely. Research is painstaking and takes years, so our understanding of these disorders changes slowly. Some doctors are more liberal in applying the criteria for a particular disorder and others more conservative. This can frustrate parents who receive different opinions from different physicians. Bipolar Disorder is a perfect example. What Bipolar Disorder looks like in children has been debated for the past decade or so. Some doctors apply a broader set of criteria and others a narrower set. The final word has yet to be determined.

Myth #3 When I was a boy, nobody had these disorders.

Fact: When I was a boy, children had these disorders, they simply were not recognized or the kids were labeled "bad seeds" and the like. Truth is, if I look back to elementary school, even decades later, I can pick out at least some of the kids who would have been given a diagnosis today.

Myth # 4 Psychiatric disorders are not real illnesses with real bad consequences.

Fact: Psychiatric illnesses carry what doctors call significant morbidity and mortality. That is they can be debilitating and deadly. For example, 5-10% of depressed adolescents will commit suicide over the next 15 years. If your child's doctor told you that there was a 5-10% chance that your child's illness could be fatal before they were 30, you would not hesitate to pursue treatment aggressively. Other disorders, like Anxiety disorders, while less lethal, also adversely affect a child's functioning. Some of my patients are unable to attend school, go to a friend's house or even leave home because of anxiety. And, ADHD is associated with higher rates of Emergency Room visits, medical costs, traffic accidents among teens, cigarette smoking, early pregnancy, divorce, job changes, and dropping out of high school. While some of these risks are probably higher among youth with ADHD combined with certain other disorders, I'd say ADHD could be a fairly nasty disorder.

Myth #5 Anyone can have a little bit of ADHD or OCD.

Fact: We all have characteristics that make us who we are. Some of us are a bit more fidgety and others more slow moving. Some are fastidious and others are a mess. But, for those with a disorder, the characteristic has become a symptom, something that significantly interferes with the person's life.

Myth #6 Psychiatric disorders are caused by bad parenting.

Fact: Parenting has an important and unique impact on child development, but children also come into the world with biological propensities and risks. For example, researchers at NYU showed that about 15% of children were characterized as being Slow to Warm. That is, when a stranger was present, they clung to their mothers, eyes open wide and saying nothing. Researchers at Harvard showed that similar children had faster heart rates and more dilated pupils during a problem solving task and that about 1/3 of them would go on to have Social Anxiety Disorder as teens. More recent research is demonstrating that a part of the brain called the amygdala is also different in children with anxiety disorders.

Myth #7 More kids are using psychiatric medicine than ever before.

Fact: Just want to keep you awake. That last one is actually a fact. Over the past 20 years, the number of prescriptions given to children and adolescents has increased considerably, perhaps 2, 3, or 4 times the rate in the 1980's. But, the number of children using cell phones and laptops has also increased dramatically. Like these other innovations, other than Ritalin, most of the medicines used in child psychiatry were not around until the very late 1980's or even later.

Myth #8 Most kids today take a psychiatric medicine.

Fact: The overwhelming majority of children do not take any of these medicines. National studies demonstrate that about 5% of children are given a prescription for a stimulant, such as Ritalin or Adderall. About 2% of children are treated with antidepressants. And about 1% or fewer are treated with other psychiatric medicines.

Myth #9 Children become addicted to psychiatric medicines

Fact: While some of the medicines used in psychiatry, such as stimulants, like Ritalin, or the anti-anxiety medicines, like Xanax, are addictive when used inappropriately, such as used at too high a dose, the responsible, physician-managed use of these medicines does not lead to addiction in children. In fact, research suggests that taking stimulants lowers the risk of drug and alcohol abuse among young people with ADHD.

Myth #10 Never take a medicine that isn't FDA approved for the condition you're treating.

Fact: The FDA approves of medicines for a specific age group and a specific condition. If the patient is not in that age group or does not have the specified condition, the use of the medicine is called "off-label." Medicines are used off-label everyday by all physicians. This is legal and ethical. In fact, about 70% of all medicines (including non-psychiatric medicines) prescribed to children are off-label. A medicine can be very effective, but still off-label. For example, the use of the SSRI's, such as Prozac, for anxiety disorders in children is off-label. There are many reasons a medicine might not have FDA indication for a specific disorder for a specific age group. But, over recent years, the government is trying to encourage pharmaceutical companies to research the use of medicines in children and apply

See Myths and Facts on page 24

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

FOUR WINDS HOSPITAL • FALL 2009

OCTOBER 2009

A COMMUNITY SERVICE

Thursday, October 8, 2009 • 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.

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

GRAND ROUNDS

Friday, October 16, 2009
9:30 – 11:00 am

Dialectical Behavior Therapy: Working with Teens and Adults to Build Satisfying Interpersonal Relationships

Patricia Trainor, Ph.D.

Licensed Psychologist, Private Practice, Mt. Kisco, New York

Dialectical Behavior Therapy (DBT) offers strategies to those who wish to decrease chaos in their relationships. Building on a foundation of mindfulness, straightforward skills are utilized to assist in observing personal limits, building self-respect, and managing relationships effectively. In this experiential workshop, participants will learn and practice effective DBT strategies for building satisfying interpersonal relationships in everyday life.

This presentation will facilitate participants' ability to:

- Identify specific obstacles to developing satisfying relationships
- Demonstrate seven skills that promote observing limits in relationships
- List four strategies that can strengthen relationships

Fee: $15.00 payable to Four Winds Hospital

1.5 CME Credits available
*Application pending for 1.5 OASAS CASAC/CPP/CPS clock hours

*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.

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 2009

OPEN HOUSE

Tuesday, October 27, 2009 • 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

NOVEMBER 2009

A FOUR WINDS FOUNDATION PRESENTATION

Friday, November 13, 2009 • 9:30 – 11:00 am

More Than Moody: Understanding and Treating Adolescent Depression

Harold S. Koplewicz, M.D.

Director, NYU Child Study Center; Arnold and Debbie Simon Professor and Chair, Department of Child and Adolescent Psychiatry, NYU Langone Medical Center; Professor of Pediatrics, NYU School of Medicine; Director, Department of Child and Adolescent Psychiatry, Bellevue Hospital Center; Director, Nathan Kline Institute for Psychiatric Research

Adolescent depression is a very prevalent disorder. It has been misunderstood for decades by mental health professionals. In the past twenty years many psychopharmacological studies have been performed with mixed results. Recent neuroimaging studies have advanced our understanding of the changes that occur in the brains of normal adolescents with depression. The results indicate that adolescent depression is different than adult depression and treatment effects are also different for this age group.

This program will enable participants to:

- Recognize the difference between adolescent depression and adult depression
- Examine co-morbid conditions
- Determine most effective treatment for adolescent depression

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

Community and Professional Education Programs

NOVEMBER 2009

SPECIAL TRAINING

Thursday, Nov. 19, 2009 • 9:30 am – 12:00 pm

Child Abuse Identification & Reporting

Valerie Saltz, LCSW, 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 2009

SPECIAL EVENT

Friday, December 18, 2009
9:30 – 11:30 am

Chopin at 200: His Mind and His Music

Richard Kogan, M.D.

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

The great Polish composer Frederic Chopin spent his entire adult life in exile from his beloved homeland and he was plagued by chronic respiratory illness that killed him at age 39. Psychiatrist and concert pianist Dr. Richard Kogan will explore the quality of resilience, which allowed Chopin to convert adversity into masterpieces of creativity.

This program will enable participants to:

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

Fee: $20·00 payable to Four Winds Hospital

1.5 CME Credits available
*Application pending for 1.5 OASAS CASAC/CPP/CPS clock hours

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.

Four Winds HOSPITAL

OUTPATIENT TREATMENT SERVICES

Child Partial Hospitalization Program

5 days a week
9:00 am - 3:00 pm
Ages 5 - 12

An intensive, structured outpatient treatment alternative to inpatient care. Services include 24 hour crisis intervention, full day scheduling, and an on-site school.

Adolescent Partial Hospitalization Program

5 days a week
9:00 am - 3:00 pm
Ages 13 - 17

An intensive, structured outpatient treatment alternative to inpatient care. Services include 24 hour crisis intervention, full day scheduling, and an on-site school.

Adult Partial Hospitalization Program

5 days a week
9:00 am - 3:00 pm

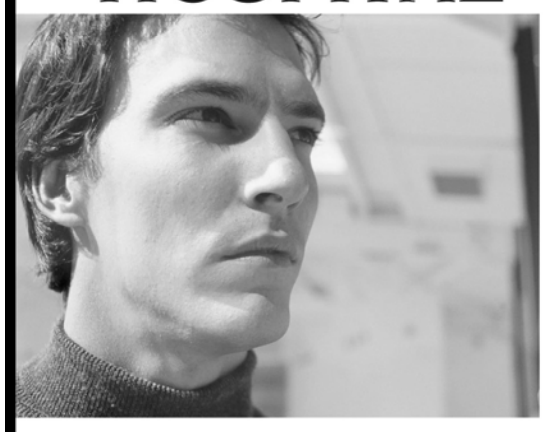
An intensive, structured outpatient treatment alternative to inpatient care for those individuals 18 years of age and older. Services include 24 hour crisis intervention, flexible full or half-day scheduling, specialized treatment tracks and individual case management.

For Information or to Make a Referral Call 1-800-528-6624

Four Winds HOSPITAL

INPATIENT SERVICES

Adult Treatment



Comprehensive, short-term inpatient evaluation and treatment for a broad spectrum of psychiatric illness

- **Co-occurring Disorder** inpatient treatment focusing on psychiatric illness co-occurring with substance abuse or dependency
- **DBT-Informed Treatment** including Relapse Prevention and Skills Training in Mindfulness, Distress Tolerance, Emotion Regulation and Interpersonal Effectiveness

Child & Adolescent Treatment

Children and adolescents are treated in distinct, age-appropriate programs with the treatment milieu focused on each age group's developmental issues.

Programs include:

- **5-9 Years Old:** provides a nurturing, therapeutic, home-like environment integrating the principles of Applied Behavioral Analysis, which promotes positive reinforcement for improved socially appropriate behaviors
- **10-13 Years Old:** focuses on developing social skills, mastering impulse control and promoting healthy communication through the use of the principles of Applied Behavioral Analysis
- **14-17 Years Old:** DBT-Informed Treatment including Relapse Prevention and Skills Training in Mindfulness, Distress Tolerance, Emotion Regulation and Interpersonal Effectiveness

Each unit, led by a multidisciplinary clinical team, mirrors a school setting that promotes shared competencies and encourages bonding. Family/caregivers are a primary focus within all age groups and we encourage their active participation. Four Winds' on-grounds school works closely with the home school district to assist the child/adolescent in a smooth transition back to the classroom.

24 Hours a Day • 7 Days a Week
www.fourwindshospital.com

Four Winds Hospital...
Just a Phone Call Away!

For Information or to Make a Referral Call 1-800-528-6624

See Myths and Facts from page 21

for FDA approval for children.

Myth #11 Never take a medicine that has the FDA's Black Box warning!

Fact: A Black Box warning is the FDA's strongest way of pointing out that a medicine has a certain risk. The FDA still approves of the use of the medicine for treating a specific age group with a particular disorder. Some of the side effects that are given black box warnings are rare. The specifics must be discussed with one's physician.

Myth #12 If medicine helps, it's the only treatment my child needs.

Fact: Research has shown that while medicine is effective for the treatment of ADHD and Depression, treatment with medicine combined with a behavioral treatment, such as Cognitive Behavioral Therapy (CBT), is more effective. For disorders such as Obsessive Compulsive Disorder, CBT has been shown to be at least equally effective as medicine and perhaps more effective in the long run. For OCD, a combination of these treatments seems best of all. Many parents also benefit from counseling that teaches them how to deal with their child's difficulties, regardless of whether their child takes medicine.

Myth #13 Too many children are taking medicines, like Ritalin and Prozac.

Fact: Some children are given psychiatric medicine too quickly when another treatment might be indicated. For example, cognitive behavioral therapy should always be considered for children with anxiety disorders or Obsessive Compulsive Disorder. However, other children would benefit greatly from medicine and never receive it. For example, about half of children with ADHD are not treated with stimulants which could be very effective.

In short, medicines are probably over prescribed to some and under prescribed to others. However, parents should be neither fearful, nor cavalier, about psychiatric medicine. Rather, with their physician, they must weigh the risks and benefits of medicine against those of other treatments and against those of not treating at all. Then, with their child in the balance, they will decide on the best course.

1 in 5 of your friends will have an emotional problem that may be too big for you to handle alone.

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Talk to a teacher
Talk to a school counselor

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MENTAL HEALTH ASSOCIATION

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Visiting Nurse Services in Westchester: Providing Mental Health Care in Tough Times

Staff Writer
Mental Health News

It is becoming increasingly understood and appreciated just how much healing and comfort extend beyond the physical. There is a decided mental well-being component as well, recognized by Visiting Nurse Services in Westchester (VNSW), the White Plains-based home health care agency that several years ago created a program of psychiatric healthcare – in the patient's home, for maximized comfort and effect. Under this unique program, VNSW's registered nurses, with advanced psychiatric training, conduct home visits to develop a plan to treat mental health issues in conjunction with medical/surgical needs, and to support community integration for its patients. Adjunct services complementing the mental health component include home health aides, medical/surgical nurses, social workers and relevant rehabilitation therapies. This program has proven to be an important component in the care and mainstreaming of psychiatric patients.

It is imperative that individuals with a psychiatric diagnosis being discharged – following either a psychiatric or medical hospitalization – get comprehensive follow-up care in the community. The role of discharge planners in the hospital is crucial. They are the link between the patient and the community and it is very important that they access all available community resources to ensure a smooth transition back home. When the client does not have a proper discharge plan, the patient's transition back into the community becomes much more difficult.

Due to the current state of the economy several referral sources for Visiting Nurse Services in Westchester have had cuts in staffing at all levels. This has impacted these agencies ability to perform timely and comprehensive discharge plans. Unfortunately, many agencies are having to do more with less. Visiting Nurse Services in Westchester's Mental Health Program has tried to help our referral sources address this need by providing a psychiatric intake nurse who will visit sites in the community and assist staff at these agencies with the discharge process to our agency. The response to our efforts has been very positive. This nurse decreases the burden of referral source staff by completing the intake process for them. We assist with case coordination and ensuring that the patient has a safe and appropriate discharge plan in place prior to returning home. VNSW also obtains all managed care authorizations for homecare services for patients being discharged to our agency. This helps our referral sources focus their energies on other pertinent matters.

Visiting Nurse Services in Westchester is typically one piece of a very comprehensive treatment plan. Patients typically have several follow-up medical and psychiatric appointments post discharge. They often have to utilize transportation provided by the department of social services or other community agency. The first week or so after discharge can be quite overwhelming for our patients. Our psychiatric intake nurse helps try to increase the patient's familiarity with their discharge plan and will assist the patient through navigating appointments and utilizing community resources those first few days following discharge. This nurse often will be the nurse admitting the patient to homecare and will often meet the patient at imperative appointments to ensure compliance. They will also provide this service for patients who are being referred to us from an outpatient program and who have compliance difficulties with medical and /or psychiatric appointments. The intake nurse will also meet frequently with the patient while in the hospital so that the patient becomes familiar with this nurse, who establishes a trusting relationship with the patient. in an effort to allow a smooth transition to the community and increase compliance with the discharge plan.

Many agencies that are part of the patient's follow-up care plan in the community have also experienced decreased staffing and funding. This has led to a decrease in the services provided. We see transportation companies putting more patients on a van route which increases the patients travel time between appointments. This can lead to increased anxiety for patients who get concerned with being prompt to appointments or who need to take a medication upon returning home. Patients are reporting a need to purchase food on their own when they previously received meals at no cost outside of the home at different programs. This increase in food expense impacts their ability to have funds available for other expenses such as medication, co-payments or Medicaid spenddown payments, and funds for transportation. Patients are also reporting an inability to pay the rent and are concerned about the cost of medications and often want to stop taking a medication due to cost.

A goal of all treatment is for individuals to be active members of the community. In order for this to be accomplished it is important to identify a person's strengths, capacities, preferences and needs, as well as, their knowledge of their local community, its opportunities, resources and potential barriers. VNSW's mental health team helps its patients capitalize on their strengths and negotiate the barriers they are experiencing while trying to access care and resources in the community. Two main components to building a life in the community are housing and employment. The current state of the economy is a strain on the ability of many of the patients who participate in VNSW's Mental Health Program to remain active members of the community. Many of those who are employed are afraid of or are at risk of losing their jobs. This causes increased anxiety for many patients. Patients with limited funds but increasing living expenses are at risk for losing their housing if they can no longer afford their rent.

Patient independence and the ability for the patient to recover at home are among the primary objectives at Visiting Nurse Services in Westchester. VNSW's services allow individuals with all levels of mental illness the ability to remain in their homes and involved in the community mental health programs that are an integral part of their treatment. The agency's ability to monitor psychiatric symptoms and medication compliance – in addition to teaching the skills needed by each individual to help manage their specific psychiatric needs- empowers patients to obtain their optimal level of independent functioning/living. VNSW nurses have the ability to help the patient advocate for their needs as they see the person in their environment and are well aware of their needs and ability to remain safely in their homes. If the patient is having difficulty managing in their home for any reason we have the ability to assist the patient in improving the situation before it escalates. For example, if we notice a lack of food or medications that aren't being purchased or taken as ordered by a physician, we can explore these issues and help address the problem. VNSW's mental health team is the link between the patient and his/her providers in the community.

Visiting Nurse Service in Westchester is a not-for-profit agency. VNSW provides care irrespective of an individual's ability to pay for services. For those individuals with insurance complications, the agency works closely with insurance companies and patients to help them understand and access their plan benefits. The agency provides free and subsidized care to the uninsured and is dedicated to helping individuals attain and maintain optimal health and functioning in their communities.

In addition to nursing care, VNSW provides a full range of rehabilitative therapies, social work and home health aide services; psychiatric patients receive comprehensive care from a coordinated team of health care professionals versed in, and sensitive to, their complete history and needs, providing a complete package of essential multidisciplinary services. With its dedicated Mental Health Home Care Program, Visiting Nurse Services in Westchester is achieving 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.

Mental Health News Winter 2010 Issue: Call for Articles and Advertising
"Understanding and Treating Schizophrenia" Deadline: November 1, 2009
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Mental Health Treatment in Westchester

The VNSW Mental Health Home Care Program provides:

- **Adjunct service to community mental health programs**
- Structure in the home environment.
- Assistance with home management focusing on inadequate levels of functioning, hygiene issues and compliance with medication regimen.
- Administration of I.M. long-acting psychotropics.
- Liaison with the community treatment team informing them of changes and important symptoms that may indicate decompensation or need for changes in the treatment plan.
- 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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www.vns.org

VNSW services are covered by Medicare, Medicaid and other health insurance plans.

Mental Health Services Restructuring Begins with Article 31 Rate Reform

By John C. Rossland, PhD
President, The Federation of Mental Health Centers

Article 31 Clinic Rate Reform

The Federation of Mental Health Centers first filed lawsuits on the issue of clinic rate parity in 1998 and since then the FMHC has been vigorously advocating for Medicaid rate reform to change the vast reimbursement disparity between Comprehensive Outpatient Programs (COPs) and non -COPs clinics. Finally in 2008 a combination of forces that included the 2007 benchmark Public Consulting Group (PCG) study on Article 31 clinic fees and productivity, the Medicaid reform orientation of the current administration, pressure from the Federal Government, and the fair-mindedness of Officials from the New York State Office of Mental Health (OMH), Department of Budget, and Department of Health all came together to result in a statewide effort to begin the process of dissolving the COPs/Non-COPs system and the creation of, in its place, an equitable, economical and uniform Article 31 Medicaid rate structure.

Led by the Office of Mental Health, numerous meetings and conference calls involving leadership and stakeholders statewide have taken place and have resulted in a rate reform concept paper. The

John C. Rossland, PhD

recommendations of this paper are expected to begin to be phased-in beginning January, 2010.

Initial Phase of Reform Now a Reality

Most Article 31 Non-COPs (Level II COPs) and low COPs (Level I COPs) agencies should be receiving by now an enhanced Medicate Rate. This is New York State's first step towards rate equity and it brings the minimum downstate clinic Medicaid rate to $100 per full visit and the upstate and western state rates to a minimum of $90 per visit.

Article 31 clinic restructuring demonstrates New York's understanding of the necessity of Medicaid rate parity and clinic reform across mental health services. These changes allow for much needed fiscal support and financial bolstering to the lowest paid clinics, which, despite lower reimbursement rates, have continued to provide and expand the delivery of highly efficient, quality services to their communities. This is especially important since it is now recognized that clinic treatment is most often the foundation and entry point for consumers utilizing New York's vast Public Mental Health system.

This investment is expected to realize returns many times over as agencies which are receiving this new support continue to utilize the most effective models of service and hire staff and pay benefits in order to enhance patient care. These agencies have historically been able to provide services at one half to one third the cost of contracted clinics.

OMH Standards of Care and Clinic Restructuring

In the fall of 2008, OMH held a series of day long clinic restructuring meetings about many important issues including the fact that clinics are going to have to document that they are carefully identifying, evaluating, monitoring and treating risk factors such as danger to self and others and substance abuse. This emphasis constitutes a focus on standards of practice instead of regulatory change and will be reflected in Recertification Audits starting in July of 2009. Other issues include licensure and the expansion of services to substance abusers and the provision of multiple services on the same day in order to better serve more complicated and seriously ill clients. Clinic administrators need to be aware that these changes will involve substantial changes to audit procedures including what is known as "tracer methodology." With some technical issues notwithstanding, the Federation generally supports this revised approach and also supports OMH's Care Monitoring Project as long as consumer rights are protected.

Other Reforms

Other progressive reforms are also taking place which include the much needed expansion of the Interim List of clinics for SED children, the creation of an Uncompensated Care Pool in order to provide the uninsured with services, and

see Rate Reform on page 37

It's hard enough to find the right doctor – mental illness and developmental disabilities can make it even tougher.

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ICL HealthCare Choices, an award-winning Article 28 diagnostic and treatment center, is an affiliate of the Institute for Community Living, Inc., a trusted provider of mental health and developmental disabilities services.

Comparative Effectiveness Research: An Introduction

By Barry B. Perlman, MD, Director
Department of Psychiatry
Saint Joseph's Medical Center

On February 17, 2009, within a month of his inauguration, President Barack Obama signed into law the American Recovery and Reinvestment Act (ARRA) of 2009, the $787 billion economic package meant to stabilize and stimulate the nation's economy. Contained within the Act was $1.1 billion dollars designated for Comparative Effectiveness Research (CER). CER looks to improve healthcare by development of evidence based practice guidelines based on systematic reviews and synthesis of existing basic and clinical research, through data mining of registries and cohort studies to understand the natural progression of diseases and factors which influence their clinical outcomes, among other approaches. This large infusion of funds into an already evolving area of research placed CER at center stage of the push towards national healthcare reform and thus evoked a great deal of controversy. Important stakeholders immediately started weighing in on the issue, either supporting it as a path to more rationale and cost-effective therapeutics or condemning it as antithetic to individualized, person centered care. Each group's arguments often seem marked by

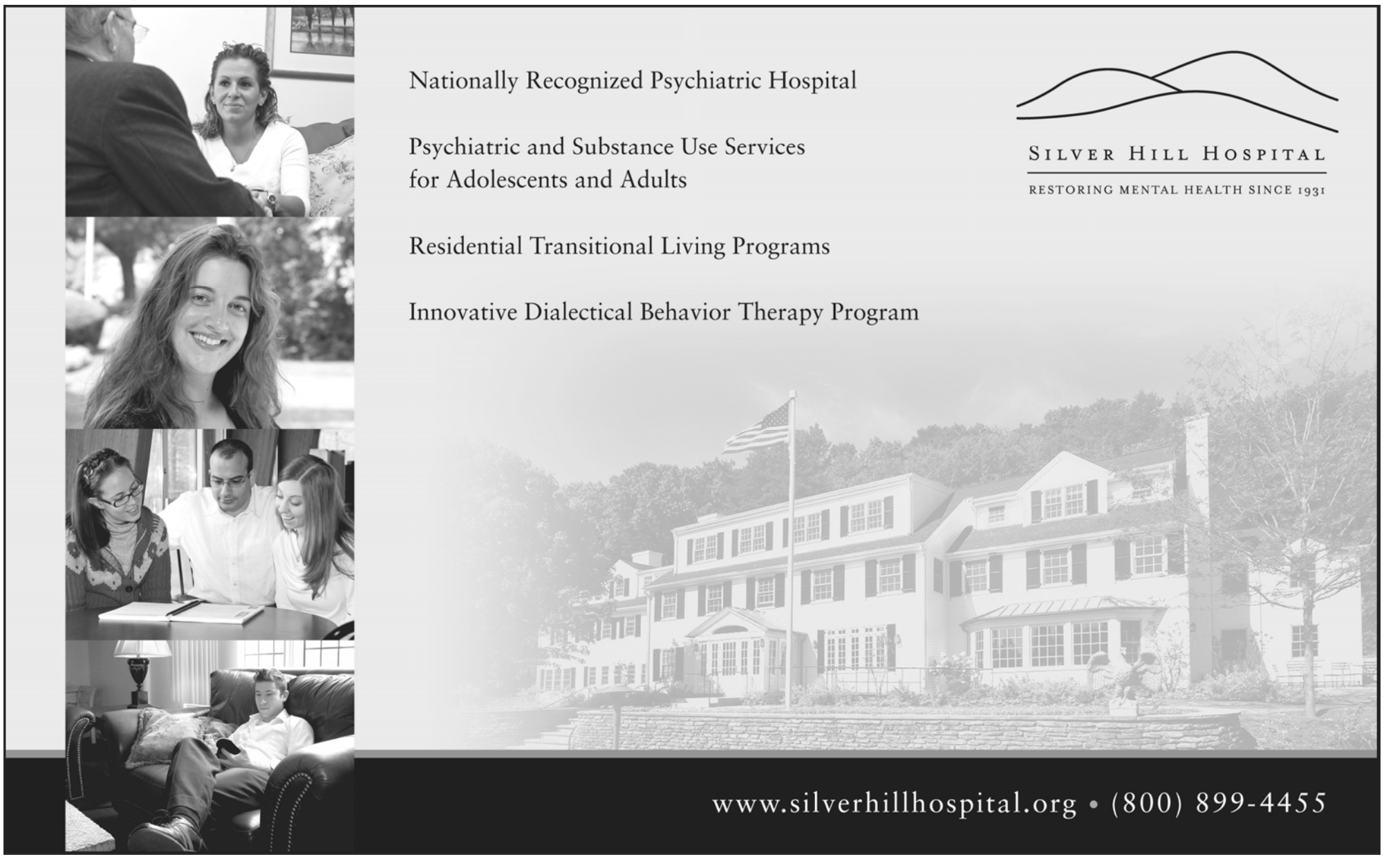
Barry B. Perlman, MD

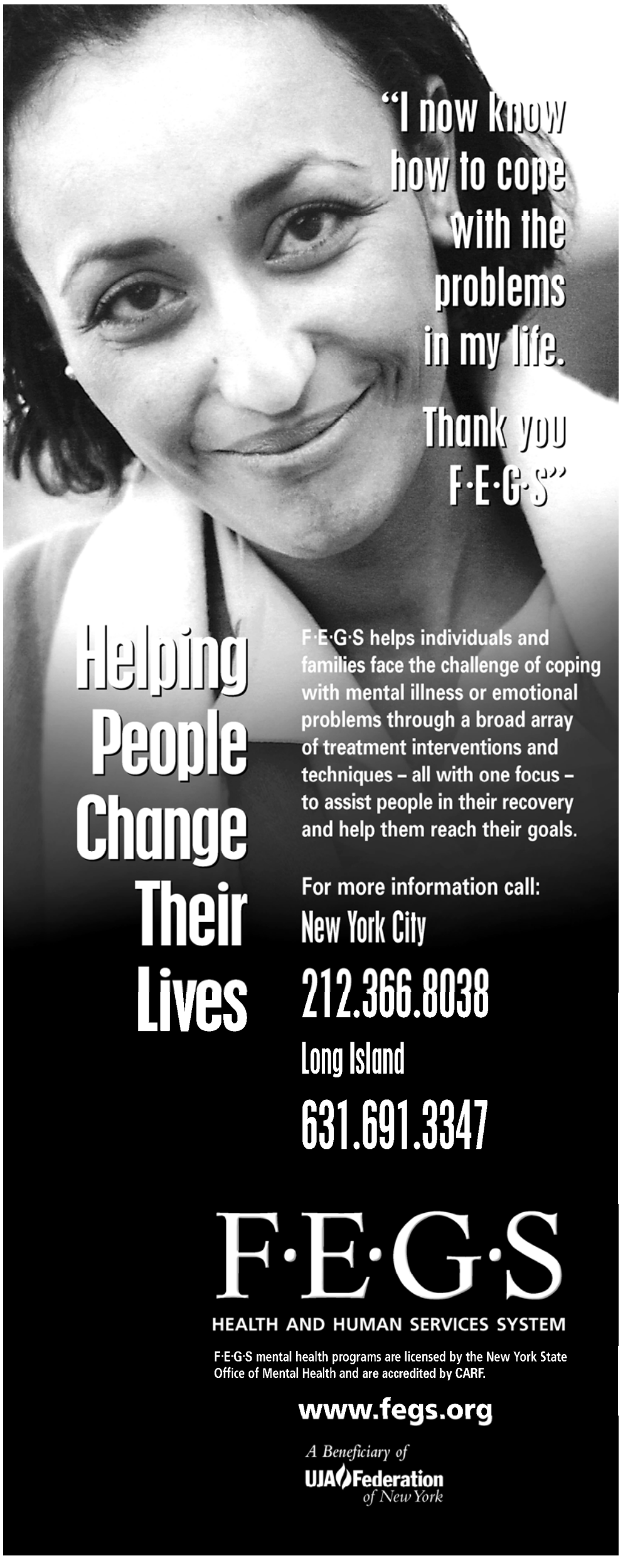
hyperbole. How the CER is structured, what questions are asked, and how its findings are engrafted into clinical decision making will be of the utmost importance to physicians, including psychiatrists, other providers, as well as to patients/ consumers and their families.

No one should fear well done research. Rather, it should be embraced as invaluable in informing clinical care. However, concern should arise when research findings are used to dictate clinical decisions rather than to inform them. This is so because medical science is complicated, difficult to control and dynamic. This observation is especially true for clinical science due to the multiplicity factors impacting on each individuals healthcare outcomes, such as their genetic makeup, environment, co-morbidities, etc.. In addition, the complexity of research methodologies make it notoriously easy to misinterpret data and misapply them to practice and policy. Individuals will need to be better informed in order to advocate about their own care while stakeholders use information to advocate with government and other powerful organizations, such as health insurers, that increasingly decide which therapies will be accessible and covered. In an age marked by calls for adherence to "best practices" and "evidence based medicine" it is important to be aware of the shallow and narrow nature of many of those clinical guidelines. Skepticism and humility about clinical research is warranted. We would do well to remember an interchange about Miles, the protagonist in Woody Allen's 1973 movie "Sleeper". A doctor observing Miles' behavior notes his request for "wheat germ, organic honey and Tiger's milk". Another informs that, "Those are the charmed substances that some years ago were thought to contain life-preserving properties." The first continues, "You mean there was no deep fat? No steak or cream pies …?" The response was, "Those were thought to be unhealthy … precisely the opposite of what we now know to be true."

That humorous yet cynical interchange draws attention to the often tenuous basis of what we think we know. While there are undoubtedly domains in which CER is likely to yield clear guidance, perhaps with medical devices, comparative therapeutics, etc., its ability to provide clear pathways is not always evident. Many recent clinical examples support the need for skepticism but not cynicism. Recent examples of radical reversals of policy within relatively short time frames have emerged from clinical research in the fields of cardiology, hypertension, endocrinology, and psychiatry among others. They have involved positions of federal agencies, the organization which certifies hospitals, and a medical specialty society. For example, as evidence mounted that antidepressants, when prescribed for children and adolescents, might evoke suicidal thoughts, the FDA in 2004 required that a "black box" warning be added to the medication package inserts. It now seems that the FDA's warning resulted in a decline in the prescribing of antidepressants

see Research on page 37





What to Say When Your Friend is Fired

By Irene S. Levine, PhD

Given the current economic climate, most of us know someone who has lost a job since the start of the recession. Last January, the Washington Post reported that 2.1 million workers were fired last year in massive layoffs (affecting 50 or more workers), the second-highest figure since U.S. Department of Labor began collecting this data. Small businesses haven't been exempt either, many folding or downsizing. According to the Bureau of Labor Statistics, the number of long-term unemployed (those jobless for 27 weeks or more) increased by 433,000 to 4.4 million between last May and June.

While the large majority of these losses aren't "personal" (e.g. based on an individual's non-performance), when someone you care about is downsized, let go, or forced to retire, it is no longer a matter of numbers. It is upfront and personal. Aside from a downward economic spiral, unemployment is associated with increased stress, sleep loss, and depression. While friends may be less able to "fix" someone's employment situation, per se, there are things they can do to help a friend deal with the emotional trauma of being fired. Yet many people, even close friends, feel uncomfortable; they aren't sure what to say or do, so they withdraw and do nothing. Yet, these are times when the support of friends can be instrumental in enabling someone to better cope with a difficult situation. Here are a few suggestions for helping a friend who has been fired:

1) Be there: Listen to what happened. Let your friend tell her story. Don't pry unnecessarily. Follow her lead in determining how much she wants to tell you. Don't recite all the grim unemployment statistics she's already been bombarded with by the media. Tell her that you're sorry and will do what you can to help.

2) Follow his lead: Losing a job is a little like losing a loved one. People go through stages from anger to acceptance. Don't try to talk your friend out of his feelings. Don't tell him know how he feels because you really can't put yourself in his shoes.

3) Reach out: If she hasn't told you about her job loss directly -- perhaps you saw it on her profile on Facebook or LinkedIn, or you learned about it from a mutual friend -- give her a call or send her an email acknowledging the loss. True friends don't pretend not to know about bad things. Recognize that it may be hard for her to repeat the same story to everyone she knows.

4) Offer concrete help: Do you have networking ideas to share? Job leads? Can you help your friend brainstorm or reinvent his career? Offer to edit or proofread his resume. Research whether there's a job support group or pink slip party locally that your friend could attend.

5) Don't be cloyingly annoying: Stay in touch. Email or call regularly but don't come on too strong or too often. There's nothing more annoying than being constantly asked if you've found a job yet. Wait for your friend to tell you the good news.

6) Distract him: Remind your friend that there are other aspects of life beyond work. Offer to join him for a walk or invite him over for dinner. Remember that your friend is on a tight budget so don't propose anything extravagant.

7) Offer her a bridge loan: Many people say that friends and money don't mix, but if you can afford it and she really needs it -- and she's a close friend -- offer a modest loan to help tide her over this rough period. Just make sure that it isn't money that you can't do without yourself.

8) Don't wallow in guilt: If you worked with the person, you may experience a profound sense of guilt that he was axed and you were left behind -- survivor's guilt. Recognize that you aren't responsible for his termination. While you can be helpful and supportive, you need to draw limits.

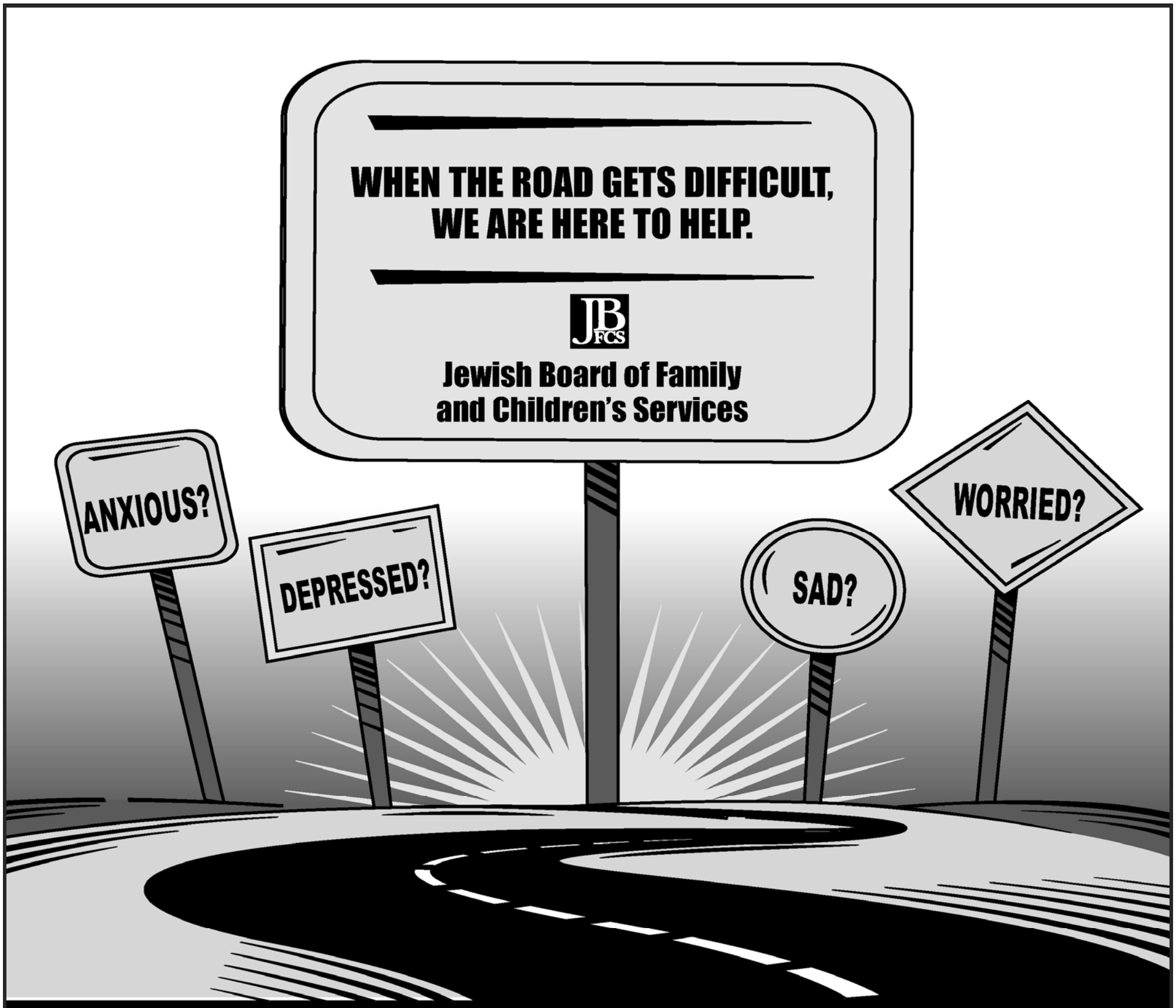
9) Watch for signs of (emotional) depression: With a sinking economy, it's tough to find a new job. Like beautiful houses that remain on the market, capable people remain unemployed for months and years. Recognize that extended unemployment takes an emotional toll. If your friend seems very distressed, tell someone close to her (perhaps a relative) and/or suggest that she seek professional help.

Yes, it's awkward to console someone who has just lost her job but everyone needs a little nurturance from their friends, especially at times like this. Think about what you would want if you were in the same situation.

Irene S. Levine, PhD is a psychologist, freelance journalist, and author. She holds an appointment as a professor of psychiatry at the New York University School of Medicine and recently completed a book about female friendships, Best Friends Forever: Surviving a Breakup with Your Best Friend (Overlook Press, September, 2009) and recently co-authored Schizophrenia for Dummies (Wiley, 2008). She also blogs about friendship at The Friendship Blog (www.TheFriendshipBlog).

Promote Your Upcoming Conference In Mental Health News and Plan One Issue Ahead

See Our Quarterly Release Dates On Page 43



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The Economy's Effect on People: A Peer Perspective

By Jeffrey Perry, CPRP, MSM
Program Supervisor, Bridger Program
Baltic Street Advocacy, Employment, and Housing, Brooklyn, New York

With the current economic recession our society has developed more fears about day to day life and what the future may hold than in recent memory. This translates into volumes for people who may require mental health treatment as well as community support services. Mental health services are increasingly seen as playing a vital role in addressing the mental health fallout of the current economic crisis. With that comes the increasingly important role of the recovery model of mental illness as an essential component of treatment. Unfortunately, many critics still question the validity of utilizing peers/consumers as a component in providing treatment services within the mental health system. Many consumers like myself, understand that our struggle for acceptance is similar to hardships endured by black Americans during the Civil Rights Movement of the 1950's and 1960's. Much of the rights of the Consumer/Peer Movement are being compromised due to the stigma attached to mental illness.

Today's economic problems are felt to an even greater extend within the peer/consumer community. People with mental

Jeffrey Perry, CPRP, MSM

illness who are already living close to the economic edge are faced with the rising cost of basic everyday needs such as food, shelter, healthcare, and transportation.

When a society is going through difficult times mental health issues typically rise at a similar pace. With the wars in Iraq and Afghanistan, our troops are returning home with more mental health issues. The not so distant events of 9/11 brought a greater awareness for the need for increased mental health services. Now, we hear more and more about how mental health issues are resulting from the wars in the Middle East, and our current economic recession. As the nation learns to be more understanding of the mental health needs of soldiers returning home from battle and with millions of people losing their jobs, homes, and life savings due to the current economy, we are seeing the ever-increasing personal side of mental illness.

Rather than simply becoming victims of everyday crises we must learn to face the mental health issues created by these events in a more effective way. Surely, when we are in good mental health we can. The increasing use of recovery, peer support, and self-help that community based services are adopting is a wonderful step in the right direction. Society's new understanding that mental illness can strike anyone has caused more people to realize the complex nature of mental health and mental illness. The stigma towards mental illness is slowly decreasing with our increased understanding that recovery is possible. In addition, we have learned that keeping people in institutions is more costly than providing community services—a more sound economic approach to be sure.

As in communities across the nation, the current economic climate has also created hardships for people living on a low fixed income who receive government entitlements such as Social Security Income (SSI) and Social Security Disability (SSD). A new and positive approach has recently been undertaken by the U.S. Treasury Department. They have introduced the "Go Direct Campaign" which enables people in government disability benefit programs to receive their monthly support allowance in the form of a direct deposit to their checking or savings account. The program also utilizes a benefits credit card which is a cost savings for the government who can transfer benefits electronically to recipients rather than sending a paper check in the mail each month. It seems like a great idea to me.

However, advocates who attended a recent internet conference sponsored by the New York State Office of Mental Health that addressed the government's new *Go Direct Campaign* had concerns about how consumers would be introduced and trained to use the new direct-deposit benefits system. The benefits credit or debit cards are being offered free to those who sign up for the program. This new initiative by the U.S. Treasury can have a real positive impact for people in mental health care. The Go Direct Campaign needs to be energetically introduced to consumers across the entire local, state and national consumer community.

see Peer Perspective on page 36

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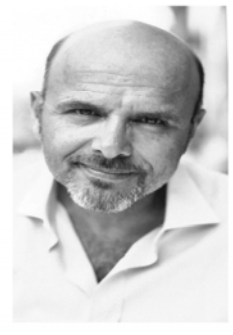

Keynote Speaker: Joe Pantoliano

Emmy Award-winning actor Joe Pantoliano, best known for his performance as Ralph Cifaretto in "The Sopranos", is the Founder and President of No Kidding, Me Too, a not-for-profit foundation dedicated to educating people about mental illness and removing the stigma associated with it.

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Westchester MHA and DCMH Present Person-Centered Conference

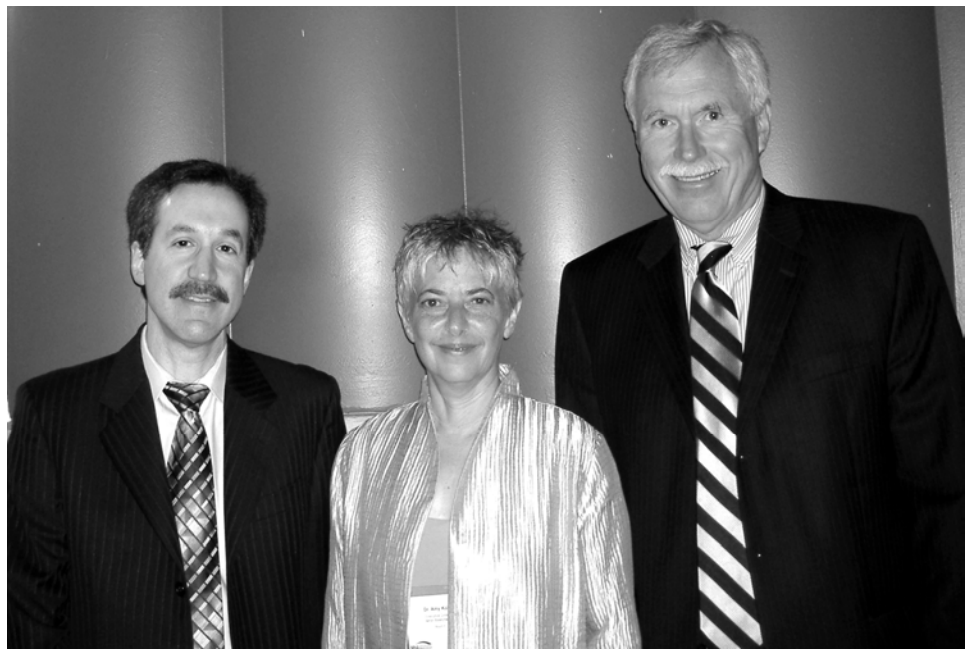
Staff Writer
Mental Health News

A record number of participants attended MHA's 29th annual Ira Stevens Conference, held recently at the Westchester County Center. More than 350 mental health individuals attended.

MHA CEO/Executive Director Dr. Amy Kohn welcomed the participants to the day's proceedings. New York State Commissioner of Mental Health Michael F. Hogan, PhD and Westchester County Department of Community Mental Health Commissioner Grant Mitchell, MD addressed the ways the County and State are implementing Person-Centered planning and service delivery.

The Keynote Speaker was Mark Ragins, MD, of California, a nationally prominent psychiatrist who has promoted and implemented effective means of preparing individuals with psychiatric diagnoses for life in the community at The Village Integrated Services Agency. The Village was founded in 1990. Ragins used the hospice movement as a model of person-centered service delivery and told how his own psychiatric practice and the programs at the Village had adopted the person-centered perspectives and values.

Lunchtime speakers were Mathew Mathai, Deputy Director of New York



Grant Mitchell, MD, Amy Kohn, DSW, and Michael F. Hogan, PhD

Association of Psychiatric Rehabilitation Services (NYAPRS) and Joshua Koerner, Executive Director of CHOICE. Each spoke of his own recovery and of serving as leaders of organizations that help others to recover. Afternoon breakout sessions provided a variety of opportunities for discussion and further examination of the principles of person-centered planning. In one session, mental health agency leaders met with Commissioner Mitchell and with Gary Weiskopf, Project Director, Mental Health Financial Restructuring Project, New York State Office of Mental Health and Glenn Gravino, Project Consultant, Coordinated Care Services, Inc. to review the state's current process of restructuring clinic regulations and rates.

Other afternoon sessions were "From Passenger to Driver: What it Takes to Be in Charge of Your Recovery," presented by Eva Dech, Director, Systems Advocacy; "Emerging Best Practices in Developing a Peer Workforce" presented by LaVerne D. Miller, Esq., Policy Research Associates, CMHS Transformation Center; "Motivational Interviewing and Person-Centered Planning," presented by Raquel C. Andres Hyman, Ph.D. Clinical Psychologist and Assistant Professor, Program for Recovery and Community Health, Yale University School of Medicine; and "The Last of Human Freedoms: Choice in a Given Set of Circumstances," presented by Mark Giuliano, MSW, Directory of Community Support, Westchester Department of Community Mental Health.

The conference theme reflects MHA's organization-wide transformation of values and practice to person-centered practice. This transformation is inspired by the 2003 report of the New Freedom Commission, Achieving the Promise: Transforming Mental Health in America calling for drastic reform of the US mental health system. The chair of the federal commission that produced this ground-breaking report was Dr. Michael J. Hogan, Commissioner of Mental Health in New York, who opened the conference.

Ira S. Stevens, (1922 - 1976), a former President of MHA and a gifted leader, was eager for and responsive to new concepts and ideas. Mr. Stevens is remembered

see Conference on page 40

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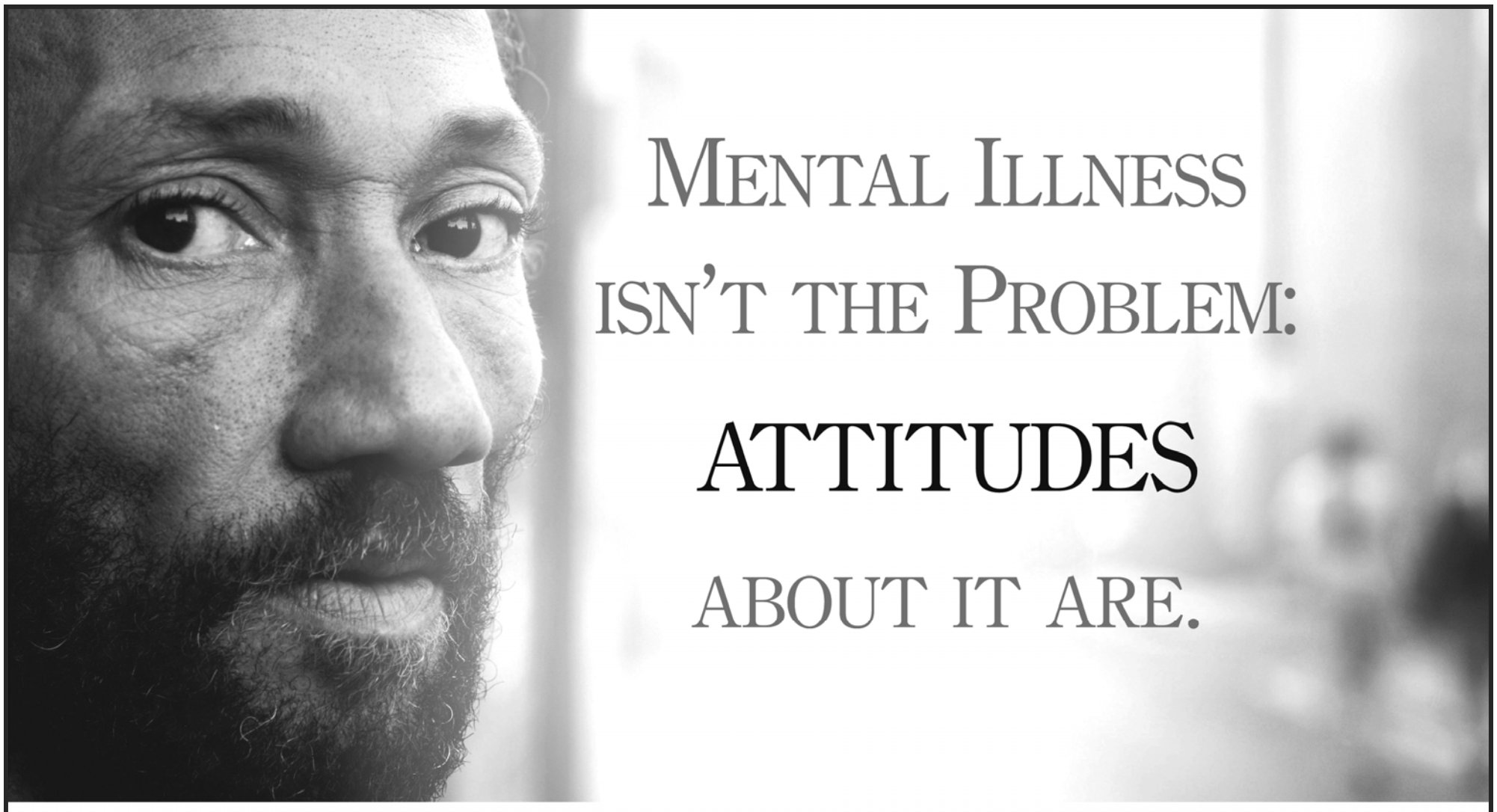

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Response from page 10

(almost all positions were filled for the past 18 months), purchased cheaper energy and fuel, maintained but reduced the cost of staff celebrations and fund raising, and most difficult of all, eliminated a pay raise scheduled for January 2009. These economies made us leaner, but not at the expense of program quality.

During this difficult time we needed to sustain faltering morale, and decided to absorb all health care cost increases in FY 2009 and again for FY 2010. The latter decision was based on the theory that this was not very expensive, but a real boost to morale. The decision was an attempt to show our concern for our employees and not place further economic burdens on staff. Because our situation improved in the last half of FY 2009, we provided a modest increase in salaries for 2010. We controlled what we could, engaged staff in controlling what they could, and provided small concrete gestures of support.

Among our responses to the economic plight, the most important was our constant reiteration of Wellspring's mission. A year ago, we began a strategic planning process with board of directors and management staff work groups. The combined process focused on mission and the development of a vision for the future. The mission was endorsed again and a new vision gave us a vital developmental goal, well-grounded in foundational activities and excitement for the future. The vision–long term connection and relational care–has sound philosophical roots for Wellspring. It created a need to engage residential and educational program alumni, board members and management staff, in new thinking. The necessity of responding to the economy created a better understanding of the mission and a new commitment to program development.

At Wellspring we attempt to engage in what I refer to as relational management, just as we follow a relational model of therapeutic care. This type of management is a long term investment in developing an organizational culture that builds relations with and among staff. To paraphrase Marshal McLuhan, we try to use "the medium as the message". How our managers manage informs therapy models and supports our therapists in how they should conduct treatment. Relational management does not negate managing the bottom line, but is an adjunct to good technical management in finance, human resource, information technology, external affairs and plant management.

The economy has pushed us to a wall, but sticking to our core business, managing "as well as we can," supporting our staff through a united and multi-dimensional response to our fiscal plight has made us stronger. I am reminded of the quote, "that which does not kill us makes us stronger." Although I hope the worst is over, or at least is greatly diminished, I know Wellspring is better for what we experienced in 2008.

Peer Perspective from page 32

Without doing so, this new program will become just another underutilized service that is of benefit to consumers yet has failed due to a lack of understanding and sensitivity needed to engage the members of our community.

On the bright side, this initiative by the Treasury Department involves consumers in "a greening campaign" by using improved technology. This type of approach may go far in helping peers/consumers feel they are a part of mainstream society by recognizing that people with mental illness are also part of our nation's economy. This redirection of energy and resources may help lessen the negative effects of stigma toward people with mental illness. It provides everyone with a renewed perspective about mental health that focuses on inclusion rather than stigmatization—an outdated and fear driven idea of social and economic separation.

More attention is needed to address the needs of our nation's mental health system of care. The issues surrounding mental health – like global warming – require increased education followed by direct action to address the many issues involved. Mental health is about all of us, and in addressing our overall health and well-being mental health cannot be viewed as an afterthought.

Providers from page 18

phone-based peer support at all hours of the day and night to help people reduce loneliness and despair. This service has been growing over the past two years and has become a vital link for people that feel isolated in their homes or living situations.

We at PEOPLE, Inc. began to realize that we had developed a very appropriate and vital hospital diversion service that was different than traditional services but at the same time was embraced as a complimentary continuum of care by peers and professionals. While all of PEOPLe, Inc's services are self-referral, the professional community has embraced the service and will educate people within their services about our services. Avoiding hospitalization is an important service but developing "community" and a different focus on wellness, hope and a self-determined lifestyle promotes a shift moving people away from a fear of crisis to a life of possibilities.

PEOPLe, Inc. has recognized as a peer run organization that we must continue to build integrity and trust within the peer community and the professional community if we want to build a wellness-focused mental health system. We have been working with local counties and providers as partners in an effort to transform the "medical" model system of care to that wellness-focused system of care. Through sharing our experiential insight and knowledge we have been partnering on a new approach that would change values and beliefs of professionals around recovery. We are in our fourth year of working in Ulster County, New York on system transformation and the county services and private mental health service providers are collaborating on many new approaches and projects to improve recovery outcomes for people.

Some of the outcomes of the work we are doing has resulted in hiring a peer to work directly in the Clinics in Ulster County. The services that the Clinic Peer offers are peer advocacy, empathetic mutual support, recovery groups, education and assistance in the development of wellness planning and education around health and wellness self- management techniques. The Peer Advocate participates in all management meetings and is a key in continuing to educate the clinic staff about the mission of wellness-based service delivery. This service has also been included in our hospital diversion model as it has been helpful for people at the clinic to know that there is a Peer Advocate there to support him/her in the clinic should there be a conflict between the person and the therapist.

A Nights Out program was also developed as a partnership between county government, local providers and peers in the community. It is a simple concept that brings people together in a community setting to plan activities and events. It first started at coffee house as a social night out. It was not about "mental health" which meant the focus was on socializing. The people that attend are of all walks of life and it has grown in popularity over the years. As the participation grew, the people that met regularly decided that a larger space was needed. Nights Out was moved to a local Church in Kingston and now averages 30 – 60 people every Thursday night and includes activities such as book club, men's club, game club, hobby clutch and many more. In addition to holding different groups within the meeting location a resource guide was designed to offer links and information to natural supports similar to the activities so that people could choose to integrate into the community on one's own time. The result has been positive in that people have developed friendships and found other interests that have promoted personhood into the community.

These and the other services that we offer have contributed to PEOPLe, Inc's success over the years and has given us opportunity to share our knowledge and gain new knowledge that promotes healthier lifestyles for the people we serve. We have become a multi-faceted organization that is attempting to partner with research to measure and show outcomes on how a peer run organization can vastly contribute to transforming the mental health system. We look forward to learning more from our peer community and to continuing to be a voice in our community to implement new ideas that truly promote a recovery-focused mental health system.

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The Psychological Impact of the Economic Down-Turn

By Herb Ruben, Executive Director
Peninsula Counseling Center

The economic down-turn has individuals deeply troubled about housing, jobs, and finances. Business and governmental leadership are involved in serious discussion about what remedial steps might be taken to alleviate the growing sense of a national crisis.

What also is at stake is the psychological impact this down-turn has on the lives of millions of Americans. People feel a loss of confidence in institutions and are left with a shaken confidence in themselves. They are worried, scared and feel threatened by a breakdown in personal security. They are concerned about their own savings and investments and the higher cost of living. They lack certainty about what they should be doing.

All this gives rise to anxiety. As anxiety mounts, this spawns the development of a whole host of related symptoms. Individuals complain that they can't fall asleep or remain asleep. Under stress, they begin fearing the possibility of a heart attack. They may turn to drinking more or taking more drugs or popping more pills to escape their despair.

Herb Ruben

They begin to brood about decisions made and feel a loss of hope about their future. They feel angry that all this could happen to take away what they've worked a life-time to build. And they feel angry at themselves that they were not wise enough to see this coming.

Inevitably, the toll extends to other family members – individuals who are being laid off or facing a reduction in work hours, individuals having to sharply tighten the belt on spending or foregoing other plans around home re-modeling, moving, and vacations.

In the face of this ominous cloud, there are steps which can be taken making it easier to weather this crisis. These include:

1. Don't keep exposing yourself to the constant stream of bad news you'll get by watching the news on TV or reading the newspaper. You already are aware that things are difficult. You don't have to be reminded around the clock that this is so.

2. Maintain a sense of perspective. Remember that we've experienced significant down-turns in the past and have had the resiliency to bounce back. There is no reason to believe that this won't happen again. Having a sense of hope about this is important to personal well being.

3. Build something joyful and pleasurable into your life. You need this for balance and for an appreciation that there are other important values in your life.

4. Your body in a state of depression will feel sluggish and fatigued. Nevertheless, compel yourself to be involved in daily physical activity, whether it is the gym or yoga or walking. Each can help drain anxiety.

5. Avoid blaming others or yourself. There is a large part of our life that we can't control, and economic down-turns is one of these. We need to live with a sense of understanding that there are forces beyond us which often shape the environment in which we live.

6. Trust your own gut reactions. There are all kind of charlatans wanting to give or sell you advice about what you should be doing living under these circumstances. The best and most effective thing you can do is to step back and listen to what your insides tell you.

7. It is a sign of strength, not weakness if you decide to turn to a counselor or coach to help sort out your options and how you want to address them. Responsible Community Resources exist all around you to give you some of the support you may feel you need.

Research from page 29

for the identified groups and, inadvertently, resulted in the reversal of what had been a declining rate of youth suicide. The take away message from these episodes is of the overriding power of government, accreditation organizations, and large health insurers' policies to influence care on a vast scale, for better or worse.

Why choose to raise the matter of CER for the readers of *Mental Health News?* First, ARRA directed the Institute of Medicine (IOM) to identify national priorities as research questions to be addressed by CER using ARRA funds. The IOM, which had no psychiatrist or other mental health expert on its Committee on CER Priorities, published its recommendations on 6/30/09 which included many addressing a wide array of mental health concerns. (The American Psychiatric Association was invited to present very brief comments at one of the Committee's listening sessions.) It is unclear whether the questions brought forward in the report were ones those in the field would have posed and whether if translated into research they will provide direction to the field's critical concerns. (The IOM Report is easily reviewed on the web.) I suggest that *Mental Health News* readers familiarize themselves with the report and the CER process as envisioned.

Second, as the IOM research topics and others are undertaken as CER is pursued, we must wonder how and by whom they will be applied to public policy and individual plans of care. Let me provide an example from the arena of psychopharmacology. What psychopharmacologic treatments will be considered acceptable and paid for in caring for persons with serious and persistent mental illness such as chronic schizophrenia remains an important and exemplary question. It is a fact that to date there has been no research which shows a "significant" benefit from using of two atypical antipsychotics simultaneously. Anecdotally such cases exist and there is some support for using 2 atypicals in the clinical literature. These medications are very expensive and costly to state Medicaid programs or private insurers. Given this background, the question then is, what latitude will clinicians retain when treating persons who have remained refractory to the evidenced based care laid out in clinical guidelines? The New York State Office of Mental Health will be using its PSYCKES data base to identify cases for which 2 "atypicals"

see Research on page 41

Rate Reform from page 28

the removal of the Medicaid Neutrality which precluded the natural expansion of services to meet consumer need.

Going Forward

In general, the Federation is thus far very supportive of OMH's clinic reforms. The Federation cautions that the momentum of this effort should not be slowed as such a state of affairs could, with COPs deregulation, drain the state of much needed mental health funds. Once these reforms are fully implemented, we can all expect greatly expanded consumer access and service expansion with perhaps some savings in aggregate clinic expenditures.

Restructuring from page 1

experience the effects of uncoordinated and/or limited access to mental health care.

To address these challenges, The New York State Office of Mental Health (OMH) has undertaken a multi-year initiative to restructure the way the State delivers and reimburses publicly supported mental health services. Quality reforms have included new "standards of care" emphasizing such key issues as patient-centered treatment, engagement, appropriate case loads, risk assessment and supervision. OMH is also updating its licensing methodology to emphasize clinical and quality of care concerns over narrower aspects of standards compliance. The goal of these and other reforms is to develop a system of quality care that responds to the individual needs of adults and children and delivers care in appropriate settings.

Clinic restructuring represents the most developed phase of this transformation process. OMH commenced clinic restructuring in the fall of 2007 and anticipates implementation beginning in January 2010. Major clinic reforms have included new resources for clinic expansion in the 2007-2008 budget, elimination of the "Medicaid Neutrality" policy that limited clinic expansion, and provisions to facilitate integrated care (for co-occurring alcohol, drug and medical problems).

In addition to clinic restructuring, parallel initiatives have begun tackling the many challenges facing adult and child non-clinic ambulatory services, inpatient services, and the treatment of co-occurring disorders in both mental health and substance abuse clinics.

These efforts include significant stakeholder participation and input. Clinic restructuring is being done with the extensive involvement of an Advisory Workgroup consisting of a broadly representative range of local government officials, mental health providers, and mental health advocates.

Over the last two years, OMH has developed a plan for clinic restructuring that reflects significant input from our stakeholder group. The plan encompasses several key elements:

1. **A redefined and more responsive set of clinic treatment services and greater accountability for outcomes.** Clinic is defined as a level of care with specific services such as outreach and engagement, crisis response, and complex care management. These services should enhance consumer engagement and support quality treatment.

2. **Redesigned Medicaid clinic rates and phase out of COPs.** Medicaid payment rates will be based on the efficient and economical provision of services to Medicaid clients. Payments will be comparable for similar services delivered by similar providers across service systems. Payments will also include adjustments for factors which influence the cost of providing services. **The new system will eliminate rate add-ons such as COPs.**

3. **HIPAA compliant procedure based payment systems with modifiers to reflect variations in cost.** The Federal HIPAA Administrative Simplification Act requires the use of a HIPAA compliant billing system. Billing codes for clinic services will consist of HIPAA compliant CPT codes with modifiers to reflect differences in resources and related costs (e.g., service location, after hours, language other than English).

4. **Address Medicaid HMOs/State insurance plan underpayments.** Medicaid Managed Care, Family Health Plus and Child Health Plus (CHP) plans frequently underpay for mental health clinic services. The average managed care payment for clinic services is approximately one-third to one-half of actual cost. This is significant because Medicaid Managed Care and Family Health Plus visits combined represent 12% of clinic visits. This percentage is expected to grow as the state expands mandatory managed care enrollment.

To ensure continued access to clinic services, OMH needs to address Medicaid managed care underpayments. We are working with DOH and Managed Care companies to address this issue as part of clinic restructuring. Additionally, OMH and DOH need to monitor managed care plans to ensure appropriate member access to mental health services.

5. **Provisions for indigent care.** Assuring access for the uninsured to mental health clinic services is a key element of clinic restructuring. Currently, OMH clinics receiving COPs are required to serve all clients regardless of ability to pay. As part of restructuring, New York State is requesting a CMS approval of federal financial participation in the existing state funded indigent care pool for Diagnostic and Treatment Centers. Under this waiver, if approved, reimbursement for indigent care would be expanded to include free-standing OMH licensed mental health clinics. Funding from the pool will enable uninsured middle class and working poor individuals and families to continue receiving care at OMH licensed clinic sites.

OMH has also put in place additional measures to help seriously emotionally disturbed low income children get access to care. For several years, OMH has excluded mental health services for children with serious emotional disturbance from Medicaid Managed Care. This "carve–out" allows children with greater needs to access specialty mental health clinics without prior authorization and allows Medicaid to reimburse these clinics at the higher Medicaid fee-for-service rate.

There is no doubt that clinic restructuring will require change on the part of providers. And this restructuring will affect clinics in different ways. Mental health clinics have a wide range of costs and staff productivity. Clinics will need to assess their current operations in light of the new array and packaging of services as well as the new payment rates. While the new approach will smooth the reimbursement differences between providers, the base Medicaid rate paid to providers will be significantly increased. Additionally, unlike the current system where clinics receive one payment regardless of the number of services provided to a recipient on one day, the new system will pay clinics for multiple medically necessary same day services to a recipient. This should help both the clinics and the recipients to avoid unnecessary trips back to the clinic to get the services they need.

Separate from clinic restructuring, clinics will also need to respond to changes in staffing requirements brought about by a 2002 New York State licensing law. This law established licensing requirements for psychologists, social workers and four new licensed mental health professionals (Mental Health Counseling, Licensed Marriage and Family Therapist, Licensed Creative Arts Therapist, and Licensed Psychoanalyst). The law also provided an exemption from these requirements to programs or employees of programs "operated, regulated, funded or approved" by the department of mental hygiene, local government units, the Office of Children and Family Services, or local social services districts. This waiver expires June, 2010. Currently, about 28% of staff in OMH licensed clinics are not licensed. OMH recognizes the difficulty this presents and is actively working for a legislative extension of the waiver to provide mental health clinics with the time they need to come into compliance.

Conclusion

To summarize, the metal health clinic system faces numerous and pressing financial and programmatic challenges. New York must and is taking the actions needed to address these challenges. Our clinic restructuring plan, developed with enormous input from stakeholders, responds to these challenges by (1) adding a range of new services to clinics; (2) restructuring rates to support comparable payments for similar services; (3) incentivizing services provided off-site, after hours, in languages other than English and by physicians; (4) complying with federal HIPAA billing requirements; (5) beginning to address underpayments by Medicaid HMOs; and (6) establishing a pool to compensate clinics for providing indigent care. While these are major changes, they are necessary to improve service delivery and ensure the survival of a quality mental health clinic system in New York.

We recognize that providers need time to adjust, to understand the service and revenue implications of the new service and reimbursement design and to respond to the incentives and disincentives in the new design. That is why we are providing a 4 year phase-in of the new reimbursement system. In the first year of the transition, almost all providers are shielded from major reduction in State financial support. Some providers will necessarily have to implement their practice changes by year two to preserve their viability. This prolonged phase-in allows time for providers to adapt and move New York toward a more accessible, person centered, and cost effective clinic system.

NYSPA Perspective from page 14

has not treated or even seen the patient. We recommended elimination of this requirement. A psychiatrist who treats or directly supervises the treatment of a patient should participate in the development and updating of the treatment plan together with the other professionals involved in the patient's care and treatment. This simple change will free up psychiatrists to focus on treatment of patients and will eliminate the need of clinics to use limited resources to pay psychiatrists for unnecessary paperwork. OMH staff have expressed support for these concerns and we look forward to reviewing OMH specific recommendations on this issue.

Finally, under the new system, a new billing system will be implemented using the same clinical service codes (the AMA CPT codes) used by Medicare and other third party payers. NYSPA strongly recommended that the permissible codes for psychiatrist's services include the CPT evaluation and management codes. Use of these codes for psychiatrist's services will enhance Medicare reimbursement for patient's covered by both Medicare and Medicaid and thereby reduce Medicaid's financial responsibility.

NYSPA has participated actively on the various OMH work groups formed to implement the change to the new payment system. We will continue to work with OMH to ensure that patients in need of outpatient mental health services can access necessary and appropriately funded care and treatment.

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Budget from page 15

an inpatient setting before they are clinically appropriate for discharge only to find themselves right back on an inpatient unit because they were never ready to leave in the first place. One can certainly ask the question how money is saved with this myopic approach.

Another ubiquitous difficulty during the best or financial times let alone these difficult times is that of housing for people with mental illness. It goes without saying that a stable home, a place to feel safe and secure, has a significant impact on one's mental health. This is true for those that do not suffer from any mental illness and is especially true for those unfortunate individual's that must struggle with a severe diagnosis of mental illness. A reduction, or even a limited increase, in dollars targeted to housing leaves people with mental illness homeless and susceptible to the dangers of the street or shelter life. Likewise, it leads to the same "revolving door" dilemma that was previously discussed.

Although more subtle than these direct impacts, but perhaps more severe, is the elimination of a cost of living adjustment in the 2009 Budget for those that work in the mental health field. Mental health services are only as good as the people that deliver them. A sparklingly new, up to date facility is worthless without the nurses, social workers, psychiatrists, and countless others needed to effectuate the implementation of services. While the large majority that work with people with mental illness are extraordinarily dedicated people who clearly are not in it for financial gain, at some point the financial reality of limited pay will force these individuals to find new careers. Likewise, low pay without the prospect of improvement will scare away the new crop of employment talent that is sorely needed.

Compounding the problem of a reduction in services is that now more than ever mental health services are needed. Recently, the World Health Organization ("WHO") issued a report on the impact on the global financial crisis on people with mental illness. As we all intuitively know, the report concluded that due to financial stressors it can be anticipated that there will be an increase in the acute exacerbation of symptoms of mental illness and of course, a rise in suicide rates. The study notes the clear link between suicide attempts and financial difficulties. Furthermore, WHO expressed its severe concern for people with mental illness in poorer nations that already receive, at best, sub-standard care.

There is no doubt that the impact of this financial climate will reverberate far beyond the borders of New York State. To a large extent however, New York will feel the pain of this crisis a bit more severely considering the State's reliance on financial institutions for a large portion of employment. A quick look at present unemployment numbers within the State and more specifically, within the New York City region, indicates that countless individuals have lost their jobs and remain jobless, without health insurance. Moreover, many of those that are fortunate enough to remain employed are gripped with fear that they may be next to lose their jobs. Hence, it is likely that those that are jobless and those that are fearful of becoming so that already suffer from a mental illness will exhibit an exacerbation of their symptoms as a result of such a significant stressor in their lives.

Even those that are financially stable as a result of the largess they acquired when times were good are not free from the psychiatric impact of these times. "The big guys, the wheelers and dealers of the hedge funds, and the mutual funds and such, their stressors come from a little bit different angle. It's not the financial so much as it is the loss of their identity. And, if they don't have a life other than their company, then they really are at a loss," was a recent quote from Deborah Cross, head of the New York State Psychiatric Association.

Conclusion

Advocates for people with mental illness must scratch and claw for every dollar of spending they achieve regardless of the state of the economy. In that respect, they are well trained to deal with times like this where cuts to spending are inevitable and the key is to target and limit them. Although spending cuts did take place it is heartening to see a recognition of the importance of mental health programs, particularly during stressful times. The question remains though, if short term savings on mental health programs really leads to long term financial sense if thrift in the present will lead to expensive future care. Perhaps a longer range view of the effects of these cuts is warranted.

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New York State Psychiatric Institute/Columbia University is accepting volunteers into an outpatient research study to treat schizophrenia and schizophrenia-like symptoms. This study uses magnetic stimulation, an investigational treatment to help with social isolation, low motivation and loss of interest. Participants must be 18-55 and in active treatment with a psychiatrist.

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Newspaper Board from page 9

mental health community, was instrumental in MHNE developing *Salud Mental*, the organization's bilingual and multicultural publication which was in circulation for over four years.

Jonas Waizer, PhD

Dr. Jonas Waizer, a founding member of the MHNE Board, has been with F·E·G·S since 1991, presently as Chief Operating Officer. He is currently serving as the President of the New York Coalition of Behavioral Health Agencies, Inc.

His career has included government service as the Associate Commissioner for the New York State Office of Mental Health from 1987-90. His prior government appointments included 12 years as the Assistant Director for the New Jersey Mental Health Department, and as past Chair of the NIMH Mental Health Statistics Improvement Project.

Dr Waizer's academic appointments included the Departments of Psychiatry at Downstate Medical Center, Albert Einstein College of Medicine, and NYU Medical Center, along with administrative positions at other general and public New York hospitals.

Dr. Waizer has a Doctorate in Psychology and is licensed to practice in New York State. He has published and presented extensively.

Leo Leiderman, PsyD, ABPP, CGP

Leonardo Leiderman, PsyD, ABPP, CGP, a member of the MHNE Board since 2004, received a Doctorate and Masters Degrees in clinical psychology from the Ferkauf Graduate School of Psychology at Yeshiva University. He is a New York State licensed psychologist and is nationally certified as a group psychotherapist. Dr. Leiderman is also board certified with a Clinical Psychology Specialty by the American Board of Professional Psychology and is a fellow of the American Academy of Clinical Psychology. He has been the director of Latino Treatment Services at Saint Vincent Catholic Medical Center Westchester for almost 15 years.

Dr. Leiderman is Supervisor of a multidisciplinary team providing bilingual and bicultural outpatient mental health and substance abuse treatment. At Saint Vincent's Hospital he has also served as Director of the Doctoral Psychology Externship Program, coordinating the student's yearly clinical training and supervision including process groups. He is a member of the Board of Directors of the Westchester Group Psychotherapy Society, an affiliate of the American Group Psychotherapy Association, where he was recently elected to serve a two year term as President Elect, before assuming the role as President of this association. For the last several months he has been working with other members of the board to plan an international group psychotherapy conference in Buenos Aires, Argentina in December, 2010. Dr. Leiderman has also been a member of Congresswoman Nita M. Lowey's Hispanic Advisory Board for the 18th Congressional District for several years. Since 2003 he has also been serving on the Westchester County Community Services Board focusing on mental health, alcohol and substance abuse, and developmental disabilities services and programs throughout Westchester County. Similarly in 2003 he was appointed to the Westchester County Hispanic Advisory Board which advises the County Executive on matters of policy with regards to Hispanic Americans and immigrants. During the last several months he has been chairing an Ad-Hoc Committee dedicated at reducing crimes and violence against Westchester's Hispanic immigrant population.. He has published many articles, lectured extensively, and made guest appearances on both radio and television on topics related to the mental health and substance abuse treatment interventions, primarily with the Hispanic population. He has a private practice in New York City and Westchester County providing individual, couple's and group psychotherapies. Being a native Argentine, he has served the Hispanic communities in New Jersey, the South Bronx, New York City and Westchester County for over twenty years as a bilingual, bicultural social worker and then as a clinical psychologist.

More about Dr. Beitchman and The Bridge

In addition to his work at The Bridge, Dr. Beitchman taught in the Masters and post-Masters programs at the Hunter College School of Social Work for more than a decade. He is also active in several mental health advocacy organizations. Dr. Beitchman was a long-time board member of the Coalition of Voluntary Behavioral Health Agencies and chaired its Committee on Co-Occurring Psychiatric and Substance Abuse Disorders. He is a member of the Steering Committee of the Urban Institute for Behavioral Health and for six years he served on the board of NAMI NYC-Metro and held the position of Treasurer for part of that tenure. He has also served as Vice President of the American Association for Psychosocial Rehabilitation, the U.S. affiliate of the World Association. For many years, he has been an active member of the New York City Chapter of the National Association of Social Workers where he chairs the Fundraising Committee and serves on the Finance Committee. Peter was honored with the Chapter Service Award, from the National Association of Social Workers NYC Chapter and was Honoree at the 2007 NAMI NYC-Metro Gala where he was presented with NAMI NYC-Metro's "Housing Leader Award".

The Bridge, Inc., a comprehensive multi-service agency for men and women with serious mental illness is located in New York City. The people served at The Bridge including the homeless, persons with co-occurring mental health and substance disorders, persons who have a mental health diagnosis and HIV/AIDS, and people with mental illness who have been in the criminal justice system. The Bridge operates more than 50 programs in Manhattan, Queens and The Bronx, providing residential, rehabilitation, clinical, and support services to more than 1500 individuals each year. The Bridge offers a variety of person-centered, evidence-based treatments and programs designed to support consumers in their recovery.

The Bridge Housing Program includes 595 beds, with an additional 232 beds in development. The agency operates eleven 24-hour congregate supervised residences, 67 scatter-site apartment treatment beds, and more than 300 single-site and scatter site permanent housing beds. Innovative programs include specialized housing for the homeless, for persons with co-occurring mental health and substance abuse disorders, and for persons with mental health diagnoses, substance abuse, and HIV/AIDS. Recent examples of innovative Bridge housing programs include Iyana House, a model permanent housing and rehabilitation program for women with serious mental illness and substance abuse released from Bedford State Correctional Facility, and Sheridan Hill House, the City's first 24-hour supervised congregate program for aging men and women who have serious mental illness and serious medical conditions. This program includes on-site medical and home health services provided by the Jewish Home and Hospital.

Schizophrenia from page 7

treatment until the disease is already well-established, with recurrent episodes of psychosis resulting is costly multiple hospitalizations and disabilities that can last for decades. People with the illness are over-represented on disability rolls, and among the homeless and imprisoned. Their unemployment rate is more than 70 percent, and the lifetime suicide rate for people with the disease is over ten percent. People with schizophrenia occupy approximately 25 percent of the nation's hospital beds.

A number of research projects internationally have signaled that early intervention–combining medical treatment with consumer and family education, and emphasizing a transition to a productive adult life–holds great promise in reducing the disability that is associated with schizophrenia.

Conference from page 34

each year by an event which presents an issue of major public concern.

The Mental Health Association of Westchester County, Inc. (MHA), a non-profit organization, is the leading resource for mental health services in Westchester County, NY. Through its advocacy, community education, and direct services, MHA meets a broad spectrum of critical needs of thousands of children, adults and families each year. MHA is committed to eliminating the stigma associated with mental illnesses and fulfilling its guiding values of hope, respect, commitment and progress. You are invited to visit the Mental Health Association's website, www.mhawestchester.org, for information on critical mental health issues and services in Westchester County.

Genetic Roots from page 7

explain just a few percent of this contribution; now we have more than 30 percent accounted for," said Thomas Lehner, Ph.D., MPH, chief of NIMH's Genomics Research Branch "The new findings tell us that many of these secrets have been hidden in complex neural networks, providing hints about where to look for the still elusive -- and substantial -- remaining genetic contribution."

The MGS consortium pinpointed an association between schizophrenia and genes in the Chromosome 6 region that code for cellular components that control when genes turn on and off. For example, one of the strongest associations was seen in the vicinity of genes for proteins called histones that slap a molecular clamp on a gene's turning on in response to the environment. Genetically rooted variation in the functioning of such regulatory mechanisms could help to explain the environmental component repeatedly implicated in schizophrenia risk.

The MGS study also found an association between schizophrenia and a genetic variation on Chromosome 1 (1p22.1) which has been implicated in multiple sclerosis, an autoimmune disorder.

"Our study results spotlight the importance not only of genes, but also the little-known DNA sequences between genes that control their expression," said Pablo Gejman, M.D., of the NorthShore University HealthSystem Research Institute, of Evanston, ILL, who led the MGS consortium team. "Advances in biotechnology, statistics, population genetics, and psychiatry, in combination with the ability to recruit large samples, made the new findings possible."

The SGENE consortium study pinpointed a site of variation in the suspect Chromosome 6 region that could implicate processes related to immunity and infection. It also found significant evidence of association with variation on Chromosomes 11 and 18 that could help account for the thinking and memory deficits of schizophrenia.

The new findings could eventually lead to multi-gene signatures or biomarkers for severe mental disorders. As more is learned about the implicated gene pathways, it may be possible to sort out what's shared by, or unique to, schizophrenia and bipolar disorder, the researchers say.

Schizophrenia and bipolar disorder share genetic roots that appear to be specific to serious mental disorders, and are not shared by non-psychiatric illnesses. Bars representing different study samples show that the same genetic variations that account for risk in both mental disorders account for virtually none of the risk for coronary artery disease (CAD), Crohn's disease (CD), hypertension (HT), rheumatoid arthritis (RA), or Type 1 (T1D) or Type 2 (T2D) diabetes.

Source: Psychiatric and Neurodevelopmental Genetics Unit, Center for Human Genetic Research, Harvard University.

Commentary from page 1

York's clinics depends. Let me state unequivocally, that although The Coalition represents community based providers; we believe deeply that quality care and continuity of care are at stake here. These are crucial issues for recipients of care. Clinics provide access to care for many needy and distressed residents of communities all around New York. If clinic programs cannot find the wherewithal to survive, many consumers will be deprived of care; if clinics cannot afford the most qualified professional staff, consumer care will be compromised. If consumers cannot access the "gold standard" of care that our clinics provide, then care will be shifted to more costly (in fiscal and human terms) providers of care, such as hospital emergency rooms, inpatient wards, and jails.

Issues that Remain Unaddressed in Clinic Restructuring

1) We all would benefit from more transparency. As of the date this article is written (July 26, 2009), we do not yet know the SOMH proposed base rates nor the weighted amounts that will be provided for specialized services. Agencies are way past their deadlines for developing FY 2010 program budgets. SOMH must quickly move to provide reasonable models that show impacts on providers, by type and location, using fair assumptions of service demand and costs of doing business. Without this analysis, we won't be able to determine how many consumers may be dislocated from their services due to clinic closures;

2) Currently, and for decades, a full Article 31 clinic visit has been defined by the State and permitted by federal Centers for Medicare and Medicaid Services (CMS), as 30 minutes in duration. Many interventions, particularly new evidence based therapies, can be delivered in 30 minutes. Many children with serious emotional disturbance and other fragile and seriously ill consumers have difficulty concentrating for more than 30 minutes or decline to participate in longer sessions. Moreover, many poor and minority communities have limited provider capacity and access to services. The unfortunate consequence of lengthening the visit duration is that it further stretches inadequate capacity and resources, commensurately lengthens waiting lists, and even would deprive some consumers from accessing clinic care. Ominously, many clinics will not be able to survive the lessened reimbursement and may have to close, even further depriving community residents of clinic care. By contrast, Article 28 community health clinics that are licensed by the State Department of Health may provide comparable behavioral health services in increments of 30 minute sessions or less for full reimbursement. We seek parity in this matter for SOMH licensed Article 31s.

3) Professional licensing requirements under New York State laws threaten the implementation of the reform endeavor. SOMH asserts this very problem in its article in the current issue of MHN. The legislature and other State authorities must be convinced to enact a longer exemption from the provisions of the law for the community based provider workforce. We also must work in tandem with SOMH (and the other impacted State agencies, including OASAS) to seek more flexibility in the application of the training and licensing requirements or many of our programs will be deprived of licensed professional staff. This will have negative consequences for service delivery and reimbursement for care.

4) Many of our agencies provide full time salaries and benefits, including health care, to their workforce. Many of these clinics are unionized and have signed agreements governing the terms of employment. Other clinics use a model of care that relies heavily on "in locum tenens," or part time consultant professional staff. These workers are paid an hourly fee, dependant on consumer attendance (they are not paid for "no shows," a widespread problem in clinics). Only the staff model approach provides health care benefits to professional staff. At a time when the nation's attention is focused on universal health care delivery, it is even more troubling that New York State would be implementing a clinic system that would, in effect, deprive professional staff of health benefits.

The Coalition believes that a model of care based on a preponderance of full time clinical staff is preferable as it promotes case conferencing and mutual help among staff that brings more expertise to bear on consumer issues, more consistent supervision, a greater guarantee of continuity of care, and not to be discounted, it strengthens the economic viability of communities whose residents we employ in considerable numbers. The new reimbursement system does not distinguish between these two models of care and is likely to push the clinic system to reliance upon the in locum tenens model. We believe that shift to be against the interests of consumers, particularly those with multiple and very high needs. We believe that it is ethically wrong to promote a system of care that will not pay health insurance to the professionals that devote themselves to this life saving work.

5) SOMH has not addressed the impact of significantly lower rates paid by commercial insurance. Many of our clinics treat working adults and children who have significant behavioral health problems, including serious mental illness and comorbid problems. Without adequate reimbursement from these payers, many adults and children will be deprived of care by community based clinics that cannot afford to treat underpaying clients. In many communities, there are no alternatives to community based clinics, making Timothy's Law and federal parity laws, a myth for these adults and children who will be unable to access care. This has major ramifications for individuals and communities as the nation and the State are undergoing economic stress, growing unemployment, housing loss and other family pressures. At a time when demand for access to quality mental health care is growing, SOMH seems to be receding from the imperative of providing care for all State residents in need. The resultant emotional and practical disinvestment in the public mental health system by working and middle class voters will have grave implications for future public mental health policy and funding.

The Coalition joins SOMH in wanting meaningful and implementable clinic restructuring and reform. We believe in cost effectiveness in service delivery. Community based care is prevention based care and person based care. Our clinics join with other community based services in helping consumers stay on the path of recovery. We intervene to help keep consumers functioning in the community and away from costly intensive hospital based services.

More time is needed to make the changes that will help improve the system. Both time and money are needed to bring IT systems up to date, especially to function in the era of electronic records, yet federal and State stimulus monies are available only to hospitals and physicians.

More attention and political pressure is needed to address all aspects of the payer systems. Bring on change; but change that is adequately planned; change that will help community based providers transition without interrupting care; change that provides technological underpinning for moving forward; change that puts into place new replacement services before the elimination of existing services. Responsible change will bring consumers of care into the new paradigm without losing any of them to care in the transition. This is the reasonable way "to move New York toward a more accessible, person centered and cost effective clinic system."

Mental Health News note: We welcome other perspectives on this important initiative. Please contact Ira Minot, Publisher at (570) 629-5960 or email iraminot@mhnews.org. All articles will be considered for publication in our next issue—deadline, November 1, 2009.

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are being prescribed as part of its quality indicator study. The NYS Office of the Medicaid Inspector General, charged with rooting out fraud and abuse, planned to review such cases as part of its 2008 work scope but deferred pending the results of the OMH initiative. The question is should all such use be adjudged improper? Scientifically the resounding answer should be "no". As a matter of policy, the answer is less certain. From a statistical perspective, the absence of a finding of significance does not mean there may not be meaningful subgroups or individuals which would benefit. The criteria of large clinical trials are so broad as to obscure what might be important treatment effects for subgroups. As statisticians know, the absence of evidence is not evidence of absence (of an effect). Once government focuses on a practice, such as the "inappropriateness" of prescribing 2 atypical antipsychotics at once, doctors become far less likely to treat a patient with the "targeted" combination, even when they have exhausted standard options, due to their fear of being sighted. Likewise, if time consuming hoops are created as barriers to such prescribing by insurers, will time pressed doctors make the necessary effort to clear the hurdles? Will clinics, whose quality may be judged on such criteria, discourage their physician employees from going beyond the "approved" prescribing practices when they perceive a need? Can we be comfortable that an insurer's policy is clinically not financially based given that industry's problematic record? Will large governmental agencies or insurers be nimble enough to adapt their policies to clinical science's rapidly changing landscape? (Perhaps, going forward, the use of data mining on vast data sets such as Medicaid's, Medicare's, or private insurer's may help identify those for whom less recognized approaches to care such as the 2 "atypicals" is beneficial, if there are enough cases to provide the statistical power to perform the analysis.)

Alerted to CER and what we may expect over the coming years as this process gains momentum, how might readers of MHN think about this movement? Readers should welcome the use of CER and other avenues to improved treatment and recovery. However, we should do so with open yet skeptical minds. Dr. Jerry Avron, Professor of Medicine at Harvard and Director of the Harvard Interfaculty Initiative on Medications and Society, in a recent article in the New England Journal of Medicine, asks, "What is the moral responsibility of the physician to care for a patient for whom the best therapy may not meet the conventional standards of cost-effectiveness?" He continues, "These aspects of the debate will need to continue as we begin to implement CER with this vital new funding." While all cannot become statisticians or methodologists, we can inform ourselves and raise questions and concerns with policy makers, both governmental and private sector, when they promote or act to circumscribe access to a variety of approaches to care.

Dr. Perlman is a past President of the New York State Psychiatric Association & past Chair of the New York State Mental Health Services Council.

If you are experiencing a difficult time in your life, always remember that you are not alone.
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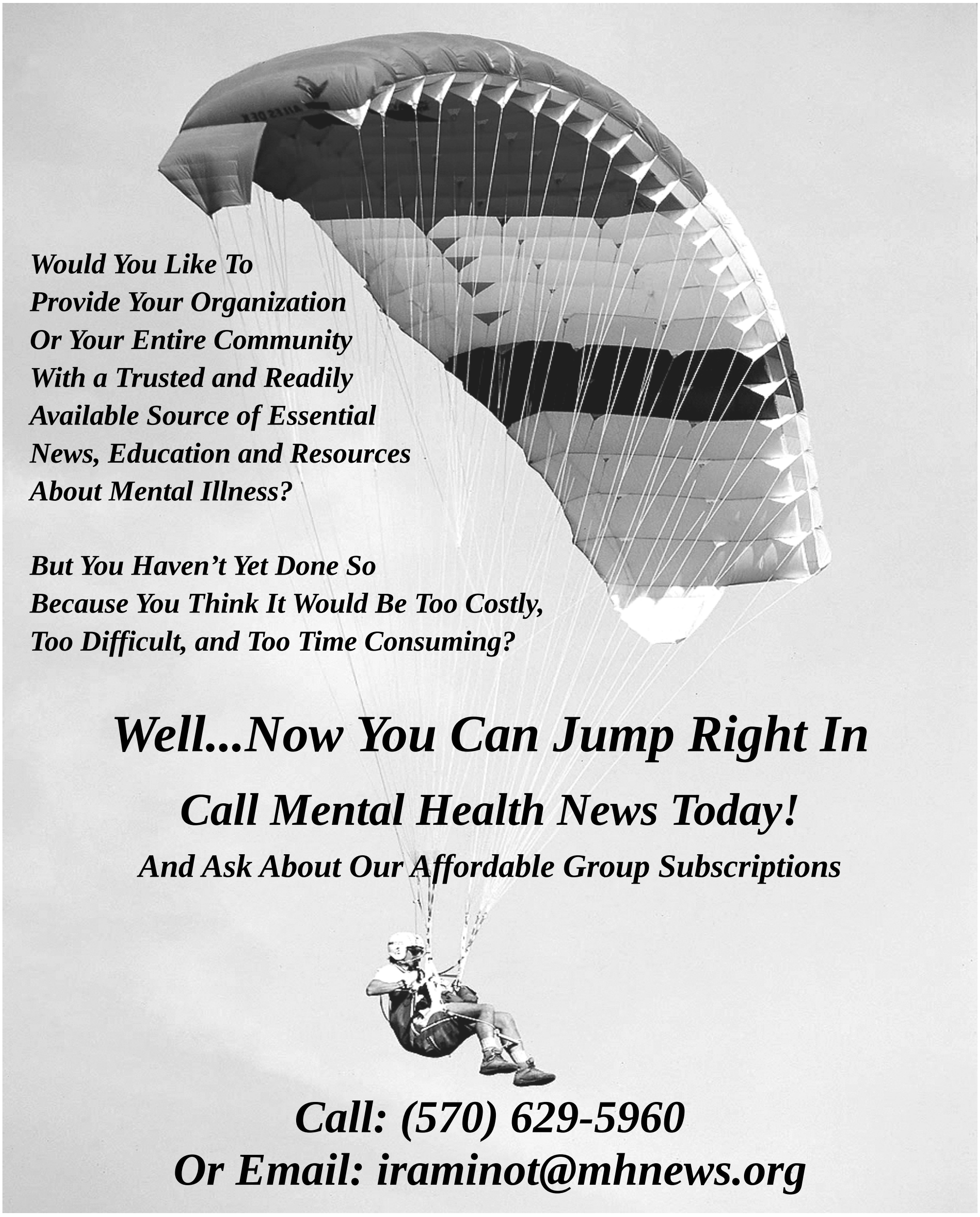
Don't feel embarrassed or afraid to ask for help, it is not a sign of weakness. Best wishes, from Mental Health News.



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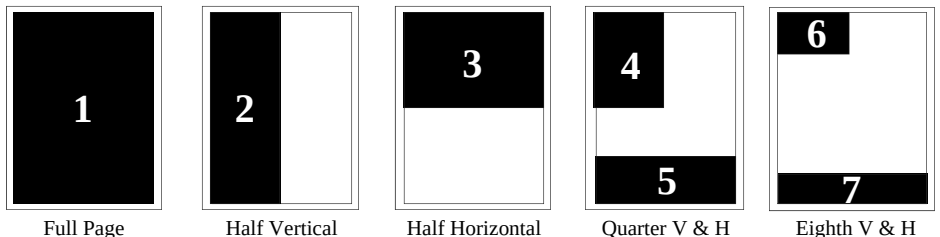

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