MENTAL HEALTH NEWS™

YOUR TRUSTED SOURCE OF INFORMATION, EDUCATION, ADVOCACY AND RESOURCES

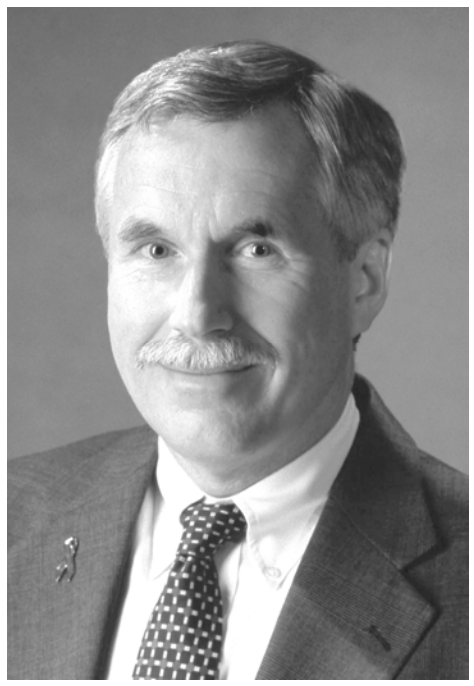
FALL 2012 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 14 NO. 4

Understanding and Addressing Our Medical Needs

Will We Need a Separate Mental Health System in the Future?

By Michael F. Hogan, PhD
Commissioner, New York State
Office of Mental Health

"If the new federal law equalizing coverage for mental conditions with that for medical-surgical care works as hoped, there may no longer he a need for a public system to handle mental health in the long run," says Michael Hogan, New York State's mental health commissioner.



Michael F. Hogan, PhD

This was the headline and lead on the Wall Street Journal's health blog April 16, 2010 story by Shirley Wang following my comments at a NYC mental health conference. (Sometimes you know there's a reporter in the crowd, and sometimes you don't.) In this case, however, I won't claim "I was misquoted." Rather, given our history and the road ahead, it's a good time for serious thinking about the future.

The theme is not new. In 1993, in an earlier era of (anticipated) healthcare reform, a group of state mental health commissioners met with the mental health task force, chaired by Tipper Gore, of the Clinton health reform effort. We had much to talk about. The Clinton reform proposal was to recommend universal health coverage, with mental health parity. Surely part of the conversation had to consider the role of the state public mental health systems.

The commissioner's group, meeting as an ad-hoc task force of the National Association of State Mental Health Program Directors, had already considered this issue. And so, when the question came: "If health reform includes universal coverage and full parity, are you willing to discuss folding state resources into the larger system?" we were prepared. And the answer was "Yes. We have lots to discuss...state responsibilities extend beyond healthcare, like forensic services and housing. These will need to continue. And we'll need a careful transition. But we should not maintain state systems if the alternative is being part of the mainstream."

Almost two decades later, the seemingly impossible future has been promised to the American people, with the combination of national healthcare reform, parity for both mental health and addiction treatment, and aggressive parity regulations that raise the bar on acceptable treatment. What can we expect in this new environment?

My crystal ball predicts two things about the future of separate public systems. It's a paradox. First, in the next couple of years, little will appear to change. The combination of uncertainty, phased-in implementation of the federal legislation and the "boiled frog effect" will mean that little is changing - or rather that few changes are apparent. (The "boiled frog" dynamic is cited in Peter Senge's Fifth Discipline: The Art and Practice of the Learning Organization, The story is that a frog placed in hot water will leap out. A frog in water that is slowly heated to boiling will not realize what is happening until it is too late. The dynamic, Senge argued, applies to human perceptions of complex change.)

The second prediction I am pretty certain about is that in 45 years distinct public mental health systems with state-operated and state-funded specialty services will no longer exist in anything like their current form.

Actually, I think the change will happen more quickly. But it's been 45 years since Medicaid (and Medicare) were created, so it is a useful analogue. Recall that,

see System on page 28

Mental Health News Interview with Jason A. Helgerson

Staff Writer
Mental Health News

Mental Health News is very pleased to present you with our recent interview with Jason A. Helgerson, Medicaid Director of New York State, and Executive Director of New York's Medicaid Redesign Team. New York's Medicaid program provides vital health care services to over 5 million New Yorkers and has an annual budget in excess of $54 billion. In addition, as Executive Director of New York's Medicaid Redesign Team (MRT), Jason is leading Governor Cuomo's effort to fundamentally reshape the state's Medicaid program in order to both lower costs and improve health care quality.

Jason A. Helgerson

Q: Thank you for speaking with us about many of the sweeping reforms now taking place throughout NYS under your leadership. How can Medicaid Redesign address the need to integrate medical and behavioral health services and enhance the quality of life for people with mental illness and substance use disorders?

A: We have heard over and over again throughout the MRT process how we need to more effectively integrate the medical and behavioral health needs of people who receive their health care through Medicaid. We also have learned about the need to break down the different silos within NYS's health care system which many feel have led to poor patient outcomes and higher program costs. These silos have a history of not being able to communicate with each other or work together, and information is not being shared between them. As a result, fragile individuals are falling through the cracks, their quality of life is declining, and the programs caring for them are incurring costs way beyond what can be achieved by creating a more integrated service delivery system.

The key to integrating medical and behavioral health services and enhancing the quality of life for people with mental illness and substance use issues are at the cornerstone of our new and emerging *Health Homes* initiative. Developing Health Homes are at the forefront of our effort to bring together disparate groups of providers. These providers have historically viewed each other as competitors rather than partners and have not necessarily shared information with each other, even though they have all touched some of our most complex patients in one way shape or form. We are bringing those groups together to form Health Homes which will be responsible for coordinating care and managing the needs of some of Medicaid's most complex patients, including people with serious behavioral health needs.

We think there's a tremendous opportunity here. The current system has not served this population well and Health Homes are a means and a strategy to integrate the medical and behavioral health services.

Q: Can you explain to our readers exactly what Health Homes are and how the average

see Interview on page 26

NON PROFIT
ORGANIZATION
U.S. POSTAGE PAID
MONROE, CT
PERMIT NO. 137

Mental Health News Education, Inc.
460 Cascade Drive
Effort, PA 18330

Mental Health News Education, Inc. Board of Directors

Chairman

Peter D. Beitchman, DSW, Executive Director
The Bridge

Chairman-Elect

Jorge R. Petit, MD, President
Quality Healthcare Solutions Group

Vice-Chairman

Barry B. Perlman, MD, Director of Psychiatry
Saint Joseph's Hospital

Secretary

Peg Moran, LMSW, Senior Vice President
F·E·G·S Health and Human Services System

Treasurer

Alan Trager, LCSW, Chief Executive Officer
Westchester Jewish Community Services

Members of The Board

Constance Y. Brown, MPA, Vice President, Corporate Community Relations
Institute for Community Living

Carmen Collado, LCSW, Director of Immigrant and Latino Services
Jewish Board of Family & Children's Services

Jonathan P. Edwards, LMSW, Assistant Director of Wellness and Recovery
Kings County Hospital Center

Alan Eskenazi, MA, CPHQ, Chief Executive Officer
Holliswood Hospital

Donald M. Fitch, MS., Executive Director
The Center For Career Freedom

Mary Hanrahan, LCSW, Government Relations Specialist
New York Presbyterian Hospital

Judith R. Omidvaran
Parent Advocate, New York

Theresa Pirraglia, Co-Founder and Board Member
The Foundation for Educating Children with Autism

Janet Z. Segal, LCSW, Executive Vice President
Four Winds Hospital

Alison Singer, President
Autism Science Foundation

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

Executive Staff

Ira H. Minot, LMSW, Founder & Executive Director
Mental Health News Education, Inc.

David H. Minot, BA, Associate Director
Mental Health News Education, Inc.

Mental Health News Thanks Our Sponsors for their Support

Platinum Sponsor

Nassau County Department of Mental Health
Chemical Dependency and Developmental Disabilities

New York City Department of Mental Hygiene

New York State Office of Mental Health

Westchester County Department
of Community Mental Health

Silver Sponsor

The Bridge

F·E·G·S Health and Human Services System

Services for the Underserved

Help Support Our Nonprofit Mission Become an Honored Sponsor of Mental Health News Education, Inc.

Benefactor Sponsor: $25,000

Benefactor Sponsors will receive two full page advertisements and article space in 4 quarterly issues of either Mental Health News or Autism Spectrum News. They will also receive multiple bundles of newspapers as needed for distribution to clients, staff, board members, and satellite programs.

Platinum Sponsor: $10,000

Platinum Sponsors will receive one full page advertisement and article space in 4 quarterly issues of either Mental Health News or Autism Spectrum News. They will also receive multiple bundles of newspapers as needed for distribution to clients, staff, board members, and satellite programs.

Gold Sponsor: $5,000

Gold Sponsors will receive one half page advertisement and article space in 4 quarterly issues of either Mental Health News or Autism Spectrum News. They will also receive several bundles of newspapers for distribution to clients, staff, board members and satellite programs.

Silver Sponsor: $2,500

Silver Sponsors will receive one quarter page advertisement in 4 quarterly issues of either Mental Health News or Autism Spectrum News. They will also receive one bundle (50 copies) of newspapers for distribution to clients, staff, board members, and satellite programs.

Bronze Sponsor: $1,000

Advisor Sponsor: $500

Friend Sponsor: $250

All Sponsors will receive recognition listing on our honor roll page in either Mental Health News or Autism Spectrum News

To Discuss our Sponsorship Opportunities Please Contact

Ira H. Minot, LMSW, Executive Director
Mental Health News Education, Inc.
460 Cascade Drive, Effort, Pennsylvania 18330
E-mail: iraminot@mhnews.org Phone: (570) 629-5960

Table of Contents

Mental Health News
2012/2013 Theme and Deadline Calendar

Winter 2013 Issue:

"Understanding and Treating Posttraumatic Stress Disorders"

Deadline: October 23, 2012

Spring 2013 Issue:

"Moving the Mental Health System Towards
a Person Centered, Recovery Oriented Approach "

Deadline: January 23, 2013

Summer 2013 Issue:

"Mind Over Body: Understanding and Treating Eating Disorders"

Deadline: April 23, 2013

Fall 2013 Issue:

"Housing and Employment: How Are We Doing?"

Deadline: July 23, 2013

To Submit an Article or Advertisement
Call Us Today: (570) 629-5960
Or Email: iraminot@mhnews.org

Mental Health News™

Is a Publication of Mental Health News Education, Inc, A Nonprofit Organization.
Mailing Address: 460 Cascade Drive, Effort, PA 18330
Phone: (570) 629-5960 E-mail: iraminot@mhnews.org Website: www.mhnews.org

Mental Health News Education, Inc. does not endorse the views, products, or services contained herein. We are not responsible for omissions or errors.

Letters to The Editor should only be sent to Mental Health News, and not to other publications. We do not publish open letters or third-party letters. Letters for publication should be no longer than 150 words, must refer to an article that has appeared in our last issue, and must include the writer's address and phone numbers. No attachments, please. We regret we cannot return or acknowledge unpublished letters. Writers of those letters selected for publication will be notified prior to press date. Letters may be shortened for space requirements. Send a letter to the editor by emailing: iraminot@mhnews.org.

Copyright © 2012 Mental Health News Education, Inc. All rights reserved. Content contained in this publication may be reproduced for one-time personal use. However, anyone wishing to reproduce and distribute any content from within this publication for purposes other than personal use, must request this intention in writing directly to the publisher. Failure to do so will be in violation of the copyright held by this publication.

— From the Publisher —
Declining Physical Health: The Other Side of the Recovery Process

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

When I was struggling through my 10-year battle with depression, the most prevalent thing in the back of my mind each and every day was a silent prayer to recover and no longer suffer with the daily feelings of hopelessness and despair that were the hallmarks of my illness. Nothing else mattered.

Now at age 61 and over twenty years since my illness began, I have paid dearly (as have many of my peers) for not paying more attention to my primary health care needs. I was a heavy smoker, I kept gaining weight, my cholesterol and blood pressure were in the danger zone, and I looked and felt like a man twenty years older than I was. I was not surprised when research reported that people with serious mental illness have a shortened life expectancy of between 10-25 years compared to healthy individuals.

Throughout my illness, recovery, and until only recently, my declining physical health seemed to be unimportant and an insurmountable problem that I was unable to address in a meaningful way. I am sure many of my fellow consumers can relate to my story and are struggling themselves with the same primary health care problems that I have gone through. It is timely then, that we take a closer look at the medical needs of people with mental illness and substance use disorders in this issue of *Mental Health News*.

Psychiatric Medications and Weight Gain

In recent years, it has been well documented that many psychiatric medications cause patients to gain weight. According to studies, weight gain may be minimal—only a few pounds over six months to a year. But in many more cases, the weight gain is medically significant, with many patients reporting at least a 7 percent increase in body weight. Such increases in body weight can raise the risk of many health conditions such as high blood pressure, high cholesterol, diabetes, heart disease, arthritis and some types of cancer. The reasons why psychiatric medications cause weight gain has to do with the effects these drugs have on our brain chemistry; they may improve our mood but they also affect our appetite, feelings of fullness when eating, our general metabolism and how our bodies store fat. During the course of my illness I was given a substantial variety of medications and combinations of medications meant to help alleviate my chronic depression. I experienced all sorts of side-effects as many of you can also attest to. Some of the typical ones were sleepiness, dry mouth, and even vision changes—which were especially aggravating because I wear glasses and had to constantly get new lenses with each new pill I was given. Some of the other side effects had to do with food. One medication I was given made everything I put in my mouth

Ira H. Minot, LMSW

taste metallic and not like what it should taste like. Other medications I was given produced cravings for sweets, carbohydrates, and gave me the feeling that I was never full—even after eating a full balanced meal. The sad thing is that some people (including myself) become so distressed at the weight gain side effects of their meds that they stop taking them, which may be more harmful if they were indeed helping them overcome a serious psychiatric condition. Like many things in life, coping with the side effects of psychiatric medications are a double-edged sword.

Quit Smoking: I Gained How Many Pounds?

Any person in their right mind (I guess some of us aren't) now knows the danger of smoking. Ok, I admit as a kid growing up in the 50's and 60's the Marlboro man made me believe that smoking was cool and real men smoked Marlboro's. They never mentioned anything back then about lung cancer, mouth and throat cancer and emphysema. Well, it turns out my older brother was also a smoker and unfortunately he didn't listen either; he now has serious emphysema, is homebound and requires oxygen therapy to stay alive. When I saw him recently I was crying inside because here was my big brother who I have loved and looked up to all my life, and his smoking related illness has robbed him of his stature, vigor and dynamic good looks and personality. Seeing him was like being struck by lightning and I went away thinking, "Wake up stupid and quit smoking." I did quit and have been smoke free for almost a year now.

How rough has it been since I have quit smoking? You have no idea. Even now, a year later, I think about smoking every day and I even dream about it at night. Oh and by the way, in the first 3 months I think I gained almost 30 pounds satisfying my craving for cigarettes and using food to comfort my added depression due to mourning the loss of a dear friend—the damn cigarette. For almost 50 years we had woken up together and spent every day with each other.

My primary care physician was thrilled that I quit. "I would rather you gain a few more pounds than continue smoking," he said to me. I felt proud of myself and saw each day as a new beginning to a healthier self. After a few months however, I was frantic about how heavy I had become and how tired I was every day—I thought I'd have all this new energy after I quit smoking. What was going on with me? I couldn't stay up for more than a few hours a day and I was napping all afternoon even after sleeping 7 to 8 hours a night!

Do You Feel Refreshed When You Wake Up in the Morning?

At my next doctor appointment a few months later I told him I couldn't take it anymore. Why was I so tired all the time? Several years prior to this I had complained about the same thing and doctors said I had a few minor blocked blood vessels in my heart, so they put me in the hospital and implanted 3 stents; the stents didn't make me any less tired. Last month when my doctor saw how upset I was, he asked me, "Ira, when you wake up in the morning, do you feel refreshed?" "No," I said, "Are you kidding me? I haven't felt refreshed in the morning for as long as I can remember!"

"I'm going to schedule you for a sleep study," he said. He suspected that I might have Sleep Apnea, and the only way to find out was for me to spend the night at a sleep lab. At the lab I would be wired up and the sensors would tell if I was sleeping normally through the night or being awoken constantly throughout the night with apneas (where you stop breathing because your airway is being constricted). Well my doctor hit the nail right on the head! I went for the sleep study and we found out that I indeed have what is called Obstructive Sleep Apnea. In the five hour period I was wired up in the lab, I had over 160 episodes while sleeping where I stopped breathing. It was clear to me that I had probably been experiencing this for years and it could account for a host of physical maladies I was trying to cope with. Sleep Apnea affects millions of people and those most prone to it are overweight to begin with. The treatment for Obstructive Sleep Apnea is to sleep with a CPAP (Continuous Positive Airway Pressure) machine which is a breathing device you wear at night that forces pressurized air into your mouth and nose to open the airways to your lungs. In part two of my sleep lab study, I went in again and this time slept a few hours hooked up a CPAP device. During the few hours I was able to sleep with CPAP, I had NO apneas. A few days later I picked up my CPAP machine to use at home.

My Obstructive Sleep Apnea is definitely linked to my feeling tired and napping every afternoon. I read that it could also contribute to depression, which in turn makes it difficult to feel like exercising, and so you continue to gain weight. If that isn't a vicious cycle I don't know what is. I have been using my CPAP machine for over three weeks and I feel better already! I am finally getting restful and therapeutic sleep every night and my daily energy reserves are on the rise.

What I Have Learned

Nothing in my life has been worse than battling severe depression for 10 years. How I ever survived that I will never know. But I did survive and I went on to devote myself to bringing mental health education to many people in the community. I have learned that we all make mistakes, we all have faults, and some of us don't always take good care of ourselves as we should. I think some people must have a special gene that enables them to never get depressed, to push through even the most difficult times in their lives, and to do what's best for their health and well-being. On the flip side of that I have found that, even as I turn 61, I am learning new things about myself every day. We can change, we can learn to take better care of ourselves, and you must never give up trying.

New Reforms in Behavioral Health

It is said, "To everything there is a season, and a time to every purpose…" And so it goes for new changes in the behavioral health landscape. I think the integration of primary care with behavioral health taking place across the country is a good thing. The more we can encourage people to think about the importance of maintaining both their physical and mental health the better - even though it might not sink in right away for many. Sometimes, people have to find out for themselves in their own way and in their own time.

My Prescription: Do Something Every Day to Make Yourself Laugh

In Woody Allen's funny 1973 movie *Sleeper*, there is a scene where two doctors are discussing Woody's unusual behavior after waking him up 200 years into the future:

Dr. Melik: This morning for breakfast he requested something called wheat germ, organic honey and tiger's milk.

Dr. Aragon: [laughing] Oh, yes. Those are the charmed substances that some years ago were thought to contain life-preserving properties.

Dr. Melik: You mean there was no deep fat? No steak or cream pies or hot fudge?

Dr. Aragon: Those were thought to be unhealthy... precisely the opposite of what we now know to be true.

They say laughter is the best medicine. I think there is something to that. Since my recovery I have made an effort to enjoy some form of humor that makes me laugh and smile each day. The more I laugh and the more I smile, the better I feel. And there is nothing wrong with that. Try starting your day with a cartoon, a funny YouTube video, or if you like the funny antics of dogs and cats like I do, visit one of my favorite silly websites, www.icanhascheezburger.com and LOL (Laugh Out Loud!). Good luck in your recovery!!

Integrating Health and Behavioral Health Services: A Personal Perspective on One Agency's Experience

By Peter D. Beitchman, DSW
Executive Director
The Bridge

In 1984, at the very first senior staff meeting I attended when I arrived at The Bridge (the non-profit mental health and substance abuse rehabilitation agency in New York City) the spotlight was on client healthcare issues. Our then part-time psychiatrist had recruited a heroic primary care physician friend who was wiling to accept the Medicaid payment (then some pitifully small amount) to conduct a full primary care screening of 10 randomly selected Bridge clients, all of whom were diagnosed with serious mental illness. At that first meeting I attended our psychiatrist reported the results: the 10 clients had almost 70 documented medical conditions that were serious enough to require treatment.

What to do? For a few years the heroic primary care doctor treated those 10 clients (and a few others) and we gave him a beautiful plaque in gratitude. But we had many, many more clients that needed medical care who the doctor could not take on because of the economics of his practice. Since there was no government funding stream that mental health agencies could use to provide primary care services, we turned to foundation support for a number of years. Beginning in the late 80s, with foundation funding, we engaged a part-time nurse who conducted some very basic health screening (no lab work), and worked with staff to identify medically needy clients and refer them to providers in the community, primarily hospital clinics (although few hospitals had primary care clinics at the time). Still, far too many clients were using emergency rooms as their primary care doctor and far too many continued to have untreated medical conditions.

In the early 1990s we became aware of a new potential resource: the Rent-a-Doc Program operated by St. Vincent's Hospital. For a fixed sum (the program did not bill Medicaid for its services) a primary care physician and LPN would provide part-time hours on site at The Bridge. We couldn't resist, given the level of medical need and the dismal experience of our clients using the healthcare system. But we had to accomplish two tasks: raise enough money to pay for the team and provide them with a proper space. Both tasks involved substantial fundraising which the board and staff dedicated themselves to and managed to accomplish.

The arrangement worked beautifully. The St. Vincent's team occupied a space in or headquarters building which also housed our day treatment, mental health clinic and vocational programs. We wrote out an annual check to St. Vincent's and more than 200 clients received excellent primary care.

The problem was sustainability. We exhausted the funding from the foundations that supported the initiative. It was then that we forged our ongoing relationship with the William F. Ryan Community Health Center, a Federally Qualified Health Center (FQHC) that provides services in numerous Manhattan neighborhoods.

Peter D. Beitchman, DSW

The partnership with the Ryan Center is now more than a decade old. Due to increasing demand, and with a recent Federal grant to do some renovation work to qualify the space, the Ryan Center will expand its Bridge services to 40 hours a week. The arrangement is simple: Ryan bills Medicaid for its services; their billing does not interfere with Bridge billing for its mental health and substance abuse services. The Bridge provides the space free of charge, Ryan provides its own equipment and supplies.

Communications between Ryan and Bridge staff is a priority. When Bridge clients enroll in the Ryan clinic they sign a bi-directional release allowing Ryan and Bridge staff to share medical information. Formal and informal staff communications occur on an ongoing basis.

The results of this partnership are outstanding. A record number of Bridge clients are receiving primary care services with follow up specialty services provided by St. Luke's Roosevelt Hospital. Clients with serious medical conditions are treated and tracked closely by Ryan and Bridge staff. It's not surprising that the FQHC partnership model with community behavioral health agencies has been singled out as an effective means to integrate care. We at The Bridge have so many stories of lives saved and lives improved.

At the Bridge, a crucial complement to providing the opportunity for more integrated services was offering clients the *Wellness Self-Management Program* developed jointly by the Urban Institute for Behavioral Health and NY State Office of Mental Health. *Wellness* provided participants with vital health information to help them achieve and maintain overall physical health and psychiatric stability. Through participation in the Wellness program Bridge clients got a great deal of new information and many developed motivation to change both their basic health and healthcare-seeking practices.

Responding to the Complex Needs Of Older Clients

The Bridge, like other community-based behavioral health agencies that work with seriously mentally ill adults, is also serving a rapidly increasing number of aging clients who have co-occurring serious medical conditions. This is particularly challenging for housing providers. Too often when agency staff is not able to provide the services needed to maintain clients in housing, the result is a move to a nursing home.

In 1997, The Bridge opened Sheridan Hill House, a residential program for 24 older adults who have serious mental illness and serious medical conditions. Each resident lives in a full Class A studio apartment. In order to meet the medical needs of the residents The Bridge formed a partnership with the Lifecare Division of the Jewish Home and Hospital. Lifecare provides a nurse practitioner on site at Sheridan Hill House who provides primary and follow up care for residents. The Lifecare nurse practitioner also works closely with Bridge staff in coordinating medical and related services and leads client health education groups. In addition to enhanced medical services a cook prepares diet-healthy meals (often with fresh vegetables and herbs from our nearby urban farm) and provides individual and group nutrition education.

As a model, Sheridan Hill House provides residents with an independent community living setting while addressing their medical needs, and avoiding nursing home placements. The medical needs of its residents are substantial. Currently six residents are in wheelchairs; 20 of 24 residents have serious hypertension; 12 have diabetes; 5 with history of stroke; 4 are undergoing cancer treatment; and 9 have COPD.

With the aging of the mental health population, it is critical that we develop housing and service models to meet their special needs. Sheridan Hill House is a promising model that, for a small fraction of the cost of nursing home care, provides integrated behavioral and healthcare services that achieve the goals of extending independent living in the community and addressing residents' critical medical needs.

Integration of medical and behavioral health services still poses challenges. Certainly the reforms of the New York's Medicaid Redesign Team recognize the need to coordinate and integrate medical and behavioral health services. The implementation of health homes, in particular, reflects a recognition of the importance of integrated services. As other Federal and State reforms are rolled out – the establishment of Accountable Care Organizations, bringing behavioral health services under a managed care umbrella – the needs of people with serious behavioral conditions must be recognized and at the forefront of system and program design.

The Bridge
MENTAL HEALTH AND HOUSING SOLUTIONS

Recovery-oriented services for over 1,800 individuals with serious mental health conditions in New York City

PROS
HOUSING
VOCATIONAL SERVICES
MENTAL HEALTH CLINIC
PEER-TO-PEER PROGRAM
CREATIVE ARTS THERAPIES
INTEGRATED PRIMARY HEALTH CARE
DUAL-FOCUSED MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT

Centralized Intake For All Services
Call: (212) 663-3000, ext. 372
For more information contact us:
248 W. 108th Street
New York, NY 10025
(212) 663-3000
Visit our website: www.thebridgeny.org

Healthy Living: A Self-Management Toolkit Promoting Full Recovery

By Rosemarie Sultana-Cordero, MA, LMHC, Marcia Titus-Prescott, RN-BC, Sonia Barolette, RN, Jennifer Meister, LCSW, Elisa Chow, PhD, Ruth Chiles, RD, Jeanie Tse, MD, and Peter Campanelli, PsyD, of the Institute for Community Living (ICL)

If you have ever tried to quit smoking or lose weight, you might recall the difficulty you had sticking to your goal. Add the challenge of managing a serious mental illness (SMI) and these health goals can become daunting. However, the pursuit of these goals has become central to addressing the staggering reality that people with serious mental illness die 25 years younger than the general population of treatable and preventable medical conditions, including heart disease, stroke and diabetes. This health crisis has moved many organizations towards making the delivery of physical health care an integral part of behavioral health services—treating patients holistically rather than only "from the neck up."

A Best Practice Approach

At the Institute for Community Living, Inc. (ICL), a New York City not-for-profit serving over 10,000 people with mental illness and substance abuse, a multifaceted approach to integrating physical and behavioral health services has been informed by the Chronic Care Model (CCM), which identifies the elements of a best-practice health care system for disease management, as well as the Four Quadrant Clinical Integration Model, which recommends nursing-supported care coordination for people with the highest levels of both behavioral and physical health needs.

Disease self-management is one of the key best-practice elements in the CCM. For people with SMI, self-management often begins with education, addressing the low level of health literacy—the ability to understand health information and its personal implications in this population. To this end, ICL has developed an integrated health toolkit that centers on the use of motivational interviewing (MI) to engage people around health education and as a therapeutic agent of change. These self-management tools are coupled with provider-oriented medical risk management tools that help to identify consumers with high risk medical conditions so that their needs could be addressed by the multidisciplinary team.

The Healthy Living Program and Toolkit

To assist ICL's behavioral health workforce (largely bachelor's level case managers working in residential and outreach settings) in using MI with persons served, the *Healthy Living Workbook* was created. This illustrated workbook is written at a grade 5 reading level and covers a range of topics pertaining to general/ preventive health. A modular style allows topics to be covered in any order and in varying levels of detail—worksheets can be pulled out to be discussed on their own. The health areas covered are: (1) Caring for your mental health; (2) Taking charge of check-ups; (3) Being physically active; (4) Choosing healthy foods; (5) Talking about sex; (6) Taking medication; (7) Taking care of my teeth; (8) Quitting smoking; and (9) Using the ER. Additional modules are available on COPD and Hepatitis C.

The workbook asks questions, in a MI style, about a person's health experiences and goals. Questions such as, "What changes have you thought about making,?" "How would your life be different if you made that change?" and "What would you have to give up if you made that change?" woven into the psychoeducational text of the workbook, facilitate the use of MI language in group and individual conversations around health behaviors. At the end of each chapter, an "Are you ready?" page provides a self-assessment of stage of change, and recommends moving forward to a commitment to action only if there is sufficient change readiness. If there is a commitment, "Action Steps" pages facilitate the development of specific, concrete, and achievable plans for change, and "Action Step Review" pages encourage self-evaluation of the change process. Small steps successfully taken accrue to generate momentum towards lasting change.

These self-management workbooks are accompanied by toolkits designed to address systems barriers to health integration. A key toolkit item is the pocket-sized *Healthy Living Info Card* that facilitates timely collection and tracking of primary health indicators, including weight. On the back of the card are several suggested questions to ask a primary care provider, including, "How can I improve my food choices and physical activity?" that are meant to develop the "informed, activated patient" featured in the CCM. Other tools are more staff-oriented, including "Clinical Pathways" algorithms that take staff step by step through evidence-based/best practice assessment and treatment for disorders. Medical risk screening forms designed to identify persons with higher levels of health risk and needs are used in ICL's programs and are reviewed in monthly team discussions involving case managers, clinicians, supervisors, and nursing staff. All tools are available in the "Clinician's Toolbox" on the desktop of every computer across ICL.

Agency Implementation

The *Healthy Living Toolkit* was piloted in 49 behavioral health programs across ICL, including residential, case management, shelter, clinic, ACT and outreach programs, starting in January 2009. With funding from the New York Community Trust and Brooklyn Community Foundation, training was provided to 146 behavioral health workers. Almost 1400 individuals participated in groups and/or individual counseling. Eighty-three individuals were able to participate in cooking demonstrations, and 27 participated in a 12-week cooking skills course. One hundred individuals participated in a ICL in-house physical activity program.

The Healthy Living Questionnaire, a 15-item self-report measure that includes the SF-8 Health Outcomes Questionnaire and 7 questions regarding health behaviors covered in the Healthy Living Workbook, was administered to participants on a voluntary basis at quarterly time points. This measure is used as a clinical tool to help staff to start conversations and provide feedback to people regarding their health. A significant improvement on the question, "During the past year, how often did you visit your primary care provider?" was found at every quarter. Participants in the physical activity program had significant decreases in weight, BMI and waist circumference after 6 months of participation.

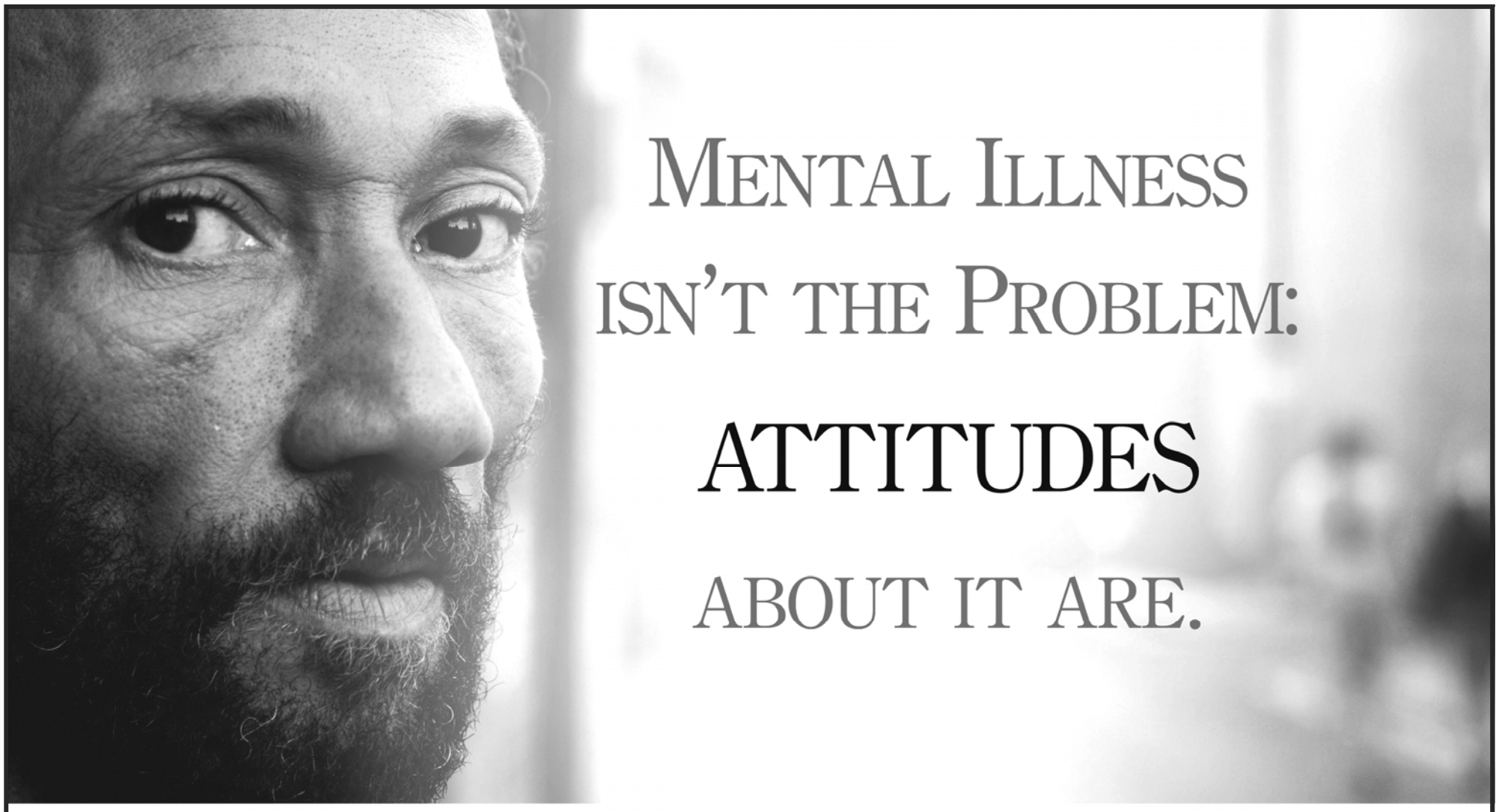
ICL has recently received funding through the New York State Health Foundation and the New York Community Trust to enhance the Healthy Living program in its mental health clinics in Brooklyn. ICL's vision is to demonstrate the mental health clinic as an important port of entry to integrated health care for people with SMI—to create a behavioral health medical home to best serve these consumers. Mental health clinicians, who often have a closer relationship with a person with SMI than does any other provider, are well-placed to serve as the pivotal contact in integrating health services.

Using grant funds, ICL has been able to introduce a registered nurse in its clinics to work with clinicians to work with people who have been poorly served by the mainstream medical system, engaging them in discussions about their health and facilitating referrals and collaboration with health providers. Clinicians receive monthly disease management trainings with the nurse, with a focus on how common medical conditions affect mental health, and vice versa. Healthy living groups have started in two clinics, and cooking demonstrations have enhanced and changed the clinic experience and culture. Thus far, these services have been well-received, and ICL anticipates that they will continue to fill an important gap in community services.

Rosemarie Sultana-Cordero, MA, LMHC, is Clinical Coordinator, Integrated Health, Marcia Titus-Prescott, RN-BC, is Associate Director of Nursing and Associate Director of Integrated Health, Sonia Barolette, RN, is Nurse Project Manager, Integrated Health, Jennifer Meister, LCSW, is Specialist, Program Design, Evaluation and Systems Implementation, Elisa Chow, PhD, is Director of Outcomes Evaluation, Ruth Chiles, RD, is Director of Nutrition Services, Jeanie Tse, MD, is Associate Chief Medical Officer and Director of Integrated Health, and Peter Campanelli, PsyD, is Chief Executive Officer, at the Institute for Community Living

Give Someone in Need the Gift of Hope:

A Gift Subscription to Mental Health News - See Page 31 for Details



Respect. Realize. Reconsider. Ignorance is not bliss. 1 in 4 adults suffers from a diagnosable mental disorder each year.

As a mental health advocate, you know the importance of compassion and understanding. To be effective in empowering those with serious psychiatric illness, mental retardation and/or developmental disabilities, we must work together. With over 25 years in the mental health field, the Institute for Community Living is here when you need us, with:

- *85+ programs in Brooklyn, Manhattan, the Bronx, Queens and Montgomery County, PA*
- *Specialized housing options for adults, families and teens*
- *Mental health clinics*
- *Evidence-based treatment and best practice approaches*
- *HealthCare Choices, a clinic integrating medical and mental health care*
- *National and state recognition*
- *CARF 2007-2010 accreditation for community housing, therapeutic community and outpatient treatment programs*

Call us any time, toll-FREE at: (888) 425-0501
or visit our website at: www.ICLinc.org

ICL
INSTITUTE FOR Community Living
Improving Lives, Building Hope, Empowering People

Meeting the Medical Needs of People with Serious Mental Illness: Will New Initiatives Work?

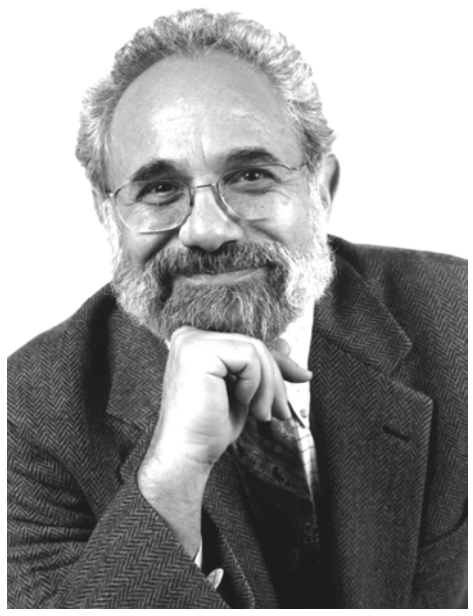
By Michael B. Friedman, LMSW
Mental Health Policy Advocate

On average, people with serious mental illness die at a much younger age than people without serious mental illness. Estimates range from about 10 to 25 years younger. They are also much more likely to have serious physical disorders including obesity, high blood pressure, diabetes, heart disease, pulmonary conditions, hepatitis, sexually transmitted diseases, and HIV/AIDS. Unfortunately, psychiatric medications that reduce acute symptoms of mental illness can heighten the risk of obesity and its sequelae. Smoking, which is much more common among people with serious mental illness than those without, also has dreadful health consequences. In addition, because people with serious mental illness are more frequently victims of crime than people without serious mental illness, they are at high risk for injuries, which heal but wear down physical strength and resilience over time. And, because they are more frequently homeless, exposed to extreme weather conditions, and without access to adequate facilities for bathing and toileting, they are at high risk of developing skin conditions and infections that can be serious enough to be life threatening. These risks are greatest for people with co-occurring serious mental and substance use disorders.

Addressing medical needs was nominally part of the original community support program initiative in the late 1970s. But without targeted funding for this population, it fell to the generic physical health care system to meet their needs, which it did poorly. Access to health care has been limited, access to good health care even more limited. In part, this reflects the failure of the health care system—despite growing reliance on Medicaid—to provide good treatment for poor people. In part, it reflects the very common discomfort of physical health care providers with people who exhibit signs of mental illness.

Over the past decade, mental health providers and policy makers have become concerned about the failure to address the physical health needs of people with co-occurring disorders. In part, this concern was driven by the "discovery" of the vast mortality gap between people with serious mental illness and the general population. But in large part, the concern has become a policy priority because of the realization that the most costly Medicaid cases are usually people with serious co-occurring disorders. Failure to anticipate and to provide adequate treatment for conditions that will become critical and require long-term inpatient care results in a very high portion of Medicaid costs (perhaps 70% or more) for non-institutionalized populations.

Four major approaches have emerged to meet the medical needs of people with behavioral health conditions, including: (1) integrated physical and behavioral health care, (2) integrated managed care, (3) health promotion and (4) management of the use of psychiatric medications.



Michael B. Friedman, LMSW

(1) Physical and behavioral health care can be integrated either in a physical health care setting or in a behavioral health care setting. The expansion of "medical homes," which are required to integrate behavioral health into physical health care, may be helpful for many people with physical and mental disorders. But for people with serious mental and/or substance use disorders who are engaged in treatment or rehabilitation for behavioral health conditions, it makes sense to build medical care into their behavioral health programs as much as possible. This can be done by including physical health care providers on the staff of the behavioral health program or through establishing formal arrangements for staff of physical health care organizations to work at the behavioral health care site.

The specialized physical health services that people with serious behavioral health conditions often need can also be provided by establishing physical health clinics that specialize in serving people with mental disabilities or substance abuse disorders.

It is also possible to achieve some degree of integration through informal, collaborative relationships between physical and behavioral health providers. After all, the essence of effective integration is actual communication and collaboration. That does not require a formal relationship. And, it is important to keep in mind that a formal relationship does not guarantee actual collaboration.

(2) Policy makers have become convinced that the best way to address the need for integration is with much more extensive Medicaid managed care. "Health homes," which emphasize coordination of services for people with chronic physical and/or behavioral health conditions and for which a federal financial incentive was created as part of health care reform, are one of the major new mechanisms for achieving integrated care. More comprehensive "special needs plans" and "accountable care organizations" are also under development.

(3) Health promotion, now called "wellness" promotion, has also become a major component of the overall effort to address the medical needs of people with serious mental illnesses. These emphasize smoking cessation, weight loss, good nutrition, exercise, and responsible management of serious chronic illnesses such as diabetes. The use of peers to help others to engage in wellness activities and to manage their illnesses is becoming increasingly widespread as part of this process.

(4) Programs to improve the use of psychiatric medication have also emerged. These medications are valuable for many people, quelling acute symptoms and enabling them to develop satisfying lives. But they have side effects, including obesity, which contributes to high blood pressure, diabetes, and heart disease. Psychiatric medications are also problematic because accidental overdoses appear to be a major contributor to the mortality gap.

Virtually all states now have preferred drug programs in Medicaid, which are primarily designed to reduce Medicaid costs but which also claim to be designed to improve physician's prescribing practices. Some states have instituted initiatives that provide training regarding the appropriate use of psychiatric medications and monitoring of prescribing practices. For example, in New York State, the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) "uses administrative data to generate quality indicator reports for use in quality management and clinical decision-making."

These initiatives are promising, but it is not clear yet whether they will succeed in improving the physical health of the overall population of people with serious mental illness or in reducing the mortality gap. And there are reasons for concern that they will not be effective.

Integration of care within the mental health system and between the mental health and substance abuse systems has been an elusive goal since at least 1977 when it was set as one of the two major goals of the community support program. There are examples of somewhat effective coordination of systems and care, but the complaint that the systems are fragmented and operate in "silos" has not abated over the past 35 years. Obviously, achieving integration is easier said than done.

Now the effort is underway to integrate the behavioral health systems (not themselves adequately integrated) with the physical health care system. This will probably be even more difficult than integration of behavioral health care services. It will not be surprising if there ends up being more lip service than achievement. This appears to be true already with regard to medical homes, where the requirement to integrate physical and behavioral health care is so weak that some physicians' groups have gotten formal "recognition" as medical homes without providing any behavioral health care at all.

Managed Care: The use of more extensive managed care in Medicaid is also of questionable promise. The goal is admirable—to engage people with serious behavioral and/or physical health conditions in care before they are in crisis and need extensive and very expensive treatment. In theory, expanded Medicaid managed care will result in more aggressive outreach to engage people in services. But the administrative complexity of these initiatives is so great that, at best, they will take years to work. In the process they will consume a great deal of money, money that could be better invested in, for example, an expansion of assertive community treatment programs. Will Medicaid managed care ultimately save money spent on unnecessary and expensive forms of treatment, and will those savings be reinvested in expanded community-based care? That is yet to be seen. In general, it is just not clear that health homes, special needs plans, and accountable care organizations will result in improved integration of care in the field and better health outcomes for people with serious mental illness.

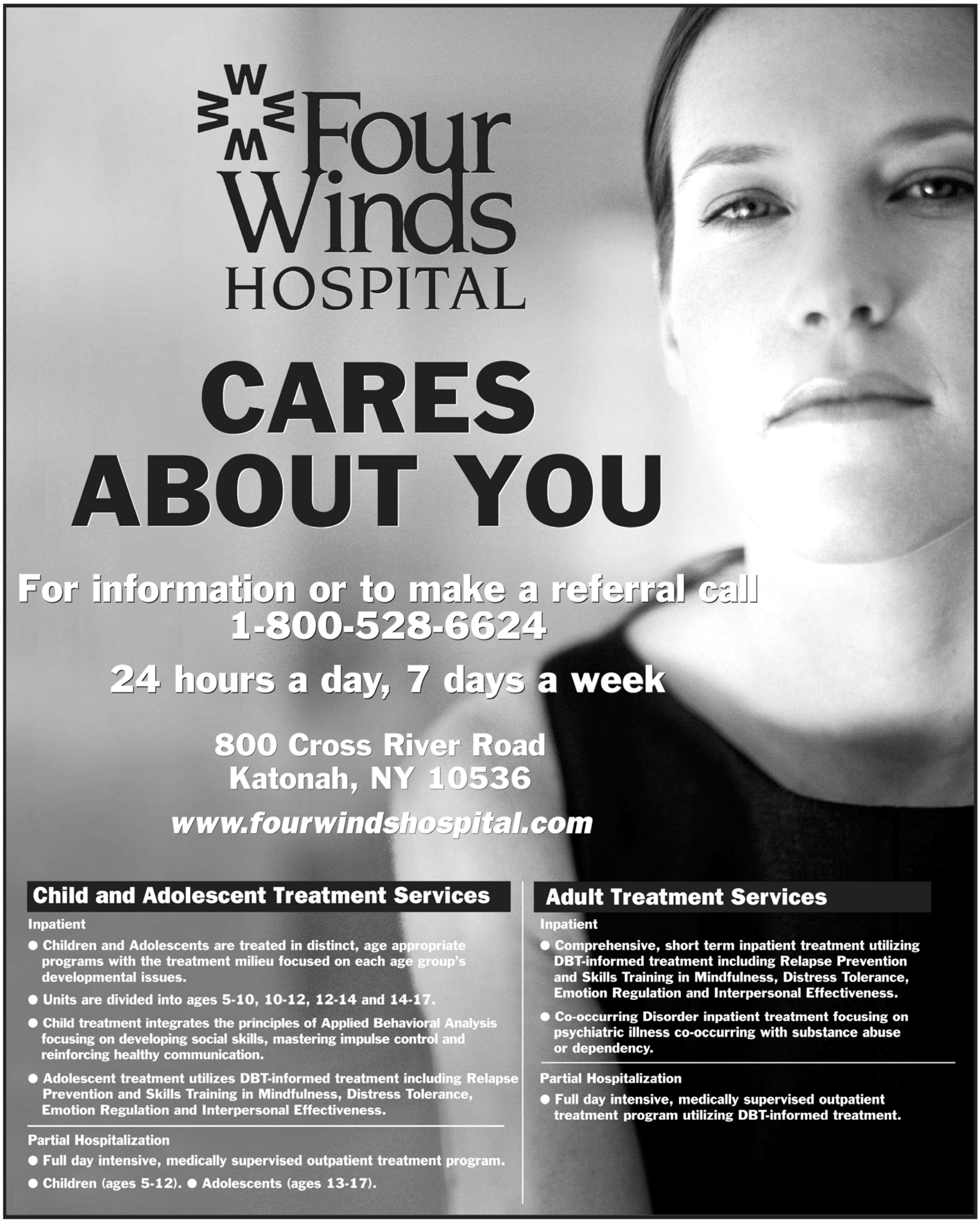
Wellness initiatives are also promising, but it is far from clear that they will be effective enough to make a significant difference in health outcomes. Of course people with serious mental illness who smoke should stop, but this is a tough addiction to break for everyone and all the more so for people who appear to get a psychological benefit from smoking. Weight loss is also much to be desired, but will wellness initiatives help people with serious mental illness keep their weight under control? Maybe, but weight control is exceedingly difficult in a nation in which obesity has become a major problem even among people not taking medications that stimulate appetite. The use of peers to help people with serious mental illness to stop smoking, lose weight, eat well, get exercise, and manage their illnesses appropriately is also very promising. But again, it is not yet clear that this will all result in improved health outcomes and longer life for most people with serious mental illnesses.

Managing Medication Use: There are also reasons for concern about programs designed to improve the use of psychiatric medications. It is not at all clear that preferred drug programs result in overall savings if added inpatient costs due to failure to provide appropriate medication are taken into account. More importantly, it is not at all clear that preferred drug programs result in improved prescribing practices.

Programs like PSYCKES in New York State are more promising, but may not address the fundamental question about psychiatric medications. Do they contribute to reduced life expectancy even when they are used well?

Life On The Streets: It is very important to note that none of the current initiatives address one of the major reasons for the poor health and premature deaths of people with serious mental disorders, especially those who are also addicted to alcohol or other drugs—the dangers of life on the streets. Stable housing is the

see New Initiatives on page 30


Four Winds HOSPITAL
CARES ABOUT YOU
For information or to make a referral call
1-800-528-6624
24 hours a day, 7 days a week
800 Cross River Road
Katonah, NY 10536
www.fourwindshospital.com
Child and Adolescent Treatment Services
Inpatient
● Children and Adolescents are treated in distinct, age appropriate programs with the treatment milieu focused on each age group's developmental issues.
● Units are divided into ages 5-10, 10-12, 12-14 and 14-17.
● Child treatment integrates the principles of Applied Behavioral Analysis focusing on developing social skills, mastering impulse control and reinforcing healthy communication.
● Adolescent treatment utilizes DBT-informed treatment including Relapse Prevention and Skills Training in Mindfulness, Distress Tolerance, Emotion Regulation and Interpersonal Effectiveness.
Partial Hospitalization
● Full day intensive, medically supervised outpatient treatment program.
● Children (ages 5-12). ● Adolescents (ages 13-17).
Adult Treatment Services
Inpatient
● Comprehensive, short term inpatient treatment utilizing DBT-informed treatment including Relapse Prevention and Skills Training in Mindfulness, Distress Tolerance, Emotion Regulation and Interpersonal Effectiveness.
● Co-occurring Disorder inpatient treatment focusing on psychiatric illness co-occurring with substance abuse or dependency.
Partial Hospitalization
● Full day intensive, medically supervised outpatient treatment program utilizing DBT-informed treatment.

Building a Recovery Toolbox

By Vickie Griffiths, JACS Program Coordinator
Jewish Board of Family and Children's Services (JBFCS)

Imagine that you are battling a mental health issue (problem, disorder, challenge). You see a therapist, receive medication, and find healthful ways to live your life. Now add in a *second* disorder. And then, top that off with an addiction! Many people facing these complex mental health challenges learn to hide their struggle from public view. Is facing this kind of ordeal inevitably overwhelming? Or can it sometimes be an inspiration to hone every coping mechanism and recovery skill you have ever learned? Vickie Griffiths, JBFCS' JACS (Jewish Alcoholics, Chemically Dependent Persons and Significant Others) Program Coordinator, tells one woman's story about dealing with multiple diagnoses, and aging, all while fighting to stay sober.

"Ida" lives in a continual struggle with anxiety and addiction. She's not sure which came first—her love of escaping, or the pain she felt from repeatedly anticipating the "worst-case scenario." Either way, living in recovery from such disorders doesn't make it easy to lead a calm, orderly life. To help herself, Ida developed a "toolbox" that she can rely on, full of techniques and skills for how to navigate stressful situations. Being in recovery means learning to build and stock such a

Vickie Griffiths

toolbox, the way that most "normal" people do to overcome life's many stresses.

Ida's recovery toolbox has replaced her alcohol and drug use, escapism, and other destructive behaviors. It has helped Ida develop a habit of steady mindfulness. Faced with life's stresses, "the burning building" as Ida calls such situations, she is now able to look in her toolbox, assess the threat, and figure out how to get out of danger. But to do this, she still must deal with her mounting anxiety and dampen her desire to "use."

Ida does not want people to look at her with pity, as a "sad story." In fact, Ida feels that she and her family have been blessed with many miracles. She and her husband found in each other the love and support they lacked in their own families of origin. They have now been married for more than 30 years, and have three adult children and five grandsons. Ida's husband has had his own problems with addictions (he's been clean and sober from one for 37 years and for 24 years from the other). Along the way, they have overcome many stumbling blocks including a range of serious illnesses, family conflict, estrangements, even deaths. But they persevered and built a loving, happy home and extended family.

However, a new challenge has recently emerged, perhaps the most difficult they have had to face. Ida's husband has been diagnosed with Frontal Temporal Dementia, a terminal and, as yet, incurable condition in which the front part of the brain literally disintegrates. Life expectancy from diagnosis is, on average, two to eight years—and it's not a pretty path. Accepting her husband's fate raised Ida's anxiety level sky high. So did telling their children. Through it all, Ida told herself she had to keep sober. She started digging through her toolbox to see what she already had and what she would need to develop. She went to daily 12-step meetings, making staying sober a priority. And she also had to work on helping her partner maintain his sobriety in the face of this new reality.

When Ida's anxiety rises, her first reaction is to want to not feel, to not accept the distress of the situation, to find a way to avoid what is actually happening. "Not feeling" means taking pills and drinking. But resorting to past "solutions" wasn't an option Ida would allow herself. No matter what, Ida was determined to remain clean. She and her husband have long been a team. Now, the partner "left standing" must remain mindful and in charge, to stay healthy and survive. Ida vows to "strengthen her backbone," and feels that taking on this greater responsibility will help her do so.

Not that this is at all easy. Even simple communication can create chaos when dealing with a loved one who has FTD. Communicating when feeling anxious adds its own pressures. And when both parties feel the escape of addiction tempting them, success is definitely not guaranteed. So, for Ida, "administering her own oxygen first" (as the flight attendants always remind us) has had to take precedence.

And, of course, there's laughter—the all-time best healer! Ida came home from work on a sweltering 90-degree day to find her husband wearing his red flannel pajamas, with all the windows closed. Ida, of course, had to use the facilities. But her

see Toolbox on page 30

YOU ARE NOT ALONE.

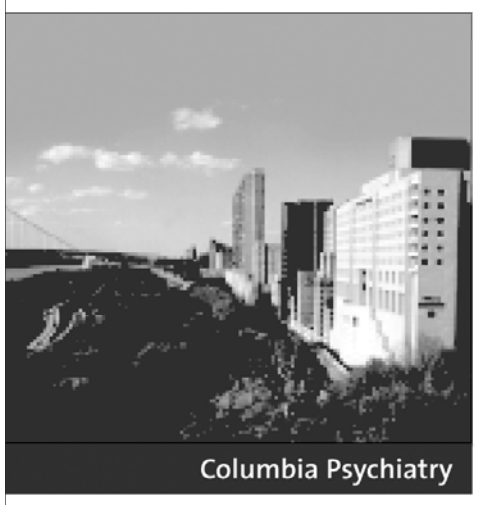
JACS (Jewish Alcoholics, Chemically Dependent Persons and Significant Others) is here to provide support, comfort, connection, and guidance in difficult times related to addiction. Through retreats, sober holiday programs, 12-step meetings, community education, and links to people who have been through what you're going through and have rebuilt their lives, JACS gives you a safe and confidential support network of Jews in recovery. Reach out to people who care! You are not alone! Call us and we'll be there for you: **212-632-4600** or **jacs@jacsweb.org.**

JACS

jbfcs
175 social service programs.
1 mission.
To get help to those who need it.

a beneficiary of UJA Federation of New York

NEWYORK-PRESBYTERIAN PSYCHIATRY


Columbia Psychiatry


Weill Cornell Psychiatry/Manhattan


Weill Cornell Psychiatry/Westchester

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

Columbia Psychiatry
(212) 305-6001

Weill Cornell Psychiatry
(888) 694-5700

NewYork-Presbyterian Psychiatry provides a full continuum of expert diagnosis and treatment services for adults, adolescents and children with psychiatric, behavioral and emotional problems.

Accomplished specialists in psychiatry, psychopharmacology, clinical psychology and neurology work together to provide the highest quality of care, incorporating the most recent clinical and scientific advances. With proper diagnosis and treatment, virtually every mental health condition can be effectively addressed. We offer comprehensive and professional treatment in both inpatient and outpatient settings.

NewYork-Presbyterian Psychiatry delivers the best psychiatric care in New York and for 2011-2012 is ranked among the top five hospitals in the United States for psychiatry, according to *U.S. News & World Report®*.

BEST HOSPITALS U.S.News & WORLD REPORT HONOR ROLL 2011-12

NewYork-Presbyterian Hospital, created through the merger of New York Hospital and The Presbyterian Hospital benefits from the collaboration of two extraordinary programs, offering the highest level of psychiatric services by experts who are recognized leaders in their respective specialties. NewYork-Presbyterian Hospital's Behavioral Health program is consistently ranked among the nation's best, and is considered a premier program in the New York metropolitan area.

Columbia Psychiatry

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

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

Affiliate

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

Weill Cornell Psychiatry

NewYork-Presbyterian Hospital/
Weill Cornell Medical Center
525 East 68th Street
New York, NY 10065
888-694-5700

NewYork-Presbyterian Hospital/
The Westchester Division
21 Bloomingdale Road
White Plains, NY 10605
888-694-5700

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

www.nyp.org/psychiatry

Supreme Court Decision Benefits People With Mental Illness

By Michael B. Friedman, LMSW and Kimberly A. Williams, LCSW

It is good news for people with mental illness and their families that the Supreme Court has ruled that the Affordable Care Act (ACA) is constitutional. The benefits would have been greater if the court had not made expansion of Medicaid eligibility optional for the states. But even if some states choose not to provide Medicaid for more people who cannot afford health care or health insurance, millions of people without coverage or with inadequate coverage—including people with mental illness—will now be able to get the health and mental health care they need.

The ACA benefits people with mental illness in six major ways:

(1) It provides improved coverage of physical health care, which is extremely important to people with mental and/or substance use disorders because (a) they are at higher risk than the general population of having co-occurring chronic physical disorders and (b) they have dramatically lower life expectancy than people without mental illness, in significant part because of poor health and poor access to good health care.

General health coverage improvements that will benefit people with mental and/or substance use disorders include:

• Insurance reforms, such as coverage of pre-existing conditions and maintenance of coverage during long illnesses.

• Access to more affordable health coverage for individuals and small businesses through state health insurance exchanges.

• Expanded eligibility for Medicaid in states that do not opt out of the "requirements" built into the Affordable Care Act.

(2) The ACA also provides improved coverage of mental health and substance abuse conditions. This is a major advance. Just three years ago, new federal laws required "parity" in the coverage of mental and physical health conditions in employer-based health benefit plans and Medicare, but the provisions were limited. The ACA carries these requirements forward and expands them considerably.

(3) The ACA also provides enhanced Medicare coverage of medication, including psychiatric medications. This will result in:

• Reduced out-of-pocket spending on pharmaceuticals by shrinking the "donut hole," i.e. the phase of personal spending on medications not covered by Medicare.

• Enhanced access to psychiatric medications prescribed by a physician that were not covered in the original version of Medicare prescription drug coverage.

(4) The ACA emphasizes the importance of integrating and coordinating the delivery of physical and mental health services and provides incentives to providers to integrate care, including:

• Rate increases for medical practices recognized as "medical homes" that provide coordinated care and preventive services, among other features.

• Increased federal funding for Medicaid payments to "health homes," which are organizations that coordinate care for people with chronic physical and/or behavioral health conditions.

• Contracts with "accountable care organizations" — a new type of structure designed to improve care quality and contain costs.

(5) The ACA also emphasizes preventive interventions. For example, it provides Medicare payments for preventive health care and health promotion for the first time. This, of course, benefits people without mental illness as well as those with mental illness, but it is particularly important for people at high risk of obesity and

see Supreme Court on page 28

1,300 TIMES A DAY SOMEONE HAS A HOME BECAUSE OF F·E·G·S

For more than 30 years F·E·G·S Residential & Housing Services have provided a wide array of residential and support services to people with disabilities. We help improve their life skills, strengthen family and personal relationships, promote independence, and encourage active participation in the community and offering housing to more than **1,300 individuals each day.**

F·E·G·S is proud to be the recipient of the 2010 Nonprofit Housing Developer of the Year Award presented by the New York Housing Conference and National Housing Conference. Learn more about our services, **call: 212.366.0068**, or visit **WWW.FEGS.ORG**

F·E·G·S EXECUTIVE OFFICES
315 Hudson Street
New York, NY 10013

T 212.366.8400
TTY 212.524.1789

A beneficiary of UJA Federation of New York

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

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

Talk to a parent
Talk to a teacher
Talk to a school counselor

CALL US TO TALK: 516-504-HELP

NASSAU COUNTY · STATE OF NEW YORK ·

www.mhanc.org

MENTAL HEALTH ASSOCIATION
OUR HELP KNOWS NO SEASON

The Family Clinical Nurse Specialist: Promoting Health in People with Mental Health Conditions

By Linda Carroll, RN, MSN, FCNS, Family Clinical Nurse Specialist, Sterling Community Center, and Program Coordinator, Northern Westchester Recovery Network, Mental Health Association of Westchester

What is a Family Clinical Nurse Specialist (FCNS)? An FCNS is an advanced practice registered nurse, who has earned a master's or doctorate degree. FCNSs are clinical experts in a specialized area of nursing practice. The FCNS has a unique role to integrate care across the continuum of three spheres of influence: patient, nurse, and system. In each of these spheres, the primary goal of the FCNS is continuous improvement of patient outcomes and nursing care.

I graduated Mercy College in 1999 with a specialty in family nursing. I am the current FCNS at the Sterling Community Center (SCC) of the Mental Health Association of Westchester. I am responsible for the treatment of health/illness states, disease management, health promotion and prevention of illness, and risk behaviors among individuals, families, groups and the community. To put it more simply, I have the traditional roles as care giver and care provider in a non-traditional setting. In the traditional setting, I was limited in what I was allowed

Linda Carroll, RN, MSN, FCNS

to do, decreasing my ability to help.

So where does a FCNS practice? Traditional settings include emergency rooms, long term care, and now something that may have never been done before, a community center that is focused on recovery. The SCC of the Mental Health Association of Westchester is a peer run service aimed at helping people with mental health conditions move forward in their recovery and reengage in their natural communities.

How is my role different from nursing care in traditional settings? For one thing, when I worked in a hospital, it would have been professional suicide to reveal I had a mental health condition. Unfortunately, I had to be a "professional" and not show how I felt. This was not healthy for me or the patient. You see, while I was personally able to empathize and relate with the patients, I had a limited ability to help. On a psychiatric unit, it is "us" and "them," and you do not want to be perceived as "them."

This is where SCC is different. Now I am the nurse and also a peer. By identifying myself as a peer, I am disclosing that I know what it is like to be a psychiatric patient in a hospital. I know from both sides: patient and nurse. My dual role as FCNS and peer, combined with my experience as a provider and patient has positive interactions with participants with whom there is mutual trust and concern. Please note I use the term participant, as opposed to patient, in referring to the people who attend SCC.

One example that comes to mind is the case of Paula. Paula was a participant of SCC who was upset about the fact that she had run out of her medication. She was agitated and loud, visibly distressed and in emotional pain. Paula's Recovery Specialist and I went with her to a clinic where a social worker asked if she could go one night without medication. Paula ran out of the office yelling that no one understood her.

In the elevator, Paula told me that she could not do without her medication for one night. I responded with "I don't like to be without medication for any length of time either." Paula said "you understand" and became quiet and less agitated. Paula and I then went to the emergency room. In the emergency waiting room, we talked quietly about my experience. Had I not been a peer, this would not have gone as well. Paula and I waited three hours in the emergency room to get one night's medications. The emergency room was so busy; the only space available was a stretcher in the hall. I was able to sit with her, and was allowed in the emergency room because I was a nurse.

Emergencies came and went and we waited patiently. I reassured Paula that we would be seen and all we had to do was stay calm. Had she been as angry as she was upon arrival, she would have been admitted, no doubt. Developing trust and showing concern, turned a potentially poor result into Paula getting her medication and getting her needs met. As a peer and a nurse, I helped facilitate positive

see Nurse on page 28

Nationally Recognized Psychiatric Hospital

Psychiatric, Substance Use and Eating Disorders Treatment for Adolescents and Adults

Residential Transitional Living Programs

Intensive Dialectical Behavior Therapy Program

SILVER HILL HOSPITAL
RESTORING MENTAL HEALTH SINCE 1931

www.silverhillhospital.org • (800) 899-4455

Finding exceptional services for the developmentally disabled and disadvantaged is hard enough.

Not being able to afford those services does not mean you cannot access them.

At EDCSPIN, our talented and compassionate staff can help you access the services, programs and resources you need. We service the undeserved and the underserved communities of New York City. EDCSPIN is always there for those who need us most. We measure everything we do against a simple standard: Is this good for persons with disabilities we serve? If not, we will not do it.

For additional information contact:
Intake Department
EDCSPIN
241 37th Street, Suite 604
Brooklyn, New York 11232
(718) 965-1998

We look forward to talking with you.

Charles A. Archer, Esq.
Chief Executive Officer

EDCSPIN **Evelyn Douglin Center for Serving People In Need, Inc.**
www.edcspin.org

Since 1996, Enhancing the Quality of Life for Persons with Disabilities and their Families.

Complete Care Integration: You Can Lead a Patient to the Doctor…

By Larry Hochwald
Nat Etrog, LCSW
and Steven Werfel, MD

Every moment of a medical appointment is crucial to the well being of an individual challenged by mental illness and treated with psychotropic medication. It is an opportunity to educate and intervene at the earliest possible stage, or to anticipate and alleviate issues that have already begun. For those chronically dealing with who and are already experiencing the effects of metabolic changes, weight gain and hypertension often associated with the latest medications, the appointment is an opportunity to set the course right without any further delay. Unhealthy behaviors such as cigarette smoking are also prevalent in the community and can be addressed without negative consequences for those challenged by mental illness.

There are many hurdles in practicing medicine. Few patients are primed to arrive, communicate the pertinent facts, be succinct, get help and be on their way---quickly. However, after speaking to physicians about their experiences treating those most affected by mental illness it is clear these patients can present unique needs. This scenario sums up one of the more common issues:

"I met with the patient and he told me about his knee pain. We spent a good deal of time because he was very focused on it. I prescribed pain meds, ordered an x-ray and on the way out he reached into his pocket and pulled out a piece of paper from his psychiatrist. It said: 'Please evaluate for hypertension. Patient's blood pressure has been spiking in the afternoon at day program." The patient's case manager gave him the note and asked him to give it to me at his appointment. On the way in he hit his knee on the bus and that was his problem at the moment. As a medical professional how might you handle that patient? As a consumer how would you have handled it differently? What could a psychiatrist or case manager have done to help improve that situation?

Larry Hochwald

Nat Etrog, LCSW

As behavioral health professionals what can we do to ensure our clients get the help they need from their physicians?

According to the National Association of State Mental Health Program Directors (NASMHPD), and the National Institute of Mental Health have found that those chronically challenged by mental illness are dying anywhere from 8 years to 25 years earlier than the general public. With an open mind, a little patience, and some easily attainable skills, we can begin to whittle away at that life expectancy gap.

Certainly lack of focus is not the only reason the mentally ill are dying younger. The NASMHPD's landmark 2006 report documented a variety of issues including that those challenged by mental illness receive less aggressive medical treatments and less aggressive interventions for unhealthy behaviors. With higher patient loads and the expectation of doing more with less---less time, fewer resources---the situation is extremely challenging.

Initiatives, such as state trends towards the coordination of care for those challenged by mental illness through "Health Homes" are a step in the right direction. For the most effective care however, coordination and improved communication isn't enough. Medical personnel will need to be educated in how stigma and anxiety are negatively impacting care. They will need to gain skills in managing difficult and sometimes stressful patient situations. They will need to explore the role mental illness and its treatments have in negatively impacting the overall health of challenged individuals.

It is this current state of knowledge that has led to the development of this program and piloting of our project educating health care professionals. We have found that educating medical personnel to most effectively and safely interact with those challenged by mental illness can help ensure a safe environment for the medical staff and a better experience for the patient. In our experience working with behavioral health professionals to better coordinate with their patients'

see Integration on page 18

Study Examines Use of Mobile Technology to Improve Diet and Activity Behavior

By National Institutes of Health (NIH)
National Heart, Lung, and Blood Institute (NHLBI)

A new study, supported in part by the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health, suggests that a combination of mobile technology and remote coaching holds promise in encouraging healthier eating and physical activity behavior in adults. The study focused on the best way to change multiple health behaviors.

The study results appeared Monday, May 28, in the Archives of Internal Medicine, with an accompanying commentary authored by William Riley, PhD, a clinical psychologist and program director for the NHLBI.

Scientists from the Northwestern University Feinberg School of Medicine, Chicago, along with colleagues from other institutions, studied 204 overweight and obese adults. Prior to enrollment, participants had a diet high in saturated fat and low in fruits and vegetables. They also engaged in little daily physical activity and had high amounts of sedentary leisure time.

Each participant was assigned to one of four groups:

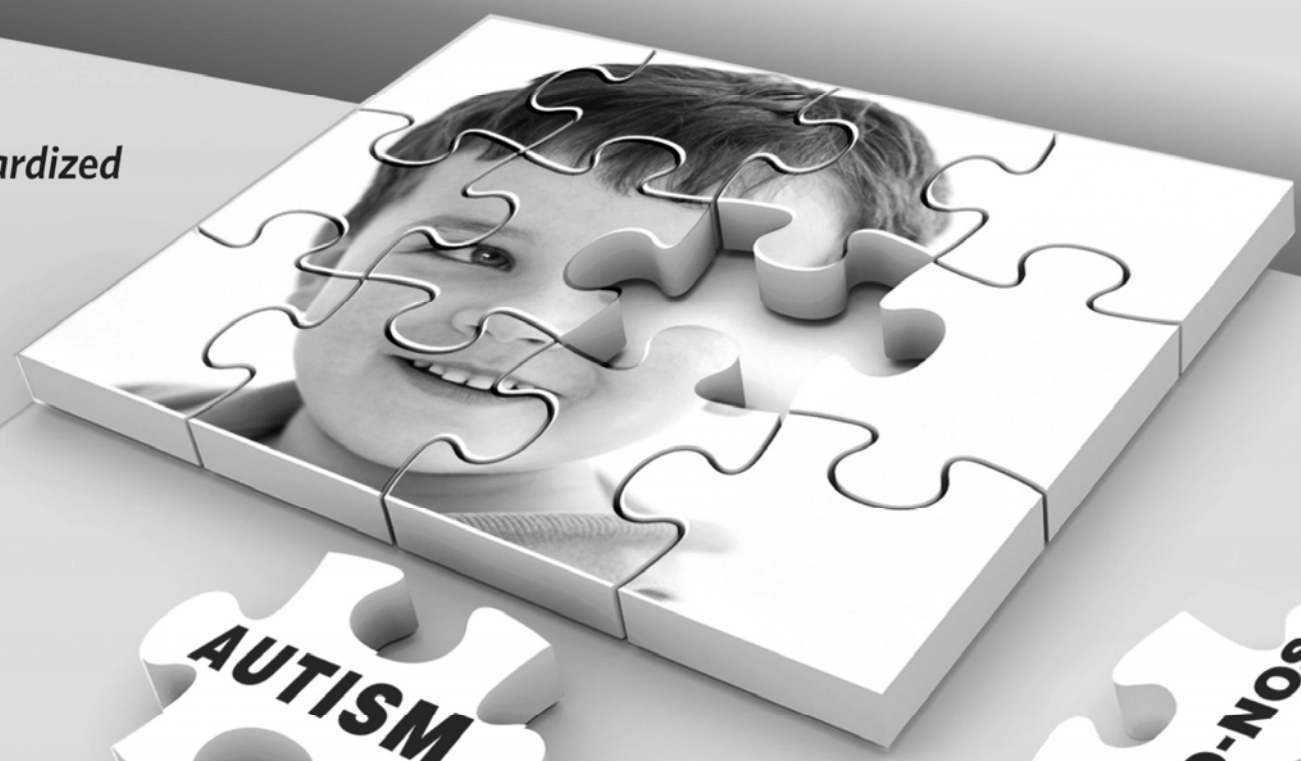
- Increase fruit/vegetable intake, increase time in moderate/vigorous physical activity
- Increase fruit and vegetable intake and reduce time in sedentary leisure activities
- Decrease fat intake and increase time in moderate/vigorous physical activity
- Decrease fat intake and decrease time in sedentary leisure activities

All participants received mobile devices and were trained on entering information about their daily activities and eating patterns. Coaches studied the data received and then phoned or emailed participants to encourage and support healthy changes during the three-week study. Participants were also asked to continue to track and submit their data over a 20-week follow-up period. Financial incentives for reaching study goals during the study and continuing participation during the follow-up period were offered.

All four groups showed improvements in reaching the assigned health goals, with the most striking results occurring in the group asked to increase fruit and vegetable intake and reduce sedentary leisure activities. The researchers found after 20 weeks of follow up that this group's average daily servings of fruits and vegetables increased from 1.2 to 2.9; their average minutes per day of sedentary leisure activity dropped from 219.2 to 125.7; and the percentage of saturated fat in their daily calories went from 12 to 9.9.

In his commentary, Riley noted that the use of mobile technology to improve cardiovascular health is worth further study of the effects on health outcomes and costs. Mobile technology offers the chance to deliver key health messages without waiting for intermittent visits with health care providers, he said.

First and Only
Nationally-Standardized
Norm-Referenced
ASD Rating Scale

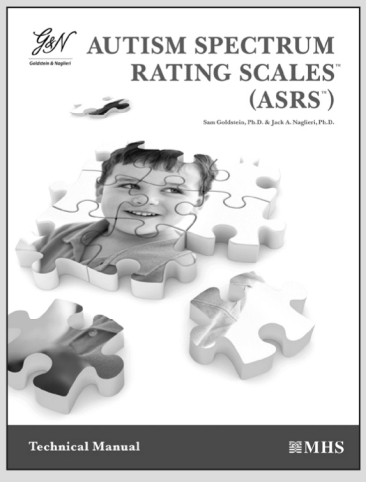


G&N
Goldstein & Naglieri

Complete the Picture With the ASRS™

"This scale is the newest and perhaps most brilliant Autism Rating Scale available."

—Kirsh, Aimee A. Assessment With Aimee. The Ohio School Psychologist, Volume 55, Number 2.



- Effectively identifies symptoms, behaviors, and features associated with Autism Spectrum Disorders (ASDs) in youth aged 2-18
- Assists and guides your diagnostic decisions, treatment planning, response to interventions, and evaluation of treatment programs
- Provides strong psychometric properties with excellent validity and reliability
- Handscored, online, and software scoring formats available

Call MHS today and place your ASRS order.

www.mhs.com/ASRS

MHS
USA Tel: 1.800.456.3003
CAN Tel: 1.800.268.6011
WEBSITE www.mhs.com
EMAIL customerservice@mhs.com

Riding the Wave of Health Care Reform

By Kathryn M. Salisbury, PhD
Vice President, Programs
MHA-NYC

Addictions and risky use of addictive substances constitute one of the largest and most costly public health issues facing the nation, but addiction care has been vastly under-resourced and remains largely separate from mainstream medical and behavioral health care practice. Unrecognized and untreated, addictions cause or contribute to more than 70 other medical conditions with costs to the government alone totaling at least $468 billion a year (The National Survey on Drug Use and Health, SAMHSA, 2010). The personal cost to families and the larger society is incalculable.

Despite, or perhaps because of, these discouraging statistics, there are reasons to be hopeful about the future of addictions prevention and treatment in the U.S. Chief among them is the focus within health care reform on cost containment, improved health outcomes and the integration of health and behavioral health care.

The convergence of the imperatives of health care reform with the rapidly growing knowledge base about addictions as a complex brain disease and the efficacy of treatments offers an unprecedented window of opportunity to bring addictions screening and treatment into the mainstream of medical and behavioral health practice. By doing

Kathryn M. Salisbury, PhD

so, we have the potential to substantially improve health and mental health outcomes for the 8.7 percent of the population aged 12 or older who were classified with dependence or abuse of alcohol and illicit drugs. Kim Williams, Director of MHA-NYC's Center for Policy, Advocacy and Education notes, "As a result of planned healthcare integration efforts, providers will have the potential to promote earlier identification of risky use of substances and addictions and ensure that consumers are getting the right addiction services, in the right amount at the right time."

The June, 2012 report, *Addiction Medicine: Closing the Gap between Science and Practice* issued by the National Center on Addictions and Substance Abuse at Columbia University (CASA-Columbia) represents the culmination of a five year research project that details current research in neuroscience and addictions and reviews the evidence base for effective screening, intervention, and disease management. Perhaps most importantly, the CASA-Columbia report provides a call to action and a roadmap for reducing the chasm that currently exists between those who need treatment and those who receive it and between the services they receive and the receipt of quality care. Key findings and recommendations include:

- Physicians and other health and graduate level mental health professionals should be on the front lines of addressing addictions within the medical system.
- Barriers to addictions treatment including: limited availability of services, inadequate insurance coverage, and lack of information on how to get help.
- Best practices require: comprehensive assessment, stabilization of the patient's condition, evidence based pharmacological treatments and/or psychosocial addictions treatment, chronic disease management and support services.
- The education and training gap between the available knowledge about the prevention and treatment of addictions and the education and training of individuals who provide or should provide addiction care must be rectified.

Our ability to translate knowledge into practice will depend not only the dissemination of relevant neuro-scientific and behavioral research and evidence based treatment models but on our ability to bring public attitudes and beliefs about the causes of addictions and the people who suffer from them in line with what we now know about addictions .

Despite overwhelming scientific evidence to the contrary, too many Americans still attribute addictions to a failure of will or lack of self-control. If we are to succeed in expanding access to scientifically based addictions treatment, it will be necessary to confront the legacy of stigmatizing attitudes through widespread public and professional education campaigns.

Although health care reform and scientific knowledge create fertile ground for systemic change in the prevention and treatment of addictions, only our collective compassion and robust advocacy efforts on behalf of and with those who suffer from addictions can guarantee a standard of care for addictions that is comparable to that of other illnesses. Let the advocacy and collaboration across disciplines continue and flourish.

The Mental Health Association operates the OASAS HOPEline for those in New York State struggling with gambling, substance abuse, and/or addiction. We urge people to call 1-877-8-HOPENY (1-877-846-7369)

Integration from page 16

medical professionals can enhance care and provide consumers better experiences and at the same time their medical providers can work more effectively and efficiently. Program development required an integrated effort involving consumers, medical and behavioral health professionals and family members.

While initiatives to coordinate care between medical professionals and behavioral health care staff no doubt can improve care, even the most skilled or experienced behavioral health care workers may unknowingly be affected by, and propagate, stigma. This can negate some of the hoped for benefits of care coordination and should also be anticipated and dealt with. While doing in-service training for behavioral health staff at several hospitals we have found many of the same mistaken beliefs about those challenged by mental illness as we have found in the community. However an anti-stigma training initiative can help to correct this.
We have found that developing any program to improve the care medical professionals deliver, to enhance the role of the behavioral health professional in care integration, and to involve consumers and their families in the process demands that certain facts be communicated and a certain skill set must be developed. The areas to include are:

- Anti-stigma education
- Priorities, concerns and care management skills specific to the needs of this population
- Understanding of the process from the consumers' and families perspectives
- Crisis Prevention and Intervention
- Monitoring and Follow Up

A program including these areas may have a quick, lasting and substantial impact on improving and prolonging the health and life expectancy of those severely challenged by mental illness. We are working with regional health care providers and NY State elected officials on both further testing and expanding this initiative. For those systems that want to start to improve the process on their own, we can offer a suggestion that has been reported to have an immediately positive impact. Checklists are an invaluable tool. Behavioral health providers, medical providers, consumers and their families should all be encouraged to co-develop and utilize this useful tool. A behavioral health provider can use a check list to make sure their consumer is adequately prepared for their upcoming medical appointment. The family (if significantly involved in their regular care) should have a check list to remind the client what they need to take with them for the appointment. The consumer should have a check list, and should get in the habit of checking it to remind them of the issues for their physician and any paperwork they have to hand in. The physician, who is often most distant from this process, should have a check list go to help them ensure that they will work the most efficiently with any tangential, forgetful or difficult patients.

For example, a simple medical appointment checklist could look like this:

- ✓ What brings you here?
- ✓ Do you have any papers to show me?
- ✓ Before we get into that, anything else?
- ✓ Did anyone tell you to come see me?
- Did your other doctor want you to see me?
- Did any other staff or family send you to me?
- What did they tell you if they did?

Difficult or agitated patients, complicated physical factors and stigma make medically managing those challenged by serious mental illness a demanding endeavor. Through education and planning excellent care and best practice can be assured. An ongoing and effective partnership between consumers, their families, their behavioral health providers and their medical providers is the key.

Larry Hochwald, is co-chair of the Staten Island Mental Health Council and a co-founder of Advanced Resources, inc. a nonprofit set up to explore innovative initiatives including those discussed in this article. Nat Etrog, LCSW, is co-chair of the Queens Mental Health Council and Vice President, Department of Psychiatry, St. John's Episcopal Hospital. Steven Werfel, MD has practiced in hospital and clinic settings and is an advocate for care integration and the rights of those challenged by mental illness.

LifeNet has a newly enhanced website:

Offering the most comprehensive, convenient and easy-to-navigate behavioral health resource featuring:

- Search LifeNet's *network of care's* behavioral health services database on Mental Health, Substance Abuse and Problem Gambling.
- Post on the Community Calendar - including professional and community workshops, trainings and support groups.
- Review the vast library of resources about mental health, addiction, parenting, relationship issues, physical health and other topics.
- Create a Confidential Personal Health Record - allows you to store your findings and personal information.
- Get an advocate by reviewing an extensive list of organizations that assist people with mental health or substance abuse problems.
- Research insurance options; low-cost or private, medication assistance programs, resources for the uninsured, and help for veterans.
- Take action by following local, state and national bills focused on behavioral health, and by contacting elected officials to voice your opinions on how to improve the behavioral health care system.

www.800LifeNet.org
1-800-LifeNet (1-800-543-3638) [English]
1-877-Ayudese (1-877-298-3373) [Spanish]
1-877-990-8585 [Asian LifeNet ~ Mandarin/Cantonese]
1-877-8-HOPENY (1-877-846-7369) [Addiction + Problem Gambling]
1-212-982-5284 (TTY)

MHA-NYC
Innovations in Mental Health

LifeNet is a program of MHA-NYC (Mental Health Association of New York City), a non-profit leader in behavioral health services. LifeNet is funded through contracts with the New York City Department of Health and Mental Hygiene and the New York State Office of Alcohol and Substance Abuse Services.

Challenges for the Treatment of Chemical Abusers with Mental Illness

By Peter Marino, MA
Group Worker
MHA of Rockland County

People struggling with co-occurring mental illness and substance use disorders (SUDs) have unique problems that when addressed simultaneously will likely result in the most desirable outcomes. Historically, mental health services as a whole have not been prepared to deal with people who have both afflictions (Sciacca, 1991). Often only one of the two problems is identified. If in fact both are recognized, the individual may bounce back and forth between fragmented and uncoordinated services leaving much room to fall in between the cracks. When a multiple team approach is used, chances for recovery improve instilling more hope and optimism for those suffering from these concurrent conditions (Sciacca, 1991).

Peter Marino, MA

Building Social/Interpersonal Skills

Since some people find themselves more easily accepted by groups whose social activity is based on drug use, an identity based on drug addiction or alcoholism is sometimes seen as more acceptable than one based on mental illness (Aharonovich et. al., 2008). Consequently, peer pressure and a lack of healthy coping mechanisms may contribute to a Mentally Ill Chemical Abuser (MICA) patient's drug use. For people with co-occurring disorders participating in support groups can serve to reinforce opportunities for healthy socialization, increase access to recreational activities, and develop more positive peer influences. Participation in such groups may also deal with education and awareness of dual diagnosis issues, medication management, communication skills, as well as improvement in activities of daily living.

Understanding Environmental Factors

As a consequence of mental illness many MICA individuals may find themselves living in neighborhoods where drugs are easily accessible increasing the potential to self-medicate. Additionally, after MICA individuals begin to seek psychiatric care continued drug use will interfere with the efficacy of prescribed medications, in turn increasing risk for instability due to a resurgence of co-occurring psychiatric symptoms. It has become common practice for dually diagnosed patients to be referred to community residence rehabilitation programs. Usually residential rehabilitation involves a stay of a few months to a year. In these facilities there is an emphasis on group affiliation and ongoing counseling to prevent relapse. However, housing difficulties at this stage may arise as there is often no tolerance of drug use in the rehabilitation facilities.

In places where there are dual diagnosis treatment centers, MICA individuals receive services that are tailored to the individual and include different types of assistance that go beyond standard therapy or medication, such as outreach, job and housing assistance, family counseling, and money management. These programs view substance abuse as intertwined with mental illness, and therefore provide solutions to both illnesses at the same time.

Relapse Prevention

Relapse of substance abuse may increase risk of experiencing a mental health decompensation by exposing individuals to triggers such as feelings of failure and alienation. Drug/alcohol use can also lead to a loss of support systems, resulting in recurrent relapses and hospital stays (Aharonovich et. al., 2008). The typical relapse prevention treatment program usually meets 3-5 days a week, 4-6 hours/day and may benefit people who require medical monitoring on an outpatient basis.

A case manager and sponsor may be available to the individual to provide routine contact and encourage follow-up with doctor's appointments, and other forms of treatment. Talk therapy offers an opportunity for emotional healing through exploration and education. Examining deeply rooted thoughts and emotions can help to

see Challenges on page 30

Mental Health Association of Rockland County
improving lives and raising awareness
Mental health services for children, adults and families
140 RTE 303, Valley Cottage, New York 10989
845-267-2172
www.mharockland.org

Newmark Schools for Learning/Behavioral Disorders
Newmark SCHOOL
• School-wide behavior modification program
• Intimate class size for K-8 and High School students
• Counseling and social thinking training
• State-approved, private non-profit serving NJ
www.newmarkeducation.com

NAMI New York City Metro
Free Programs for Parents & Caregivers of Children & Adolescents
NAMI Basics Family-to-Family Support Groups Parent Matching Program
"Your Child's Mental Health" Lunchtime Conference Call Series
Helpline: (212) 684-3264 www.naminycmetro.org

DISABILITY STUDIES
BRIDGING PERSPECTIVES THROUGH EDUCATION
Large Print
Disability sits at the intersection of many different disciplines and viewpoints.
We're connecting them all through programs that will enhance your understanding of **Disability Studies** and prepare you for leadership roles in the field.
PROGRAMS:
■ New Online Bachelor's Degree
■ Master's Degree ■ Advanced Certificate
CUNY School of Professional Studies
The City University of New York
Contact us to learn more.
www.sps.cuny.edu
212.652.CUNY
information@sps.cuny.edu
A convenient, affordable, high quality education fit for the life you lead.

— The NYSPA Report —
The Changing Face of the VA

By C. Deborah Cross, MD
Past President, NYSPA
Attending Psychiatrist, VA HVHCS
Community Living Center Units

Much has been written in the last several years about returning Veterans and their mental health issues. The VA health care system has gone from being a rather low key assortment of hospitals and clinics around the country, often situated in urban areas or close to military bases, to a "hot topic" in the media and in politics. Funding of VA services has increased exponentially to keep pace with the needs of the Veterans and the increase in government and public attention.

Prior to 2002 VA mental health services were still, by and large, utilized by Vietnam era (or earlier) Veterans. This meant that the majority of patients were male, and rapidly aging (at least 50 years of age, or older)! Over the last 10 years the profile of the "typical" Veteran receiving health care services at a VA facility has changed dramatically. In fact, there are now two distinct groups of vets; the "traditional" ones, that is, the older, usually male, Vietnam era Veteran and the "new" Veterans from Desert Storm and the Iraqi and Afghanistan wars.

These new returning Veterans present significant challenges to the VA system in many areas. First, of course, are the sheer numbers of returning Veterans seeking services. Recent statistics show that since 2002 about 1.5 million Veterans have left active duty and become eligible for VA health services, of which about 56% are former active duty troops and the other 44% are Reserve and National Guard. It is also important to note that Reserve and National Guard Veterans often return to areas of the country which have relatively sparse VA services. Since 2002 about 800,000 (54%) of those eligible have obtained VA health care, with about 93% being seen only as outpatients and about 7% having been hospitalized at least once in a VA facility. As mentioned above, there are many more women Veterans than in the past (12% of the 800,000 seen were women). Approximately 50% of the 800,000 seen were 30 years old or younger! Of these returning Veterans 52% were seen for "Mental Disorders" (clearly a broad diagnostic classification). About 55% were seen for "Diseases of the Musculoskeletal System" (back and shoulder pain, etc.) and about 45% were seen for "Diseases of Nervous System" (Traumatic Brain Injuries/TBI, etc.). Traumatic Brain Injuries are much more prevalent now than in any time previously because of advanced techniques both in weapons (IEDs) and in medical life-saving techniques. Of course, what is not detailed in these statistics is the incredible amount of overlap in these diagnoses. It is not at all uncommon for a returning Veteran to present to the VA with a combination of TBI, significant back and shoulder problems (from the extremely heavy loads of equipment carried), PTSD, and an addiction to

C. Deborah Cross, MD

drugs and/or alcohol, all at the initial intake interview. Clinical staff from various medical specialties must work collaboratively with each other and with the Veteran to put together a treatment plan to address all these, often overwhelming, problems in as short a time as possible to ensure that the Veteran can begin to readjust to life outside the military.

The VA had become accustomed to treating older Veterans who had over many years adapted to their conditions, which by and large had become chronic, both psychiatrically (such as PTSD) and medically. This new influx has presented the VA with challenges to adapt to much more acute traumatic stress symptoms of poor frustration tolerance, impulsivity, mood swings and often significant substance abuse issues. Additionally, with the significant increase in TBI the need for all branches of medicine to work together has increased dramatically. This has put additional burdens on the Veterans with having to coordinate multiple appointments often in different physical locations. The psychosocial problems for these Veterans have been tremendous: interpersonal conflicts, family problems, domestic violence, unemployment, problems in school, legal problems, etc.

The VA has become a much more aggressive health care system, and has begun the very difficult task of integrating all of the services which are needed. One example is the creation of specific offices and services devoted specifically to the returning Veteran. At the VA Hudson Valley Health Care System (HVHCS) these staff are the front line staff for all returning Veterans to this area. They reach out to all of them, and provide overviews of the VA services. For example in May 2012 the VA HVHCS staff enrolled approximately 1,750 returning Veterans in VA services from the surrounding areas. Each of these Veterans is offered a "Post Deployment Screening" and a TBI Screening. The staff offer drop in services and see themselves as a "safety net" for those who have difficulty trying to come to appointments and get services. The staff also "follows" the Veterans through the continuum of care, and attends meetings at the inpatient, residential and outpatient settings.

The VA across the country has also become a leader in Telehealth (using video to provide health care services). Telehealth is used in both general medicine and in psychiatry. The VA HVHCS has a number of "CBOC's" (Community Based Outpatient Centers), such as in Port Jervis, New City, Goshen, etc., but even with that, the need for Telehealth is great. A dermatologist at Castle Point can consult with a primary care doctor and patient at Goshen and can quickly and efficiently help the patient and the primary care doctor decide what the next step needs to be, if any. Additionally, a psychiatrist at Montrose can consult with a therapist and a patient at New City and help diagnose and treat Major Depression. Of note is that in 2003 8,000 VA patients received mental health care via telemedicine. In 2011 this figure had jumped to more than 55,000. Telemental health at the VA is done by psychiatrists, psychologists, social workers, nurse practitioners, and all other clinical specialists.

Even with all the increase in services provided by the VA, many Veterans still seek and receive medical and mental health services in the private healthcare community. Because of this the New York State Psychiatric Association (NYSPA) has applied for and received a grant from New York State to educate primary care physicians and other professionals in primary care on Veteran-specific mental health issues, such as PTSD, TBI, suicide and other mental health conditions including alcohol and/or substance abuse. There is much new clinical information regarding treatment of PTSD (both medications and therapy, e.g. Cognitive Processing Therapy), co-occurring Substance Abuse (e.g., Motivational Interviewing), interface of TBI and psychiatric problems, and differential diagnoses of anxiety, panic and ADHD. All clinicians who treat Veterans need up-to-date clinical information to ensure that they receive the best medical and psychiatric health care we can provide. If you or a loved one need access to health care at the VA, please contact the Returning Combat Veteran Program at (866) 400-1237, a national outreach number, or www.oefoif.va.gov. Additionally, the afterhours Nurses Helpline is (800) 877-6976.

AMERICAN PSYCHIATRIC ASSOCIATION
BENJAMIN RUSH, M.D.
1844

New York State Psychiatric Association

Area II of the American Psychiatric Association

Representing 4500 Psychiatrists in New York

Advancing the Scientific and Ethical Practice of Psychiatric Medicine

Advocating for Full Parity in the Treatment of Mental Illness

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

Please Visit Our Website At:

www.nyspsych.org

New Housing Venture in Suffolk County

By Barbara Faron, LMSW, CPRP
Executive Director
Federation of Organizations

Federation of Organizations was awarded the contract to operate the Transition to Community Residence (TCR) Program in Suffolk County, an innovative program that recognizes the need to address the complex medical conditions of individuals who have been living in state operated settings and moving into supported housing. Funded by the NYS OMH the Transition to Community Residence (TCR) Program will assist seventy-five people with mental illness and chronic medical conditions now living in a state-operated Residential Care Center for Adults (RCCA) and people who are being released from Pilgrim Psychiatric Center to transition to community living with the specialized supports the program will provide.

Founded by family advocates in 1972, Federation has been serving people with serious mental illness and complex needs since 1981and is a pioneer in employing peers to deliver mental health services. Federation operates over 380 residential units including CR/SRO's, community residences, apartment treatment and supported housing. In addition Federation provides case management, clinic treatment, Personalized Recovery Oriented

Barbara Faron, LMSW, CPRP

Services (PROS), Assertive Community Treatment (ACT), peer outreach, advocacy and linkage to services, employment, affirmative business experience, and education to individuals with serious mental illness living in Suffolk, Nassau, Queens and Brooklyn.

The RCCA on the grounds of Kings Park will close this year as part of an OMH commitment to promoting community integration. Federation will open three 25-bed Transition to Community Residences (TCR's) on the grounds of Pilgrim Psychiatric Center into which the last seventy-five residents of the RCCA will move on a temporary basis. (The other residents have already moved into the community.) Two of the residences will phase out in two years and will transition to 75 Supported Housing beds within the community. Two mobile residential support teams will be available to provide crisis intervention, rehabilitative and supportive services, linkage to community resources, networking and hospital diversion for TCR residents who have moved into the community and become a resource to all supported housing programs in Suffolk County. The TCR program will be available to assist people leaving Pilgrim Psychiatric Center also. The decision to continue operating the third 25-bed TCR unit will be made by OMH depending on the need.

People who have lived for years in institutional settings need hope and a vision for their future. Peers will be integral to this effort. Peers will work with residents to instill hope and share their own experience of the recovery process, assisting residents to actively explore educational, residential, vocational, social, religious and community groups, recreational activities, and all the opportunities the community has to offer. Many of the people now living in the RCCA have complex medical conditions and have not lived independently for many years. They need assistance in learning to manage chronic health conditions such as diabetes, high blood pressure, heart disease, asthma, COPD, and seizure disorders. Staff will focus on working with residents to make their health a priority and to make the connection between good physical and mental health. During their stay in the TCR each person will learn skills, explore options and move into community settings with the resources they need to succeed. Staff will have medical and mental health expertise and include nurses, LPN's, peers, rehabilitation associates and behavioral specialists to teach life skills and to stimulate residents to reimagine their future.

The Transition to Community Residence Program in Suffolk County provides enhanced resources to supported housing residents, many of whom are managing complex medical conditions. The TCR program is an effort to ensure the successful transition to community living for people who have been living in institutional settings and expand options for housing providers who are working hard to meet the complex and evolving needs of the people they serve.

Federation of Organizations

A Premier Not-For-Profit Human Service Agency
Invites You To Join Us For A

Networking and Business Event

Keynote Speaker

Jason Helgerson

Medicaid Director, State of New York

Join us as Jason Helgerson highlights the changes that will be brought about in the financing and delivery of healthcare services as a result of the Medicaid Redesign and the Affordable Care Act

Friday, October 5, 2012
Cocktail Hour 11:30 a.m. -12:30 p.m.
Luncheon & Keynote 12:30 p.m. – 2:30 p.m.
Coffee and Networking 2:30
Russo's On The Bay, 162-45 cross Bay Boulevard, Howard Beach, NY

Tickets $65 – Table of 10 $650 • Sponsorship Opportunities Available
For more information call (631) 669-5355 extension 1102 or visit us at www.fedoforg.org

Saint Joseph's Medical Center

Setting the standard for care.

Saint Joseph's Medical Center
is pleased to welcome
St. Vincent's Hospital Westchester
Into its Family

We now provide one of the
most comprehensive
Behavioral Health Programs
in the Region

One Hospital
One Mission
Outstanding Patient Care

Saint Joseph's
Medical Center
127 South Broadway • Yonkers, New York 10701
914-378-7000 • www..saintjosephs.org

St. Vincent's Hospital
Westchester
A Division of Saint Joseph's Medical Center
275 North Street • Harrison New York 10528
914-967-6500 • www. stvincentswestchester.org

Saint Joseph's Medical Center in Yonkers Hosts Maniscalco Lecture

Staff Writer
Mental Health News

Susan Stuard, MBA presented the Twenty-third Annual *Anthony Maniscalco, MD Lecture in Public Psychiatry* to the Department of Psychiatry of Saint Joseph's Medical Center in Yonkers, N.Y. on June 14, 2012. 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 a number of the full range of mental health services currently available at Saint Joseph's were established.

Dr. Barry B. Perlman, Director of the Department of Psychiatry, introduced this year's lecturer. Ms. Stuard, who received her M.B.A. from the Yale School of Management, is the Executive Director of THINC, the Taconic Health Information Network and Community. THINC's mission is, "To advance health care quality and coordination of care among health care organizations in the Hudson Valley." It works to realize its goals by sponsoring health care transformation initiatives and by promoting health information technology adoption, care coordination and secure health information exchange.

Supported by NYS Department of Health HEAL grant, THINC has collaborated with primary care providers, hospitals, community health centers, commercial health plans and local governmental health departments in working to establish medical homes, health homes and enhanced health data exchanges throughout the Hudson Valley Region. As a result of these efforts, the region has a high penetration of the use of electronic medical records which meet "meaningful use" criteria set by CMS. Through incentive financial programs and the establishment of "meaningful use" criteria, the federal government is helping providers to make the transition to the adoption and utilization of electronic medical records. To meet "meaningful use" criteria providers must e-prescribe, report certain quality measures, implement a clinical decision support rule, make drug-drug and drug-allergy interaction checks, maintain active medications and allergy lists, and protect electronic health information among other requirements. It was noted that many of the current criteria necessary to establish "meaningful use" do not easily lend themselves to use by psychiatrists and other providers of mental health services.

Grant Mitchell, MD, Commissioner, Westchester Department of Community Mental Health, Susan Stuard, MBA and Dr. Barry B. Perlman

Ms. Stuard went on to address potential benefits and concerns about electronic medical records and regional or even broader sharing of clinical information. She acknowledged that from a patient perspective there is a real concern that sensitive information may be inappropriately disclosed but that there also exists a wish for information sharing among their treating physicians and for the ease of email communications with their providers. While both paper and EHRs can be insecure both can be quite secure if appropriate safeguards are rigorously adhered to. However, she pointed out that only an EHR allows for an audit trail. She spoke about some of the obstacles to obtaining true "informed consent" from patients being asked to permit their clinical information to be shared as well as the paradox of the inability to withdraw previously entered clinical information should an individual subsequently decide to opt out of clinical information sharing. Ms. Stuard ended by observing that while all of the above technical matters were of importance, the most important concern, whether using paper or EHRs, is the covenant with the patient, the respect given to their wishes and the reassurance that any breech of security would be quickly and robustly addressed.

The Department of Psychiatry at Saint Joseph's Medical Center, with campuses in Yonkers and at St. Vincent's in Harrison includes a wide array of outpatient, inpatient, and crisis mental health services as well as substance use disorder treatment programs.

Paul Levine Retiring from JBFCS

Staff Writer
Mental Health News

Paul Levine has announced that he plans to step down as Executive Vice President and CEO of JBFCS on June 30, 2013. David Rivel, Chief Administrative Officer/ Associate Executive Vice President, is named his successor. Levine has been with JBFCS for 30 years and without question has strengthened and broadened this large multi-service agency serving New Yorkers in need.

In 1982 Levine served as Director of the MBCS North Brooklyn Clinic and quickly moved on to work with diverse communities and families to provide mental health services. He became known as an expert on the interface of mental health and child welfare in New York City. As he moved up the ranks, he assumed responsibility for operational aspects of JBFCS, and in 2007 Levine became Executive Vice President and CEO, guiding the agency through enormous growth and change, including his commitment to confronting organizational racism and the recent positioning of the agency as a strong leader in the health reform environment.

By unanimous vote of the Executive Committee of the Board, David Rivel has been named Levine's successor. Rivel is the former Executive Director of the City Parks Foundation, where together with 50,000 volunteers and a very active Board, he built a unique parks organization responsible for enhancing the quality of life in more than 750 communities across New York City and reaching 600,000 people every year through parks programs. Rivel has already led the charge on a new strategic plan at JBFCS since coming on board one year ago, and he brings 20 years of experience in finance, management, government relations, and nonprofit organizations. Rivel takes the helm on July 1, 2013.

Paul Levine

JBFCS is a $185 million human services agency, offering more than 175 distinct programs to all New Yorkers. The depth and breadth of JBFCS's services is matched only by the diversity of the population they serve.

Kenneth Popler Retiring from SIMHS

Staff Writer
Mental Health News

The Board of Directors of the Staten Island Mental Health Society (SIMHS) has announced the retirement of the Society's President and Chief Executive Officer Kenneth Popler, PhD, MBA, effective July 31. Dr. Popler has headed the SIMHS for 31 years and is credited with piloting the West Brighton-based children's mental health services agency from modest size and scope to its current status as one of the largest and most respected children's mental health service providers in New York City and State.

With 27 programs at 20 sites throughout the Island, the SIMHS is known for its top-notch mental health and related services for Staten Island children and adolescents, and their families, who are challenged with emotional/behavioral disorders, developmental, intellectual or neurological disabilities, alcohol and/or drug dependencies, and economic limitations. The Society's professional staff have often been cited as "highly competent and compassionate." The SIMHS was named Agency of the Month in the May issue of New York Nonprofit Press, a widely read and highly regarded statewide trade newspaper.

According to SIMHS statistics, since Dr. Popler took on the leadership of the Society in 1981, the number of children served by the agency has increased from 3,100 to 5,300, while the number of individual sessions conducted each year has more than doubled from 82,000 to 166,000. The SIMHS's workforce grew from 155 to 360, with volunteers numbering 500, its total annual budget rose from $2 million to $21 million, and funds raised from non-governmental sources increased from $256,000 to $1 million yearly.

Kenneth Popler, PhD, MBA

Board of Directors Chair John G. Tapinis stated, "Dr. Popler's devotion to carrying out the important mission of the Staten Island Mental Health Society are evident in his achievements on behalf of people with special needs. He has raised the quality of their lives and given them hope for a better future, and in doing so, has earned the deep respect and gratitude of the community."

Alan Eskenazi New Holliswood CEO

Staff Writer
Mental Health News

On March 26, 2012 Mr. Alan Eskenazi, MA, CPHQ, was appointed Chief Executive Officer of Holliswood Hospital, a 125-bed private psychiatric hospital located in Queens, NY. The hospital is notable for its visionary programming including its Military Wellness Program which serves active military personnel and their families, its children and adolescent services, clinical research, and the only on-site equine therapy program in New York City. The hospital also offers an adult Partial Hospital Program. Coming from a quality and performance improvement background, Alan brings an extraordinary focus on improving quality and patient satisfaction to his role as CEO. In the time that he has been there he has introduced many improvements to the services provided by the hospital as well as enhancements to staff competencies.

Prior to joining Holliswood, Alan served as Deputy Commissioner for the New York State Office for People With Developmental Disabilities (OPWDD) and, previously, was the Vice President of Quality and Regulatory Affairs for Behavioral Health Services at Saint Vincent Catholic Medical Centers. He earned his Bachelor's Degree in Psychology at Brooklyn College of the City University of New York, and his Masters Degree at New York University. He is a New York State Credentialed Alcoholism and Substance Abuse Counselor (CASAC), and a Certified Professional in Healthcare Quality (CPHQ). Prior experience included six years as a Program Administrator for the Alcohol and Substance Abuse Unit at the Westchester County Department of Community Mental Health, and many years of direct clinical provider experience.

Alan is a member of the American College of Healthcare Executives; the

Alan Eskenazi, MA, CPHQ

National Association for Healthcare Quality; the New York Association for Healthcare Quality; is a Board member of the Westchester Chapter of the American Foundation for Suicide Prevention; and has served on the Board of Mental Health News Education, Inc., since 2010. He is the recipient of numerous awards for quality improvement projects including awards for reducing patient falls, reducing restraint and seclusion, and decreasing readmissions. Alan has had the honor of speaking at events throughout the country and has published and/or contributed to many articles relative to falls prevention, minimizing readmissions, restraint reduction, and treatment planning performance improvement initiatives. His overall mission at Holliswood is to develop effective processes and procedures that yield the highest possible quality of care and patient care experience for all who seek care at the facility.

INPATIENT Behavioral Health Care

The Holliswood Hospital

A Trauma Informed Clinical Approach

Serving **Children**, **Adolescents**, **Adults** and **active duty Service Members**

87-37 Palermo Street, Holliswood, New York 11423

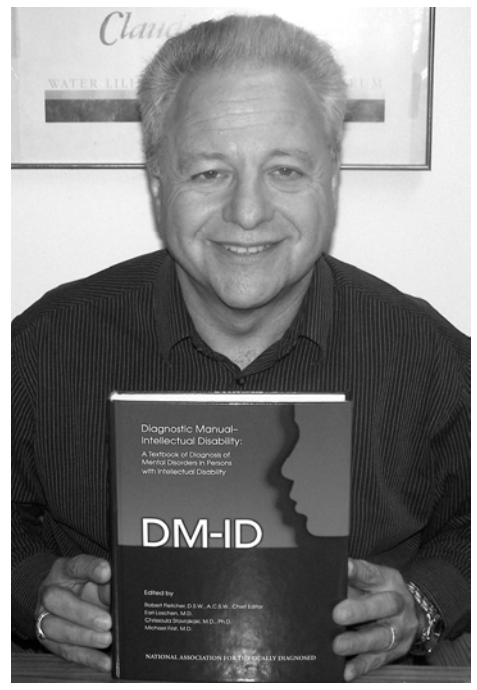
(800) 486-3005 • (718) 776-8181 • FAX (718) 776-8572

Letter to The Editor

To the Editor:

I read with interest and appreciation the article by Adam Goldberg on *Recognizing Suicide Risk for Autism Spectrum Disorder* in the Summer 2012 issue of *Mental Health News.*

Although I agree with much of what Mr. Goldberg says on this important topic, I disagree with his assertion that "The diagnosis of depression depends primarily on people's verbal and communication skills in order for them to convey their depressive symptoms." Many symptoms of depression are observable by others. The *Diagnostic Manual – Intellectual Disability* (DM-ID), published by the NADD Press in association with the American Psychiatric Association, addresses the difficulty of arriving at accurate psychiatric diagnoses in individuals with limited receptive or expressive verbal ability. In the chapter on Mood Disorders, the *DM-ID* provides criteria adaptations, symptom equivalents, and helpful observations for diagnosing depression in individuals with IDD including those with limited or no verbal skills.



Robert J. Fletcher, DSW, ACSW, NADD-CC
Founder & CEO, National Association for
the Dually Diagnosed, www.thenadd.org

NYU Silver
Silver School *of* Social Work | McSilver Institute
for Poverty Policy and Research

UPCOMING CONFERENCE

Provision of Care in a Changing Healthcare System

Wednesday, December 5

Full-day conference hosted by the NYU Silver School of Social Work and the NYU McSilver Institute for Poverty Policy and Research

Presenters will include NYU Silver faculty, healthcare providers, and consumers

CONFERENCE GOALS

Understand and examine the core competences for effective and efficient clinical and business practices resulting in quality care

AUDIENCE

Social workers and related behavioral health practitioners

FOR MORE INFORMATION, VISIT: *www.nyu.edu/info/ssw/workforce*

NEW YORK UNIVERSITY

New York University is an affirmative action/equal opportunity institution.

Advertise in Mental Health News - See Page 31 for Details

Interview from page 1

consumer of mental health or substance use services will access and experience them?

A: Good question. With regard to Health Homes, we hope consumers will first receive a mailing sent directly to them by one of our Health Homes to let them know there is a new set of services for which they are eligible. The Health Homes will let consumers know about the range of services that will be offered to them and the kinds of coordination/ assistance the Health Home can provide to them. The consumer will then decide whether or not they wish to participate–it is not a mandatory program. We hope the individuals that will be told about their options to join will see the value of it.

On the managed care side, we hope to have a number of plans from which individuals can choose – some highly specialized and others more general in nature. Our goal is to make this as seamless a transition as possible. Our goal is to create a host of health-care choices for folks to choose from.

Q: What will become of all the mental health and substance use provider agencies and organizations that are currently providing all the services now available to consumers today?

A: There will continue to be providers. What we have been trying to do is to bring the agencies together and to integrate them into Health Homes – because they continue to be vital providers. One way the behavioral health provider community will directly benefit from Health Homes will come from our ability to provide them with the funds necessary to develop electronic records for the sharing of information. These funds have until now been only available to primary care providers and hospitals.

Q: Currently, behavioral health services for people with serious mental illness and substance use disorders in NYS are "carved out" of managed care. The Medicaid Redesign Team vision is to fold these services into managed care. Given the high utilization of services in these populations, how do you address the concern that a managed care structure may result in the rationing of services?

A: The other area we are going to be looking to integrate (still a work in progress) is trying to find ways to get those services into more effective management – to also try to integrate those services effectively with the acute care/physical health side but not to do it in a way that leads to a draining of resources away from behavioral health. That's always been the concern within the behavioral health community around carving in the services into mainstream managed care – that services would no longer be available or no longer be provided. Where we've been going on the managed care front is moving forward with contracting with behavioral health organizations initially with a set of management services but eventually on capitation and then also looking to find ways to integrate those behavioral health organizations and get them working together with both Health Homes as well as the mainstream plans.

The other integration technique we are really excited about are Special Needs Plans, particularly in high-density areas like New York City – we'll be able to create specialized, fully integrated managed care plans that are uniquely situated to manage the complex needs of people with significant behavioral health challenges. These Special Needs Plans would manage the physical health as well as the behavioral health needs. We have done this successfully in New York for people with Aids and HIV and we think we can replicate this strategy which holds a lot of promise of both achieving true integration and at the same time making integration is being done by an organizations that have the expertise to manage the population.

Q: In recent years the mental health system has increasingly embraced the concept of "recovery," which envisions recipients achieving independence in multiple spheres of their lives, including: housing, employment, education, etc. In what ways will the current reforms in NYS promote recovery as a major goal in consumer's lives?

A: Absolutely, we are working very closely with our colleagues at the NYS Office of Mental Health. Commissioner Michael Hogan speaks often about the need to make sure all of our strategies focus on moving people towards recovery. In terms of recovery, the MRT has now had to take a look at things like housing which was not on our radar screens when we began designing the new reforms back in January of 2011. Housing has now become a vital part of our current plan, thanks to the advocacy of a lot of different folks throughout the mental health community of NYS. We learned from them the importance of housing in the recovery process. Stable housing, for many of our highest needs Medicaid patients is the number one impediment to their getting well. What we need to do is to look to use the Medicaid programs (to the extent to which we are allowed) and partnering with funds from other programs to further expand access to supportive housing. We are very interested in trying to use Medicaid as a progressive force for expanding access to housing options.

Q: Can MRT funding be used to invest in vital services like supportive housing?

A: The first step of the MRT plan had initial funding of $75 million dollars. We also have approval for an exciting initiative that allows us to create and capture savings as we close institutional settings such as nursing homes or other types of underutilized settings this year and plug these captured savings back into things like adding addition supportive housing units next year. The big next step is that we are pursuing a Medicaid Waiver Amendment to allow us to be able to reinvest some of the Federal savings we are generating by all of our efforts – then to reinvest some of those dollars into supportive housing and other housing options. The total value of our "ask" to the Federal government for the Waiver is $2 billion dollars per

see Interview on page 27

Search for Change has been rebuilding lives and strengthening communities for more than 30 years and continues to be a major force that provides a safe haven for individuals recovering from mental illness.

- ***Residential Services***
- ***Career Support Services***
- ***Private Case Management***
- ***24 Hour Staff Support***

115 E. Stevens Avenue - Suite 203
Valhalla, NY, 10595
(914) 428-5600 www.searchforchange.com

Ameriprise Financial

Your financial needs are unique.

Preparing for the financial future of a child with special needs presents special challenges. As the father of a special needs child, I understand the complexities of your situation. I'll look at all aspects of your finances, then find solutions that are right for your unique needs. And as your goals and needs change, I'll be there to help keep your family's plan on track.

Our Advisors. Your Dreams. MORE WITHIN REACH®

Call me today at (516) 345.2600

Philip P. Andriola, JD
Private Wealth Advisor
Andriola, Goldberg & Associates
A private wealth advisory practice of
Ameriprise Financial Services, Inc.
An Ameriprise Private Wealth Advisory practice

401 Franklin Ave
Ste 101
Garden City, NY 11530

516-345-2600

philip.p.andriola@ampf.com

www.ameripriseadvisors.com/
philip.p.andriola

Brokerage, investment and financial advisory services are made available through Ameriprise Financial Services, Inc. Member FINRA and SIPC. Some products and services may not be available in all jurisdictions or to all clients. © 2011 Ameriprise Financial, Inc. All rights reserved.

Interview from page 26

year over 5 years for a total of $10 billion dollars. There is significant opportunity for us then to invest in vital services like supported housing.

Q: The behavioral health system includes both hospitals and nonprofit community-based agencies. Continuity of care between these two systems continues to be a serious problem. Does the Medicaid Redesign Team have a strategy to address this issue?

A: Continuity of care has yet to be addressed. This relates to quite a few strategies such as making sure patients coming out of inpatient psychiatric stays have an effective care plan that reconnects them with community-based services. That is phase one of the behavioral health organization's efforts. A key fundamental measure of the success of that initiative will be the degree to which those plans make sure that within their network there is strong collaboration and partnership between the hospitals and the community-based agencies. Lastly the Health Homes – that's what they are all about – are to build those relationships across a wide array of providers – including all the agencies and organizations that see these same individuals now for only a small piece of their total health care needs. Our goal is to bring all that effort together community by community with the Health Homes initiative.

Let me speak a bit more about the nature of a Health Home. Each Health Home is a little bit different. We have so far certified thirty-four Health Homes all across New York State. There are about three thousand people already enrolled in Health Homes. A Health Home is like an Accountable Care Organization (ACO) for very high-needs individuals – because it is more holistic and comprehensive than a traditional ACO which is very much the medical model.

Q: Is the Health Home housed in a physical location that consumers will go to for assistance, or is it simply a 1-800 number people will call to speak with a case manager?

A: The Health Home consists of actual people helping consumers across NYS. Depending on their level of acuity, every individual who uses a Health Home will have a case manager to work who has a case load of individuals who they are responsible for. Very high acuity level individuals will have a case-worker with a very low case load – like ten to one. In quite a few cases, the Health Home has an actual physical office location. The overall idea is that all of the organizations within the Health Homes (30 or more in some cases) that consumers may frequent will all have access to that consumer's entire health and medical records. They will know who your doctors are and what services you are connected with – so when they see or speak with you they can help you with information that is shared within the Health Home partners. Everyone is connected in a single point of entry system that can help the individual consumer in a much more comprehensive fashion.

Q: If for example a mental health or substance use consumer is having difficulty with their medication not working for them, how will their Health Home worker remedy the situation?

A: The Health Home workers will connect that consumer back with their psychiatrist or primary care physician to help you navigate the system to get you what you need. It will be different than it is now, where in many cases consumers with significant needs have to visit multiple sites to receive help and those entities are not connected in any way. Our hope is that by providing the new integrated service and getting people what they need, this will hopefully reduce the likelihood that they will need to use an emergency room, and reduce the likelihood that they will need to be admitted to an inpatient psychiatric stay.

The interesting thing is that for people with significant behavioral health needs, the major expense in caring for them is not for their behavioral health needs, but rather for their physical health needs. Somebody with significant and persistent mental illness who also has diabetes, hypertension, COPD – when they are not being effectively treated for their depression or their schizophrenia, they are not able to take care of themselves with regards to their other physical health conditions. What ends up happening and the reason they are getting admitted is because their diabetes is completely out of control or because of their COPD related breathing difficulties, they are ending up in extended stay hospitals. When you draw back the real root cause of why their health is in such terrible shape – it's because they have a behavioral health challenge that's not being addressed.

What I like to tell people is that for a lot of the patients that we are working with through the new Health Homes – we're going to be spending *more* money on the behavioral health side to make sure they are on the medications they need to be on and we're getting them whatever other form of treatment that they need. This greater expenditure on the behavioral health side will save us money down the line in fewer hospital admissions.

Q: Years ago behavioral health consumers were placed in continuing day-treatment programs (CDT's) where they had a place to go every day for treatment and support, rather than stay isolated in their SRO or supportive housing apartment. With the new sweeping reforms and Health Home models coming about, will consumers have a place to go every day to help them feel connected to a caring community?

A: I think you're right. There have been reductions in funding for far too many of the behavioral health programs over the years due to budget constraints here in NYS and nationally throughout the mental health community. A lot of that was a result of how we pay for things. In a fee-for-service world, we had a host of programs of various types which we continued to cut funding back on, to the point where providers were no longer able to provide them. What happened was a result of having a very narrow view of budgets – where you end up cutting things that in reality ended up cutting costs

see Interview on page 29

When you or someone you love needs help…

WJCS offers comprehensive mental health services

Outpatient Treatment for People of All Ages
Specialized services for individuals with developmental disabilities

Intensive Community-based Services for Children & Their Families

Learning Center for Children & Adults
Psycho-educational evaluations
Educational tutoring
Diagnostic evaluations for autism spectrum disorders

Geriatric Care
Continuing Day Treatment
Mobile clinical service
Case management

Social Clubs
COMPEER

All services offered on a non-sectarian basis

914-761-0600

WJCS
WESTCHESTER JEWISH COMMUNITY SERVICES

Strengthening lives… Shaping futures

www.wjcs.com

System from page 1

when enacted, Medicaid had no specialty mental health benefit, and that state (and private) psychiatric hospitals (IMD's) weren't covered. And then consider how things have changed in the past four decades.

Acute care was moved to newly covered units in general hospitals, so that there are only a few thousand "state beds" still devoted to acute care in the entire country. Nursing homes were covered for intermediate care while state hospitals were not, so by the mid 1980's several hundred thousand elderly patients (and some not so elderly - in an unfortunate lesson about the power of financial incentives) had been moved to nursing homes. By 1985, Gronfein had demonstrated that the (indirect) impact on mental health policy of the Medicaid program was already greater than the impact of the community mental health centers program. And that was before things really ramped up; you know the rest of the story. Medicaid benefits for community care (clinic, case management, rehabilitation) were in place. Special services like Assertive Community Treatment were covered. "Medicaid it" became a cry of cash-strapped budget offices and an army of consultants. Today Medicaid's funding levels, policy influence, and - in many states - impact on mental health care, is greater than that of the state mental health agency (if one still exists).

And the changes since 1965 were not explicitly called for. Now, parity is the law, and the administration proposes rules for parity that do not allow different approaches for managing overall health benefits. So think about it again. Will we need a separate mental health system in the future?

The long term, I admit, is all speculation. The question before us now is what mental health managers, providers and advocates should be seeking, and acting on, as we move forward. We know what consumers will be seeking. The evidence is before us, in data showing that behavioral issues are the number one cause of pediatric visits and also that the treated prevalence of depression doubled after the introduction of the SSRI's - although most care in general medical settings is not up to recommended standards. People want care in the mainstream, for complex reasons that no doubt include stigma, convenience and coverage.

I believe our challenge is at the heart of healthcare reform. It is also evident in the statistics above. While people want care in the mainstream, the general health sector, without our help, is incapable of reliably delivering good behavioral healthcare. We see this across the lifespan in care for depression (a prevalent disorder that is reliably diagnosed and usually well treated by specialists). In the general medical sector, depression is often undiagnosed and when diagnosed it is usually undertreated - from peri- and post natal depression to adolescence to middle age to late life chronic illness. (Keep in mind that depression is usually simpler to diagnose and treat than other disorders.) The research and demonstration programs yield clear results. With a mental health "depression specialist" on the team (not across town, not in another agency, not available via referral, but on the floor - along with screening, treatment protocols and measurement) good care can be reliably delivered.

Our mission, in the next years, is clear. We must lead to achieve integration of care, everywhere. We also have to integrate medical care into our specialty settings, because without it our clients will never get decent medical care, and the rates of premature death will not improve.

We also must work to integrate mental health competencies into all clinical general medical settings - because emerging standards of care will demand it. We have to demand and assist health plans to pay attention to behavioral health in a fashion that goes beyond inadequate measures (did discharged psych patients make a single timely follow-up visit?...puhleez) to fully integrated care expectations and outcomes. At the national level, we need leadership to increase access to appropriate psychotherapies, recognizing that we have over-corrected to a dominance of medication treatment.

I am of the belief that the path ahead will see a few entrepreneurial leaders embrace the challenge of achieving true integration at every level from policy to plan to practice. These entrepreneurs will also succeed in business, because the game will come to them. Most of us will stumble along the road that we are on. For many, it will turn out to be a dead end, because someone got to the integration mandate ahead of us. And in some circumstances, we will have no leadership, and no mission except cost control - leading to a kind of deinstitutionalization revisited. In the next round of state budget cuts, in fact, we may see some early evidence of this unfortunate trend.

There are certainly other challenges that will continue to require state, federal and local mental health leadership. Key supports (e.g. housing, employment) are outside of health care. Special responsibilities like forensics are in statute. More must be done to support prevention/early intervention services that now have the force of evidence behind them. But the topic of the day, and the biggest area of federal reform, is in the area mentioned in our name - health.

How do the events of the past 18 months affect this commentary? Very little, in my view. But we see signs of accelerating change. Almost all the new service models unleashed by the Accountable Care Act - from Medicaid Health Homes to Accountable Care Organizations to patient-centered Medical Homes - cannot succeed without integrating behavioral and general medical care. The theme of "integration" is popping up everywhere. Yet the mainstream is not prepared. They need our help. On almost every crucial test - for example people discharged from an emergency room after self harm, or people who commit suicide after seeing a primary care provider - the mainstream still gets it right only about half the time.

What's your vision of the road ahead? Does it depend on specialty state agency leadership? Does it depend on protected status for particular providers? Or do you have a business plan for success, in an integrated health AND behavioral health environment?

Michael Hogan is the New York State Commissioner of Mental Health. His experience in mental health administration and research is unparalleled and includes leadership roles with the President's New Freedom Commission on Mental Health, the Joint Commission, the National Institute of Mental Health's National Advisory Mental Health Council, and the National Association of State Mental Health Program Directors. He has coauthored a book and several national reports, written more than 50 journal articles and book chapters, and received numerous awards for his service and leadership.

Special Thanks: This article was originally published in National Council Magazine, 2010; revised February 2012. Mental Health News wishes to thank Linda Rosenberg, MSW, President and CEO of the National Council for Community Behavioral Healthcare for granting us permission to reprint this article.

Supreme Court on page 12

the diseases it drives such as hypertension, diabetes, and heart disease. These are conditions that are particularly common among people with serious mental illness.

(6) Finally, the ACA emphasizes services in the home and community instead of in institutions. There are new demonstration grants as well as new opportunities for Medicaid waivers for state efforts to reduce the use of nursing homes and other institutions and instead provide care for people with disabilities in their homes and communities. In this way it carries forward the policy goal of helping people with psychiatric and other mental disabilities to live in the community rather than in institutions. It also will help states to fulfill the mandate of the Olmstead Decision of the Supreme Court, which interpreted the Americans with Disabilities Act as requiring states to provide supports to enable people with disabilities to live in the "most integrated" setting in the community rather than in institutions.

All in all the Affordable Care Act is a great step forward in America's efforts to meet the needs of people with mental health conditions and to do so in the community rather than in institutions whenever possible. As it is implemented, it should be a great boon to people with mental illnesses and their families, contributing to recovery and improved quality of life.

This will depend, of course, on how well the provisions of the ACA are implemented. Sadly, it is not likely in the current political atmosphere in the United States that ideological disputes will shift to the background so that federal, state, and local governments, providers, insurers, and advocates can focus on critical issues of implementation. We would be happy to be wrong about that.

Michael B. Friedman, LCSW, teaches at Columbia University. Kimberly A. Williams, LCSW, is the Director of the Center for Policy, Advocacy, and Education at the Mental Health Association of NYC.

Nurse from page 14

outcome from a negative experience.

The influence of an FCNS as a peer is synergistic. It is similar to when you take two medications at the same time and the result of the two is more potent than one. This is a very potent role. It produces a result not independently attainable. As seen in the example of Paula, a crisis was averted due to my dual role as a nurse and a peer.

How else do I promote health with the participants at SCC? I perform the usual nursing skills in conferring with participants regarding medication, blood pressure, smoking cessation, weight management and other issues. I assess, plan and evaluate immediate concerns, such as vomiting, sweating, dizziness and headaches.

Here is where the rubber meets the road. I conduct medication safety, advanced directives, shared decision making and sexual awareness classes. Why are these classes so different? Being a peer, there is created relationships of shared power and equality. I am not "better than" as a professional, I am an equal. These classes have integrity in that we are all in recovery, and working on our hopes and dreams together.

People with mental health conditions die on average 25 years younger than the general population. Wouldn't it be something if people with mental health conditions lived to a ripe old age? This is where the importance of a FCNS in a mental health setting comes in. The implementation of this new program at MHA, has given me, a FCNS, and a peer expert, the opportunity to help others build recovery from physical and mental challenges. I, in turn, am able to build a better life for all involved.

Change is a difficult and sometimes an uncomfortable process. The turmoil of emotional and physical pain does not have to be a hindrance in the quality of life. Health is the right of everyone. With a commitment to recovery and a desire to improve health, you too, can knock it "out of the park."

NATIONAL SUICIDE PREVENTION LIFELINE 1-800-273-TALK (8255) suicidepreventionlifeline.org

If you're feeling lost, desperate, or alone, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) The call is free and confidential, and crisis workers are available 24/7 to assist you

NATIONAL SUICIDE PREVENTION LIFELINE 1-800-273-TALK (8255) suicidepreventionlifeline.org

Interview from page 27

(in some cases) at the other end of programs. The way things were budgeted wasn't dynamic enough to show those costs elsewhere in the system – and as a result we made penny-wise pound-foolish decisions at the end of the day.

Let's look at some of the advantages of capitation and managed care in the long run. Let's assume we can get all of our complex patients into managed care organizations that are competent to manage the complete needs of complex patients. By giving the managed care organizations the capitation payment, they will actually have an incentive to try to keep people out of hospitals and other types of settings. This encourages programs to look at lower cost alternatives and why supportive housing and other types of services will be very attractive in that environment because they will help the plans keep their costs down by meeting the needs of the patient. It's not going to be a silver bullet quick solution to rebuild capacity. We need to look at the budget as a whole and think about the needs of the patients as a whole and then as time goes on the funds and recourses will begin to flow to those services that are most cost effective.

Q: Delivering mental health services to seriously emotionally disturbed children is enormously complicated, involving mental health and health care providers as well as the education and child welfare systems. How does the Medicaid Redesign Team envision structuring children's mental health services?

A: There are very significant challenges there. The MRT had a work group specifically focused on behavioral health which created its own sub-group on children's behavioral health issues. That group continues to meet today and is really grappling with the needs of children with significant behavioral health needs – whether they are in foster care or other types of institutional settings. The system that has grown up around them to provide services is fragile and has an antiquated financial system. What we've been working on may become a Health Home type solution specifically for children.

The other questions for children with very significant behavioral health needs include: 1) What managed care solution will best meet children's needs? (2) How do we strengthen delivery systems that provide children with services? and (3) How do we work with this small but important population and what measures do we use to gauge our success in meeting these children's needs?

To be honest, it remains a very vexing issue for us, but I think we have the right people around the table working on this. We are hoping that in a matter of a few months we will have a much more comprehensive strategy about how to address the needs of this population.

Q: As people with serious mental illness age, their medical needs increase. Does the Medicaid Redesign Team have a vision of how to provide services to older adults who have serious mental illness and co-occurring serious medical conditions?

A: For older adults we think there are some wonderful opportunities. With older adults much of the Medicaid focus tends to be on long-term care service. Obviously for older adults the vast majority of those over the age of 65 are on Medicare as their primary insurer. Very low-income older adults are also enrolled in Medicaid (dual-eligible).

We are rolling out one of our most successful and unique managed care models in the country called the *Managed Long-Term Care Program*. It focuses on those dually-eligible individuals' long-term care needs. We recently did a survey of customer satisfaction and found 90% satisfaction with consumers – an unusually high satisfaction rate for a government program, which we feel really good about.

Beginning in 2014, we are going to start integrating Medicare benefits with long-term care Medicaid benefits. In addition we will also bring in Medicaid funded behavioral health services. We will then have a fully integrated product for older adults receiving in-home and community-based services. We think that by building off this very successful model of bringing those pieces together, looking at the holistic needs of the patient, engaging the consumer, and getting them out into the community we will prevent the kind of isolation so common in this population of older adults. When an older adult does not have family support and only a home aid, they are cut off from the greater community around them and are more prone to depression. We think that a plan to get those individuals into social settings and re-involved in their community is a really exciting project. On the behavioral health side a lot of older adults have an un-diagnosed behavioral health issue. By bringing the behavioral health benefit in, we plan on making that a real part of the assessment that is done for these older adults through the Managed Long-Term Care Program. A very individualized care plan for each older adult will be developed within 30 days of enrollment, where the member and their family have a sit-down face-to-face meeting with the care plan manager to go over the complete needs of that member to put together an individualized care plan. I think we will end up with a highly individualized, highly integrated product for that aging population which is becoming bigger and bigger over time with the aging of the baby-boom generation.

Q: Will there be a monitoring process to keep the new MRT reforms on track and to give periodic report cards on their performance to stakeholders in NYS?

A: Absolutely. The MRT website (http://www.health.ny.gov/health_care/medicaid/redesign/) enables us to be very transparent with stakeholders throughout NYS, not only in the development of our plans which are available for review on our website, but also in monitoring implementation. We are also in the process of putting out an MRT quarterly newsletter on implementation from MRT to give the public a better sense of the direction of programs. On the financial side, we publish a monthly global *Medicaid Spending Cap Report*. We track our expenditures

see Interview on page 30

FREE COMPUTER TRAINING*

*For Persons with a Psychiatric Disability and/or ASD who reside in Westchester County. Call (914) 288-9763 for an Appointment.

Center For Career Freedom

One East Post Rd, White Plains, NY 10601

Microsoft® Office Specialist Authorised Testing Center

Go to www.freecenter.org for a tour & application.

Steve Vernon, Director - Drop-In Center

Proprietary School — NYS Education Department Licensed — Supervision

HDSW

Human Development Services of Westchester

Human Development Services of Westchester is a social service organization providing quality psychiatric, rehabilitative, residential and neighborhood stabilization services in Westchester County.

HDSW is dedicated to empowering the individuals and families we serve to achieve well-being. The mission is accomplished through the provision of housing, vocational services, case management, community support, and mental health rehabilitation services.

HDSW - Main Office
930 Mamaroneck Avenue
Mamaroneck, NY 10543
(914) 835-8906

HOPE House - Clubhouse
100 Abendroth Avenue
Port Chester, NY 10573
(914) 939-2878

Interview from page 29

very carefully. Program-wise for the first time, there will be a series of performance measurers with short, mid and long-term goals for each measure and every year these measurers will be updated on a regular basis. If we see any problems of failure to hit any targets, our intention is to think about what strategies need to be deployed to address the areas where we may be lagging. It's going to take us a full five years to implement all the initiatives the MRT has been charged to complete, and we're not going to stop engaging the public throughout this process.

Prior to arriving in New York, Mr. Jason A. Helgerson was Wisconsin's Medicaid Director. In that capacity, he administered the state's nationally recognized BadgerCare Plus program for children and families (Wisconsin's Family Medicaid, SCHIP, and Healthy Start Program); BadgerCare Plus Core Plan; SeniorCare (Pharmacy Plus Waiver); FoodShare (Supplemental Nutrition Assistance Program); and Wisconsin's Chronic Disease Program.

Jason was also the principle project sponsor for BadgerCare Plus, former Wisconsin Governor Jim Doyle's signature health care initiative. Through this program, 98% of Wisconsin residents have access to affordable health care, including all children.

Jason served as Executive Assistant/ Policy Director to the Secretary of the Wisconsin Department of Health and Family Services (DHFS) from February 2005 to March 2007. Prior to joining DHFS, Jason served as the Executive Assistant for the Wisconsin Department of Revenue.

Prior to joining the Doyle Administration, Jason served as the Senior Education Policy Advisor for Mayor Ron Gonzales of the City of San Jose, CA. In this role, he provided advice and counsel to the Mayor on all issues related to children. Before joining Mayor Gonzales' staff, Jason worked for the Milwaukee Public Schools (MPS) where he served as both the chief lobbyist for the district and as a deputy budget director. Prior to taking the position with MPS, Jason worked for Milwaukee Mayor John Norquist where he was the Education Policy Advisor and served as a senior official in the Mayor's Budget Office.

Mental Health News wishes to thank Bill Schwarz, Director, Public Affairs Group at the New York State Department of Health, for arranging our interview with Mr. Helgerson. We would also like to thank Dr. Peter Beitchman, Executive Director of The Bridge, and Chairman of the Mental Health News Board for his assistance in helping us develop many of the questions used in our interview.

STATEN ISLAND MENTAL HEALTH SOCIETY, INC.
A Multi-Service Children's Agency

116 years of experience providing award-winning programs staffed by highly skilled professionals

HEADQUARTERS:
669 Castleton Avenue
Staten Island, NY 10301
(718) 442-2225

www.SIMHS.org

New Initiatives from page 8

single most important need of people with serious mental illness (in fact of everyone). Absent the development of more housing, integrative models, expanded managed care, wellness initiatives, and better management of psychiatric medications are likely to have limited impact on the mortality gap. The good news is that more housing is planned. The bad news is that it is, as it has always been, very little housing compared to the overall need. Of course, incremental improvement is better than no improvement. But we should not fool ourselves that it is enough.

Conclusion: Despite the many reasons to doubt the ultimate effectiveness of the initiatives now underway to meet the medical needs of people with serious mental illness, the mere existence of these efforts gives reason for hope that over time their health will improve and the mortality gap will be reduced. But hope is not certainty, and it is critical to monitor the outcomes of these initiatives carefully and to make changes rapidly if they are not working.

Michael B. Friedman is an Adjunct Associate Professor at Columbia University's schools of Social Work and Public Health. He can be contacted by email at mbfriedman@aol.com, and you can visit his website at www.michaelbfriedman.com.

Toolbox from page 10

husband sees her and bursts into tears, screaming, "Larry is dead!" Ida immediately freezes like a deer in the headlights. The thought of a cold margarita passes through her brain, but she stiffens her newly developed backbone—she must remain calm in order to keep her husband calm.

She reaches into her toolbox (which she has taken to calling her "makeup kit") and the first skill set says: "Find out the facts." She asks, "Larry my brother or Larry the fish?" Her husband answers, "Larry the fish." She takes a deep breath and walks to the fish tank. The filter in the tank looks funny. Apparently Ida's husband decided to clean the tank, but something in his deteriorating brain led him to replace the plain cotton filter with Ida's makeup remover pads, which had the unfortunate consequence of poisoning the fish and frog. To add insult to injury, Ida's bladder couldn't hold out anymore and she's now standing in front of the fish tank in wet pants, looking at floating fish and a clogged filter. She reaches once more into her healthy toolbox and pulls out "Go to a meeting." Anxiety and addiction must wait. A meeting, and the laughter of fellow addicts hearing this incredible story, will soothe both the anxiety and the lure of addiction.

Daily, Ida learns to stock her toolbox with new skills and techniques. The sad fact is that her husband won't get better and feeling sorry for him or herself isn't going keep either of them sane or sober. The only way to do so is with a toolbox that includes spiritual fitness, 12-step meetings, and therapy. Ida realizes that she's not alone and she needn't ever feel alone.

What's the worst thing in the world, right now? That Ida wet her pants? That her husband is dying from a terminal illness and she must watch his slow demise? No, the worst thing right now would be to pick up a substance and let the stress and anxiety of the situation win. Later that week, Ida's husband was able to acknowledge that his dementia caused the mishap. His sense of humor remains present; a great gift! A few days later, she heard him whisper to their dog: "Stay away from the fish tank. It could be deadly."

Ida's toolbox/makeup kit grows more effective every day. Her husband is doing as well as can be expected right now. He's still working and trying to live as normal a life as possible. Neither Ida nor her husband is alone. The support of their family, 12-step meetings, therapists, prayers, and meditations make each day livable. As people age, their circumstances change. Mental health issues and addictions are often joined by increasing physical fragility and, in this case, terminal illness. But strong backbones can stay straight, and people in recovery can walk the straight path. And we can learn when to stay away from the fish tank.

Vickie Griffiths is currently completing her CASAC training and is an OASAS/CCAR Certified Recovery Coach, also a CCAR/NY State Trainer of recovery coaches.

Challenges from page 20

identify the vulnerability factors for SUDs, and can be helpful in making constructive choices promoting healthier coping mechanisms.

Addressing Denial in Group Work

The most significant component in group work is the supportive nature of the group process. When clients are in denial it may be good to emphasize this supportive feature by asking: "Even though you don't see substance abuse as a problem for yourself, do you think you could be supportive of the other group members who are seeking help for their substance abuse?" In this way the MICA group leader accepts the denial state, while at the same time setting the tone for a supportive group process. Most clients respond affirmatively to the question, and their ability to contribute is inherent in that response. Group members are informed that they will encounter various stages of treatment readiness in other group members: "In our group there are persons like yourself who don't think they have a substance abuse problem; there are also persons who think they may have a problem and want to abstain, but are not yet able to do so; and there are persons who know they have a problem and who are successfully abstaining." This information prepares group attendants to accept the varying readiness levels in others, and helps to eliminate discussion regarding comparisons with other clients (Sciacca, 1991).

A secondary component in group work is the educational aspect of the process. The MICA leader attempts to establish a reason for the person in denial to participate by asking, "In this group we learn a lot about alcohol and drugs. Do you have any interest in learning about this?" Members who have denied any involvement with substances at this point, may comfortably express interest in receiving education at the very least (Sciacca, 1991). Interest in education is perceived as an acceptable purpose for participation allowing for the group process to take effect without the resistance that may be brought about in some individuals when addressing denial.

Specific education on both mental illness and substance abuse is an essential part of the treatment process. Areas can include: mixing medication with substances; the symptoms and syndromes specific to each disorder; the forms of treatment utilized for each disorder; the physiological disease concepts for each disorder in contrast to moral judgment and stigma; and the process of rehabilitation and recovery for each disorder (Imel et. al., 2008).

Providing appropriate, integrated services for people with dual diagnosis can improve recovery and overall health, and restructure the effects the disorders have on their family, friends and society. By helping these people stay in treatment, finding housing and jobs, developing better social skills, and enhancing insight and judgment, there is the potential to reduce the prevalence of HIV/AIDS, domestic violence and violent crimes.

According to *Rethinking Substance Abuse* by William R. Miller and Kathleen M. Carroll: 1) Fifty-three percent of drug abusers and 37% of alcohol abusers have at least one serious mental illness; 2) Roughly 50% of individuals with severe mental disorders are affected by substance abuse; 3) Twenty-nine percent of all people diagnosed as mentally ill abuse either alcohol or drugs; and 4) Sixteen percent of jail and prison inmates are estimated to have severe mental and substance abuse disorders.

Group work for dual diagnosis should provide treatment for: Drug and Alcohol Use, Behavioral Addictions, Codependency Patterns, Mental Health and Psychiatric Status, Trauma Issues, Eating Disorders, Sexual Addiction and Compulsivity, Family Functioning, Social Relationships, Physical Health and Fitness, Diet and Nutrition, Vocational and Educational Needs, and Legal Problems.

Subscribe to Mental Health News

Yes! **I want to receive each Quarterly issue by Mail**

- ☐ Student ($20/year) School/Program _____
- ☐ Individual/Family ($40/year)
- ☐ Professionals ($50/year)
- ☐ Group - 50 Copies Each Issue ($300/year)

Give a Gift of Hope
Order a Gift Subscription for Someone in Need

Name & Title: _____

Address: _____

_____ Zip: _____

Phone: _____ E-mail: _____

Include your Check Payable to:
Mental Health News Education, Inc.
(or pay by credit card at www.mhnews.org)

cut out this coupon and mail it with your check to:

Mental Health News Education, Inc.
460 Cascade Drive, Effort, PA 18330

Phone: (570) 629-5960 E-mail: iraminot@mhnews.org

Advertise in Mental Health News

*** 25% Savings - Book 3 Get 1 Free!!**

- ☐ Business Card - 4 issues ($500)
- ☐ Eighth Page (1 issue $300 - 4 issues* $900)
- ☐ Quarter Page (1 issue $500 - 4 issues* $1,500)
- ☐ Half Page (1 issue $750 - 4 issues* $2,250)
- ☐ Full Page (1 issue $1,000 - 4 issues* $3,000)
- ☐ Inside Covers & Back Page (please call)
- ☐ Special Multi-page Supplements (please call)
- ☐ Honorary Sponsorship (please call)

Name & Title: _____

Address: _____

_____ Zip: _____

Phone: _____ E-mail: _____

Include your Check Payable to:
Mental Health News Education, Inc.
(or pay by credit card at www.mhnews.org)

cut out this coupon and mail it with your check to:

Mental Health News Education, Inc
460 Cascade Drive, Effort, PA 18330

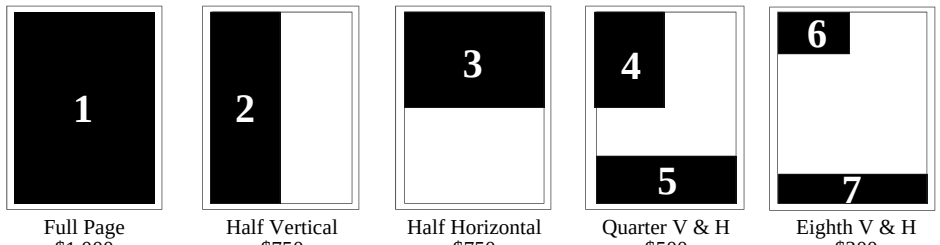
Phone: (570) 629-5960 E-mail: iraminot@mhnews.org

Promote Your Vital Programs and Services for the Mental Health Community
And Reach Our 160,000 Readers
Place Your Advertisement for the Year In Advance and Save 25%

Deadline Calendar & Ad Size Specifications

Deadline Dates

Winter Issue - October 23, 2012
Spring Issue - January 23, 2013
Summer Issue - April 23, 2013
Fall Issue - July 23, 2013



Full Page $1,000 | Half Vertical $750 | Half Horizontal $750 | Quarter V & H $500 | Eighth V & H $300

Ad Sizes - In Inches

	Width	Height
Full Page (1)	10.4	12.8
Half Vertical (2)	5.1	12.8
Half Horizontal (3)	10.4	6.4
Quarter Vertical (4)	5.1	6.4
Quarter Horizontal (5)	10.4	3.1
Eighth Vertical (6)	5.1	3.1
Eighth Horizontal (7)	10.4	1.5
Business Card (not shown)	5.1	1.5

MENTAL HEALTH NEWS

Recovery from mental illness is possible but it takes a community of support.

Mental Health News provides news, information, education, advocacy, and resources in the community that adhere to our strict evidence-based standards and is a vital link to that community of support.

Learn how Mental Health News can help provide your organization or community group with an affordable and trusted source of mental health education.

Call us today at (570) 629-5960 or visit our website at www.mhnews.org