MENTAL HEALTH NEWS™

YOUR TRUSTED SOURCE OF INFORMATION, EDUCATION, ADVOCACY AND RESOURCES
SPRING 2003 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 5 NO. 2

Housing For People With Mental Illness

Housing Options For People With Mental Illness

By The Center for Mental Health Services (CMHS) U.S. Department of Health and Human Services

Home, to most people, means much more than shelter. Whether it is one's own room, an apartment, or a house, a home can offer stability and a chance to be part of a community. For people with severe mental illness, home can be a place to live with dignity and can be conducive to recovery.

Many factors influence where you live, such as:

- How much you can afford to pay?
- Is the neighborhood pleasant? Is it safe?
- If you share a living space, are you and your housemates compatible?
- Is the house, apartment, or room in good condition?
- Is transportation available and near to your treatment center, pharmacy and stores?
- How much support do you need to carry out everyday activities?

Finding out whatever you can about the landlord, such as, does he or she have a reputation for responding promptly and courteously to tenants' requests is also a good idea. Were previous tenants happy living there? Has the lease been reviewed before you sign on the dotted line? If you need help with finding a place, filling out forms, or reviewing a lease, your caseworker is a valuable resource. If you do not have a caseworker, you may wish to contact the advocacy group or the housing specialist at the public mental health agency nearest you.

Home Ownership

Most of us dream of owning a home. Yet this dream remains out of reach for many Americans, especially those with mental disabilities. However, programs such as those administered by the U.S. Department of Housing and Urban Development do exist opening the door to home ownership for people with disabilities and who have low to moderate incomes.

The level of help varies with the programs, which are joint ventures between State and local home ownership coalitions. Examples of the kinds of assistance you might receive include: financial counseling; assistance with a down payment, closing costs, and property repairs to meet inspection requirements, and financial support to prevent delinquency on a loan if you are unable to make your mortgage payment due to hospitalization or another unforeseen difficulty.

However, it is important to keep in mind that not all States and localities have these programs, and funds for these programs are often limited. For a referral to a local agency that has information about such programs, call the Housing Counseling Line of the U.S. Department of Housing and Urban Development at 1-800-569-4287 or 1-888-466-3487.

Public Housing

The Federal government provides housing assistance to people with low incomes through two programs administered by the

see *Housing Options* page 55

New Fairfield County Section Premiers

We are pleased to announce that Mental Health News will now be covering the mental health scene in Fairfield County, Connecticut.

Thanks to the leadership and vision of Dr. David Brizer, Chairman of Norwalk Hospital's Department of Psychiatry, a committee of Fairfield's mental health leadership has been formed.

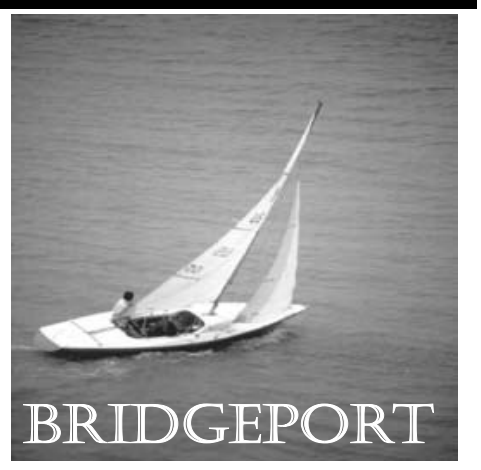
A rich blend of consumers, families, treatment providers, and the Connecticut Department of Mental Health and Addiction Services have united to work with Mental Health News to bring its mission of delivering mental health education to the region.

According to Brizer, medical editor of MHN's Fairfield section, "Mental Health News will help us close a huge information gap that exists, and greatly help many people find the professional and peer help and support they need."

The development of our new Fairfield County section follows the successful launch of the New York City section.

We wish to welcome our new readers in Connecticut and invite everyone to participate.

See page XX for the full story.



Ridgefield **Stamford** Greenwich Norwalk Danbury

Also Inside This Issue Of Mental Health News!

- **State Budgets: How Will They Affect the Mental Health Community?**
- **The Myth & The Reality of ECT: A Comprehensive Report by NYSPA**

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Mental Health News Wishes to Express Its Sincere Gratitude And Appreciation To The Members Of Our Advisory Council And To The Organizations and Supporters Who Make This Publication Possible

The Publisher's Desk

The Keys To Recovery

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

Every day in our mental health community, peoples lives are significantly changed by the simplest of objects. Most of us take them for granted. We carry them around in our pockets without even a thought. They are our house keys.

If you didn't have them, what would you do? Imagine not having a home to go to, a place to call home, a roof over your head, a bed to sleep in every night. For people with mental illness, that thought and that reality can mean the difference between life and death.

Hard to believe? Not if your thoughts and reality are being altered by depression, schizophrenia, bipolar disease and other forms of mental illness.

I take special pride in having this issue of Mental Health News focus on *Housing for People With Mental Illness* and wish to thank everyone who helped bring this special edition to our readers. When research began, I found the topic to be vast and began to realize that we would merely be scratching the surface. There are many policy, as well as therapeutic, issues that come into play and so many organizations providing an array of unique services that it would not be fair to say that we have covered all the bases.

It would not be fair to say we have made a complete analysis to the issue of housing if we didn't also explore the dark side. I am referring to housing abuses and shortfalls, which have come so sharply into focus thanks to the writings of Clifford Levy in the New York Times. Since his expose on the scandalous adult and nursing home situation received much applause and a hoped-for remedy, I have chosen to look more at the accomplishments within the system. Yes, there are many; however, I remain committed to decrying these abuses and urge everyone to press for change. The time has come to correct the wrongs and make them right once and for all.

While working on this issue, I felt a poignant sense of reminiscence. In the very first issue of Mental Health News, which premiered in the Fall of 1999, I wrote a vignette which expressed my gratitude to an organization by the name of Westchester Residential Opportunities—better known simply as WRO. I titled the article, "Somewhere Out There Somebody Cares—There Really Is A Safety Net." I would like to let you read part of it again.

"Just imagine you become stricken with a mental illness. Your whole life becomes torn apart. In an extreme, yet not uncommon scenario, you become unable to work and face repeated hospitalizations. Your illness creates a personal loss of self-esteem, and you face negativity in the form of stigma that society hurls at your condition. Finally, as if that wasn't enough, the personal, material and financial costs of your illness completely brings you to your knees. You struggle to be well again, but you have lost everything you have worked so hard for. Homeless and penniless, you find yourself on a psychiatric inpatient unit—afraid to leave the hospital. That's because you have no home to go to and nowhere to live anymore—you are homeless."

"Somehow your difficult situation is brought to the attention of an organization called WRO which helps people with mental illness find affordable, safe housing. Members of a skilled team called, The Independent Living and Shelter Plus Care Program, visit you at the hospital to reassure you that they will help you find an apartment. Meeting these wonderful and caring people, you feel your eyes well up with tears. That's because it is so comforting and reassuring to know that people are working to help you make it. Suddenly, you feel hopeful again and some of the fears and anxieties that haunted you concerning where you would go begin to fade away."

I wrote that article three years ago, and it has been five years since I was *that* person in the hospital.

Fortunately, the treatment I received after my ten-year battle with depression enabled me to turn the corner on my illness.

Thanks to the help I received from WRO and other community mental health agencies, I was given a chance to rebuild my life. It meant starting over, but I found myself guided by the difficult journey I had endured and the lessons about life I had learned.

Ira Minot

At that moment, everything seemed to come together in my mind. I decided to devote all my energy to mental health education and Mental Health News was born.

I could not have done this without the help of WRO and the Shelter Plus Program. The housing which was provided to me during a most critical time of my life was by far one of the most significant factors in my recovery.

The reason housing is so vitally important is twofold: Having secure, safe and affordable housing gives a person with mental illness the basic stability and normalcy of their own space, and provides a place to practice and re-develop the skills needed to participate in the regular daily routine of life.

While attending treatment along with a neighborhood drop-in center or clubhouse, a consumer is able to come back to their own apartment and know they have the ability and support to wake up tomorrow and conquer another day.

The organizations which provide housing to people with mental illness are the diligent and quiet advocates for some of the best that our mental health community has to offer. They are the unsung heroes and deserve our attention, applause, and commitment to provide more funding so that they can better serve the growing ranks of clients in every community.

More funding would allow for better monitoring of the daily living of consumers placed in an apartment or residence. It's not enough to give someone the keys if sometime later their treatment stops working, and they isolate themselves in their room and about to attempt suicide. Believe me, I know...it happened to me.

And by more funding I am referring to money from both the State and Federal government.

It is appalling that Federal Shelter-Plus and Section 8 programs in my community have mile-long waiting lists because slots are just not available. An average wait for a Section 8 apartment is five years, that's right, five years!! What are consumers supposed to do in the meantime? That is just not right, and there has to be a better way.

In closing, I want to give thanks and salute the many organizations that are represented in this issue of Mental Health News. The newspaper has continued to inspire people with our mission of bringing vital mental health information, education and advocacy directly to the individuals and families who need it most.

Our last issue saw the premier of a vital and continually expanding New York City section of the newspaper. This issue continues that success with the premier of our new Fairfield County Connecticut section.

Mental Health News Education, Inc., the new non-profit organization behind Mental Health News, has begun to chart a course for the future and is developing a wonderful new personality as well. The volunteer leadership behind our new organization has been working with me over the past year. Our plan calls for the development of the infrastructure and resources required to become a vibrant, multi-faceted mental health, educational organization. We are already off to a great start!

I am honored and proud to announce that Dr. Alan B. Siskind, Executive Vice President and CEO of the Jewish Board of Family and Children's Services, has been elected to be the first Chairman of the Board of Mental Health News Education, Inc.

I know that with Dr. Siskind's leadership, our vision for the future will be clear, focused and attainable.

Together, with our other wonderful and committed volunteer leadership, we will continue to develop not only as an award winning mental health newspaper but also as a lifeline of hope.

Best Wishes
Ira H. Minot, CSW

MENTAL HEALTH NEWSDESK

National News

President Proposes $1.75 Billion to Assist People With Disabilities Transition from Institutions to Community Living

NAMI E-News
2003 Vol. 05

This past week, the Bush Administration announced its intention to develop a 5-year, $1.75 billion initiative to help states move forward on efforts to move people with severe disabilities—including children and adults with severe mental illness—from institutional care to the community. The program is part of the President's "New Freedom Initiative" for people with disabilities and will include a proposal for $417 million in new funds as part of the Bush Administration's FY 2004 budget proposal.

The largest share of the $417 million request for FY 2004 is $350 million for state Medicaid demonstration programs that would allow Medicaid dollars to follow an individual from institutional care (including long-term hospitals and nursing homes) into the community. These Medicaid demonstration programs would be 100% federally funded for the first year (unlike traditional Medicaid funding which is based on a joint state-federal match). However, after the first year of a demonstration program, a state would be required to assume the cost of community services at its regular federal matching rate.

NAMI is currently seeking clarification from the Bush Administration as to how such a demonstration program would apply to non-elderly adults with mental illnesses residing in Institutions for Mental Diseases (IMDs) that are not eligible for federal matching funds under Medicaid. Having the federal government immediately assume 100% of the cost of community-based care for individuals transitioning from IMDs would be an enormous step forward in addressing the many inequities in the IMD exclusion. However, there is concern about the willingness of states to include IMDs in such demonstration waivers if they are forced to assume 100% of the costs under Medicaid after the first year.

White House photo by Eric Draper

Other key provisions in the Administration's new proposal are a new demonstration program for community-based care alternatives for children residing in psychiatric residential treatment centers and renewal of a previous proposal for respite care services for caregivers of both children and adults with severe disabilities. The Bush Administration also plans to seek authority from Congress for a $95 million, 5-year program to extend Medicaid eligibility for spouses of people with disabilities who return to work (currently spouses are often discouraged from working because the household's extra income makes them ineligible for Medicaid).

Finally, the Bush Administration plans to develop a proposal for Medicaid presumptive eligibility for individuals being discharged from institutional settings directly into the community. NAMI will be seeking clarification as to whether non-elderly individuals with severe mental illness residing in IMDs will be able to participate in this automatic, immediate Medicaid eligibility.

This $1.75 billion initiative is part of an even broader proposal still under development within the Bush Administration to achieve long-term systemic reform of the Medicaid program. The proposal, which will be highlighted in the President's FY 2004 budget plan, would distribute funds to the states in separate annual allotments for long-term and acute care rather than on the basis of a federal match as the Medicaid program currently operates. Early indications are that the proposal would require states to continue to provide "comprehensive" benefits for all mandatory Medicaid populations, including children and adults with severe mental illness receiving Supplemental Security Income (SSI). States would then be given enhanced flexibility for services to "non-mandatory" Medicaid populations.

National News

HUD Targets $35 Million For Chronic Homelessness

Individuals With Severe Mental Illnesses and Co-Occurring Substance Abuse Disorders To Benefit

NAMI E-News
2003 Vol. 04

On January 27th, the U.S. Department of Housing and Urban Development (HUD) issued its long awaited Notice of Funding Availability (NOFA) for a $35 million program to address chronic homelessness. This initiative is part of an overall Bush Administration effort to shift federal homeless policy toward ending chronic homelessness over the next decade. The new program includes funding for permanent supportive housing, mental illness and substance abuse treatment, primary health care and veterans' services. It is being coordinated by the White House Interagency Council on the Homeless and involves the participation of separate agencies at HUD, HHS and the VA.

Numerous studies have demonstrated that individuals with severe mental illnesses and co-occurring substance abuse disorders are disproportionately represented among the nation's chronically homeless population, i.e. individuals that have been homeless for a year or more and who typically cycle through the streets, shelters, jails and hospitals. Several recent studies have revealed that supportive housing (permanent housing linked to support services) is extremely effective in breaking this cycle and promoting recovery and full community participation. The Bush Administration's new program is designed to help localities develop and promote supportive housing programs in order to move toward eliminating chronic homelessness at the community level.

MENTAL HEALTH NEWSDESK

New York News

Governor Pataki's NYS State Budget Stirs Relief and Anxiety Within The Mental Health Community

Staff Writer
Mental Health News

Mental health advocates have reacted to Governor Pataki's budget request with a mix of relief that there are no substantial cuts to community mental health services funding within the OMH budget and with anxiety about possible loss of research and of inpatient services. Here is an initial look at the Governor's 2003-2004 budget proposal.

The budget request proposes the closing of three psychiatric centers (PC) as of July 1, 2003, including: Hutchings PC in Syracuse (inpatient services move to Mohawk Valley PC, Utica), Elmira PC (inpatient services move to Rochester PC), Middletown PC (inpatient services move to Rockland PC). Further psychiatric center closings, effective October 1, 2005, are to include: Bronx PC (inpatient services move to other NYC metro hospitals), and Bronx Children's PC (inpatient services move to other downstate children's facilities).

It proposes merging The Nathan Kline Institute with the New York State Psychiatric Institute as of April 1. Both campuses would remain open, but the plan to cut 113 positions—all of NKI's state funded staff—has aroused fear that vital research will be lost.

The Governor also proposes to re-enact the Community Mental Health Support and Workforce Reinvestment Program and to redirect savings from downsizing the state-operated inpatient system for community-based services beginning in fiscal year 2004-2005. The program is anticipated to foster 600 new community supported housing beds, expanded community services for children, and workforce related investments to improve recruitment and retention. Advocates welcome the re-enactment of Reinvestment but are distressed that savings from hospital closures in 2003-4 will not be reinvested.

The Budget Request also calls for capital funding for 1000 units of new housing—in part to address the needs of people in adult homes and in part for people who are homeless, people who are leaving state hospitals, and for children and adolescents. There are promises of additional funding in future years.

The Governor has also proposed in the Department of Health's budget $8 million for adult home assessments, case management, medication management and improved services. Advocates are generally pleased that the Governor as earmarked some funding to address the scandalous conditions in adult homes, but have expressed concern that it is not nearly enough to overcome the problems.

The Department of Health's Budget also includes a proposal to establish a preferred drug list but appears to exempt psychiatric medications from these controls. Other controversial proposals in the DOH budget include reductions of Medicaid coverage for elderly and disabled people whose first health payer is Medicare, the shift of some children from Medicaid to Child Health Plus, which provides less mental health coverage, and reductions of funding for psychiatric services in general hospitals.

Governor George Pataki

See our *Columns* section for more details and analysis.

New York News

MHA's of NYC and Westchester Establish New *Metropolitan Center for Mental Health Policy and Advocacy*

Staff Writer
Mental Health News

The Mental Health Association of New York City and The Mental Health Association of Westchester County have announced the establishment of The Metropolitan Center for Mental Health Policy and Advocacy.

"The Center," said Giselle Stolper, Executive Director of The Mental Health Association of NYC, is an extension of the traditional mission of Mental Health Associations to provide leadership in the development of mental health policy. We believe it is important to step up our efforts now because the downturn of the economy jeopardizes progress in mental health policy."

"Historically, Mental Health Associations have brought together the diverse components of the mental health community. A major function of the center will be to foster communication and cooperation among all those in the metropolitan New York City area with an interest in the well being of people with mental illnesses or emotional problems," added Carolyn Hedlund, Executive Director of the Mental Health Association of Westchester County.

"A major goal of the center," said Stolper, "is to promote data-based mental health policy. The Center will collect information relevant to mental health policy from a variety of sources and organize it into a data-base which will be accessible to mental health advocates, policymakers, the media, and others."

"The Metropolitan Center will not compete with the many mental health advocacy groups which already exist," Dr. Hedlund stressed. "In fact, we will be available to provide supportive services for these groups. In addition to sharing the data base we develop, the Center will provide sophisticated policy analyses and consultation and training regarding mental health policy and advocacy."

"We are very pleased," Dr. Hedlund and Stolper said, "that Michael Friedman has agreed to serve as the Director of the Center and to devote himself to building it from concept to reality. He has thirty-five years experience as a mental health clinician, advocate, administrator, and policy maker in New York City and the Hudson Valley. It is hard to imagine anyone more qualified than he to lead this enterprise."

"I am delighted to be given this opportunity," Friedman said. "Mental health policy historians often argue that mental health policy goes through cycles of improvement—in good times—and decline—in bad times. Protecting and improving mental health policy in these troubled times is a critical challenge. I hope the Center will make an important contribution to meeting this challenge."

The activities of the Center will include: Convening diverse parts of the mental health community to discuss mental health policy concerns, gathering information essential for the development of mental health policy, sponsoring ongoing committees on selected mental health policy topics, developing mental health policy proposals, providing public education regarding mental health policy including: (conferences, briefings, written reports, and web sites), providing mental health advocacy training for advocacy, service, and educational organizations, and providing consultation to assist interested organizations with the development of advocacy activities.

For further information contact Michael B. Friedman at 914-686-2886.

NYS Office of Mental Health Funds Community Housing

By Christine Madan, Director of Housing New York City Field Office NYS Office of Mental Health

"This is where I live."

At any time during John's life he might have said that about a shelter, a street corner, or a psychiatric hospital. Today, however, he is proudly showing his studio apartment to some visitors from the New York State Office of Mental Health. John's studio is one of forty-eight apartments in a Community-based residential program in Brooklyn operated by Services for the Underserved, Inc. (SUS).

SUS is a not for profit Agency that has received funding from the New York State Office of Mental Health (OMH) to construct and operate John's building. Instead of eating at soup kitchens or sleeping on a cot in a barracks-style shelter, John has a self-contained unit with a bathroom, kitchen and sleeping/living area. Perhaps as important as the apartment, John has SUS staff available 24 hours a day to help him manage his mental illness and engage in activities that will allow him to make progress toward living independently—health services, employment, education, social activities. When more support is needed, John has the choice of receiving additional services through Supported or Intensive Case Managers.

These same services will also ensure that he is able to manage living with mental illness and hopefully prevent future hospitalizations. If he needs help in learning to budget money, staff can help. If he wants to have a meal with a larger group, the building offers community meals to residents. When staff sees that John is spending too much time alone, they will encourage him to join in community activities or take advantage of something in the community.

Finding this housing wasn't easy for John. He had spent many years either on the streets or in shelters and never thought his life could change. Through the efforts of a case manager, an application to OMH-sponsored housing was finally made on John's behalf. When some agencies considered John a poor candidate for housing because of his years on the street and his problem with alcohol, the Single Point of Access (SPOA) committee intervened with the housing agencies. The SPOA oversees how persons are admitted to OMH-sponsored housing. Across the State the SPOA is operated by localities and in New York City it is collaboration between the City and the State. The SPOA identifies what issues must be resolved in order to ensure that everyone who needs housing in the OMH system has fair access. Once additional information and support services were made available to the housing agency through the SPOA process, John was accepted into the studio apartment building where he has lived for 18 months.

The building where John lives was made possible by an initiative that involved both New York State and New York City resources.

In 1990 New York State and New York City entered into a partnership called "The New York/New York Agreement." Under this agreement the State and the City agreed to provide construction capital or rental assistance for more than three thousand new units for homeless mentally ill adults in New York City.

The state agreed to provide service funding to all these new units. In 1995 a second NY/NY agreement was signed creating 1,500 new units. Since the first NY/NY agreement, more than 8,300 adults have found decent housing with support services. Some residents have been able to move on to independent living.

In addition to the housing created under the New York/New York Agreement, the New York State Office of Mental Health funds many different types of community-based housing for people like John. Although all residents have a diagnosed mental illness, the type of housing each one needs may be very different.

There was a time when the mental health system depended almost entirely on state hospitals as the primary focus of care. In the past two decades there has been a dramatic decrease in the number of people housed long-term in State hospitals. Much acute inpatient care is now provided in general hospitals and in private psychiatric hospitals.

From early 1983 to 2002 the census at state-operated psychiatric hospitals for adults has been reduced from 21,500 patients to approximately 4,300. During that same period there has been major growth in community housing options throughout the state: from 4,953 beds in 1983 to more than 24,500 the end of 2002. An additional 2,500 beds are projected to be available before April 2005. In the 2003-04 proposed Executive Budget, an additional 2,600 would be developed over the next three years. With these new beds the number of new OMH community-based beds will have increased by 60% since 1995.

The OMH network of housing includes highly structured and supervised housing (Congregate Treatment Community Residence), moderately supervised, (Treatment Apartments, Community Residence SRO, Family Care placements) and minimally supervised apartments known as Supported Housing.

In addition to these housing resources, an array of new outpatient and community support programs has been funded by OMH in recent years. A person who now lives in the community can choose to take advantage of the services he or she most needs whether it is intensive case management, supportive case management, Assertive Community Treatment (ACT) teams, or peer operated support groups.

This network of community-based housing and support services is available throughout New York State, with the highest number sites located in New York City. In addition to providing housing for persons who do not require inpatient hospitalization, these residential programs furnish support services and offer a connection to other resources in the community. The combination of stable housing and support services allows each resident to remain in the community and function at his or her highest level. In some instances residents are able to become employed, reunite with children, or leave the housing to live independently.

Residents of OMH-sponsored housing, such as John in his apartment in Brooklyn, can look forward to working with staff and community supports to overcome the challenge of living with mental illness.

A NYS OMH Housing Project Under Construction

A Completed Studio Apartment

Services for the Underserved: A Resident Success Story

Jim is 52 year old. He has been living with mental illness (Paranoid Schizophrenia) for more than twenty years, despite that he had a family, held a job, and became a parent. However, Jim's illness eventually took its toll.

Once his delusions and thought disorder became out of control, he eventually lost his job, became estranged from his family, and became homeless. With no family or friends to help him cope with his illness, John's life changed over the course of a few months. His life on the street also brought with it the abuse of alcohol and other substances.

After receiving treatment through a local hospital, Jim was referred by his hospital team to a Congregate Residential Treatment Program operated by SUS. Once he moved into the housing, Jim had the support and intervention of staff to help him regain his living skills and maintain control of his mental illness. Staff at SUS worked with Jim to help him keep his room in order, to battle his addiction to alcohol and drugs, and to learn how to prevent the things that had left him alone and homeless.

Initially Jim was suspicious and anxious. He was withdrawn and stayed by himself. He met with his Residential Case Manager at least three times per week. Gradually he began to develop a small level of trust. Jim maintained his abstinence from illicit drugs and alcohol and cooperated with staff monitoring of his medication regimen. With patience, support and encouragement by residential staff, Jim eventually expressed interest in reconnecting with his adult children. Initially he gave all his money to his daughter, which left him with very little to support himself.

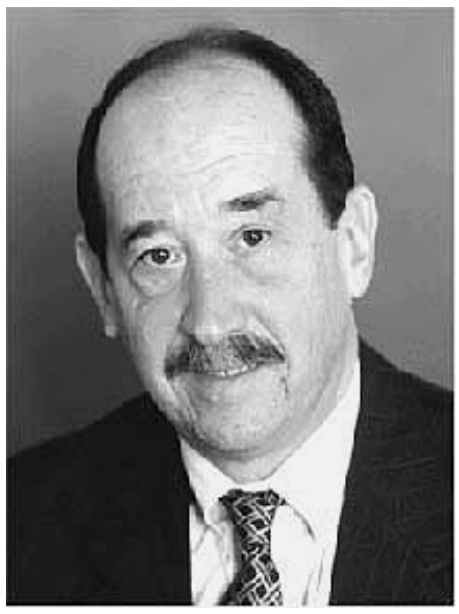
With counseling and support Jim learned to budget and fulfill his need to be a caring parent without compromising his own well being. While he continues to suffer through periods of self-doubt and depression, he has learned to reach out to others as he strives to create and sustain meaning in his life through relationships. He is actively involved in advocating for his peers who continue to struggle with their mental illness and addiction.

Jim is now working in the SUS Supportive Employment Program and encouraging others to seek vocational training. He assists with the cooking in the residence and motivating others to participate in completing their chores. This progress did not come easy for Jim. Along the way he relapsed and abused alcohol, but his setback was brief and it served as an opportunity for him to confirm his trust in others and strengthen his resolve to turn his life around. Jim continues to seek support from Residence staff while he waits for a residential slot in a shared apartment through the SUS Apartment Treatment Program to become available.

Services for the Underserved
305 Seventh Avenue, New York, NY 10001

A Look at the 2003-2004 Executive Budget

By James L. Stone
Commissioner
NYS Office of Mental Health



James L. Stone

The Office of Mental Health (OMH) is currently in the midst of a multi-year plan to restructure New York State's public mental health system. The priorities of accountability, best practices and coordination of care are shaping the agency's efforts to improve outcomes for individuals with mental illness and promote their recovery. We have made substantial progress to date: case management service capacity for adults and children has doubled; the number of children receiving Home and Community Based Waiver services has nearly tripled; across the State, single points of access are ensuring that adults and children with the highest need are receiving priority access to case management and housing services; and Assisted Outpatient Treatment has led to improved outcomes for thousands of individuals.

We continue to move forward on our agenda for positive change, but this year New York is facing challenging fiscal times. There are courageous and difficult choices made in the 2003-2004 Executive Budget, which provides approximately forty-six million dollars in financial relief without any significant reduction of mental health services. Instead, savings are realized by consolidating programs and facilities, increasing federal reimbursement, reducing spending on non-care-related functions, and streamlining operations.

There were many hard choices. Nathan S. Kline Research Institute in Rockland County will close on April 1, 2003, and merge its research activities with those at New York State Psychiatric Institute in Manhattan. This will allow OMH to operate a single, cost-effective entity while maintaining its commitment to research at the two campuses. But even after the closure of Nathan Kline – which does not provide patient care – New York will still be the national leader in per capita State funding for mental health research.

Community-based initiatives have proven to be successful at averting unnecessary inpatient admissions. In fact, the number of adults receiving inpatient care at State-operated civil psychiatric centers is less than one-half of what it was only eight years ago.

As a result of this reduced need for inpatient capacity, OMH is funding underutilized and empty inpatient beds, and expects a system-wide reduction of 90 beds during the coming year. This will not compromise access to quality mental health care, and in fact the savings from this bed reduction will be used to preserve the community-based system – which is where about 90 percent of our clientele receive their mental health services.

OMH can achieve substantial savings without compromising care, by restructuring State-operated inpatient services to enhance administrative efficiencies. As such, OMH plans to close four adult psychiatric centers and one children's psychiatric center, and relocate their inpatient capacity to nearby facilities.

Three adult psychiatric centers will close on July 1, 2003. These closures will not reduce inpatient services, as there is no bed reduction specifically associated with these closures. In all three instances, the State-operated outpatient programs will remain where they are. They are: Elmira Psychiatric Center, with inpatient services relocating to Rochester Psychiatric Center; Hutchings Psychiatric Center in Syracuse, with inpatient services relocating to Mohawk Valley Psychiatric Center in Utica; and Middletown Psychiatric Center, with inpatient services relocating to Rockland Psychiatric Center.

These three facilities are among the smallest in the OMH system, each having fewer than 125 inpatients. The three receiving facilities have all had the full benefit of capital renovations and have excess capacity to accept the transfer of all inpatients without major capital costs.

Mohawk Valley and Rochester Psychiatric Centers both operate children's inpatient units and are fully prepared to accept the children transferred from Elmira and Hutchings Psychiatric Centers' children's units. Related to that, under the new Reinvestment program, the flexibility will exist to convert and expand local children's services as needed.

Two facilities will close on October 1, 2005. They are: Bronx Psychiatric Center, with inpatient services relocating to other psychiatric centers in the New York City Metropolitan area, and Bronx Children's Psychiatric Center, with necessary inpatient capacity relocating to other downstate children's facilities.

Concomitant with the later closures, funds from 50 underutilized children's inpatient beds will be reinvested to expand community programs for children in the greater metropolitan area. This includes but is not limited to creating new crisis intervention beds and new home-based crisis intervention teams and expanding the numbers served through the Home and Community-based Waiver Program. Redirecting these dollars quadruples the number of children who can be served with those resources, and allows them to remain at home while receiving services.

The Executive Budget also transitions the funding for 315 Shared Staff and Reinvestment State positions to the counties in which those services have been provided. This will give the localities more control over the planning and use of staffing resources and also result in savings due to increased federal reimbursement.

We have made some hard choices, but there is also much good news in this budget. The Executive Budget provides full funding for the Enhanced Community Services program, which has significantly expanded case management, housing, family support, family-based treatment, and other services. It funds the programs established under Kendra's Law, the New York/New York II agreement and other housing development, and it also continues full support for adult and children's programs initiated under the Community Mental Health Reinvestment Act.

The Executive Budget adds 2,600 beds to the current housing pipeline, which more than doubles the 2,400 beds under development. Once these beds open, there will be over thirty-one thousand residential units, an increase of more than sixty percent in beds operating since 1995.

The Governor's budget advances the new Community Mental Health Support and Workforce Reinvestment Program. This program will become effective in fiscal year 2004-2005 and will redirect State savings from future bed and facility closures to community services. New York's current fiscal crisis precludes new reinvestment funds for fiscal year 2003-2004. Instead, these savings will be used to preserve the existing system, including the salary and fee enhancements effected to strengthen the community-based system of care. However, the proposed Reinvestment Program will redirect future savings toward local program enhancement including the development of 600 new supported housing beds, expansion of children's community-based services, and future workforce related efforts.

One area of interest that does not appear in OMH's budget is Adult Homes. Eight million dollars have been budgeted by the Department of Health to support initiatives to improve the quality of life and safety for adult home residents. OMH, the Department of Health, the Commission on Quality of Care and the State Office for the Aging are working together to conduct client assessments, improve medication management, initiate enhanced service coordination and other advocacy services, and expand social and recreational activities.

The Executive Budget reaffirms Governor Pataki's commitment to quality mental health care and continues to focus on providing quality care to New Yorkers with mental illness by increasing community residential capacity for children and adults, establishing a new Reinvestment Act and preserving existing programs established under the original Reinvestment Act, increasing community services for children, preserving necessary adult inpatient capacity, preserving State outpatient capacity, and preserving New York State's position as a leader in psychiatric research.

As we look ahead, we look to a future that continues to promote recovery, a future that enables many individuals with mental illness to live meaningful, fulfilling lives.

NewYork-Presbyterian Hospital's Second Chance Program Works in Partnership with Community Residences

By Andrew Bloch, MSW and Steve Silverstein, PhD

Despite advances in psychopharmacology, many mental health consumers remain too impaired to be discharged from state hospitals. One response to this problem in New York State was the establishment of a unique partnership among a private hospital, the NewYork-Presbyterian Hospital, Westchester Division (NYPH-WD), the New York State Office of Mental Health (OMH), and four community residence providers in New York City. The goal was to develop an alternative treatment model for those "untreatable" patients who had been in state hospitals for more than three years or who had otherwise been unable to establish any substantial tenure in the community. Such patients would be placed in what was called the Second Chance Program, a specialized 30-bed inpatient unit at NYPH-WD. The program opened its doors in the winter of 1998.

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

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

The Second Chance Program model has proved to be quite effective for treating patients who were considered unlikely to be discharged from state hospitals. We have demonstrated that when intensive behavioral treatment is combined with appropriate pharmacology the number of patients deemed to have treatment refractory psychosis is far lower than when medication alone or medication plus traditional milieu approaches are used. As of October 31, 2002, Second Chance had admitted a total of 236 individuals. At that time, 79% of these individuals were discharged to the community at least once, and 65% were currently in community settings.

At the Program's inception, forethought was given to the need for available community residence beds where the patients could be placed once they were ready for re-integration into the community. OMH used reinvestment monies at the time to provide the program with 30 supported housing beds dedicated to Second Chance patients being discharged who needed the support and structure provided by a community residence. This was a vital component of the Program as many of our patients have comorbid medical problems such as diabetes and high blood pressure, serious substance abuse histories, as well as histories of involvement with the criminal justice system that make them very difficult to place in the community.

We obtained a commitment from four well-established housing providers in New York City to prioritize the Second Chance Program patients. Specifically, The Bridge committed to 3 beds; Pibley Residential, Inc. in the Bronx committed to 5 beds; FEGS Riveredge on Wards Island committed to 8 beds; and Pathways to Housing, a supported housing program which provides Assertive Community Treatment (ACT) to all patients committed to 14 beds. It was decided at the time to concentrate the 30 beds among fewer housing providers to promote closer and more intensive working relationships between the inpatient setting and housing providers taking the patients, and this proved to be a good decision. We also wanted to use housing providers located close to where the patients had family and/or other community supports.

Initially, there were regularly scheduled meetings with OMH, NYPH-WD and the housing providers to discuss the newly developing working relationships and to facilitate a better understanding of the special needs and perspectives of the partners. There was genuine excitement and enthusiasm among those embarking on this new relationship and a trust that developed as we worked together in the service of providing the best transition for patients who had been institutionalized for many years.

To date, almost all of the 30 dedicated beds have been filled with individuals who have graduated from Second Chance. The housing providers have done an excellent job supporting the patients in the community and continuing to teach the community living skill in vivo that were reinforced in the inpatient setting. Andrew Bloch, Program Coordinator, has been the liaison between Second Chance, OMH and the housing providers since the program opened its doors. Having one contact as the "point person" has facilitated the smooth transition of patients from one level of care to another.

Housing providers find working with Second Chance advantageous from several perspectives. They know that the patients being referred have been through a comprehensive rehabilitation program that maximizes the acquisition of community living skills. They also know that the patients have been stabilized on a medication regimen that best addresses their psychotic and affective symptoms while minimizing troubling side effects. The housing agency earns "credit" toward their requirement for taking state hospital patients when they take a Second Chance patient. The agencies work closely with Second Chance to have someone readmitted to the hospital for stabilization if that should be required. This provides a supportive safety net for the housing agencies when working with individuals with such challenging difficulties.

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

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

For further information about the Second Chance Program, call Andrew Bloch at (914) 997-5738 or Dr. Steve Silverstein at (914) 997-5745.

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Single Point of Access for Housing In Westchester

Staff Writer
Mental Health News

The Westchester County Department of Community Mental Health established the Single Point of Access (SPOA) in March 1999 to help all individuals living with mental illness have equal access to housing available in the County. Prior to the establishment of SPOA, individuals looking for housing opportunities had to apply to 15 different agencies and/or residences. This process was overly burdensome to individuals suffering from mental illness and to their families and professional staff trying to expedite the process. In addition, the various agencies had no way of knowing if the same individual was on more than one waiting list. Individuals whose history indicated difficulties in prior residences or apartments, were sometimes discriminated against in the old system because any one provider could reject that person hoping that another program would offer an acceptance. DCMH streamlined this system by centralizing this process and created one application for all state or federally funded housing opportunities in Westchester.

All applications are sent directly to Barbara McKenna, B.S.N., M.P.A Program Coordinator, DCMH who compiles all requests into one list. Barbara and her staff meet weekly with all housing providers in the County to review the requests of each individual, taking into consideration the type of housing they are looking for and which community they want to live in. Centralizing this process has made securing housing easier and more efficient for everyone. It is also more fair since all providers sit around the same table simultaneously and decide to share equally in creating opportunities for individuals who may not have succeeded in the past.

SPOA, as this process is known throughout the County, has been recognized by the New York State Office of Mental Health as a "Best Practice." NACO, the National Association of Counties, recognized SPOA in 2000 and awarded the program a special achievement award. Last year alone, the county received over 1000 applications for the limited number of housing opportunities available. This year looks more promising in that we hope to receive more funding from New York State to increase housing for individuals living with mental illness. We all know how important permanent housing is to the overall well being of individuals. In the past, individuals with mental illness have had fewer opportunities than others to secure permanent housing due to their illness and its impact on their ability to work. "Any and all increases will be welcomed and quickly utilized," said Jennifer Schaffer, Ph.D., Commissioner of the Westchester County Department of Community Mental Health.

If you or anyone you know is interested in applying for housing, you should call Barbara McKenna for an application at 995-5278. Applications are also available and can be downloaded from the County's web site at www. westcherstergov.com/mental health/. Once on the site just click on forms and publications on the left menu bar.

Barbara McKenna

If you would like general information please feel free to call 914-995-4534.

The Personal Side of the Housing Story

Experiencing and Benefiting from Mental Health Residential Settings

In March of 1997, suffering from acute bipolar disorder, I was hospitalized at the New York-Presbyterian Hospital, Westchester Division. For the first two weeks of my hospital in-patient stay, I was heavily sedated.

During the next two and a half years, I spent my life living in various residential settings. I came into contact with many caregivers that put forth a tremendous amount of time and effort towards helping me to turn my life around and become the productive working person that I am today.

During my stay at the hospital, I often lacked the freedom to do the things that I wanted to do. However, in spite of my desire to immediately leave, the staff on the Unit worked very hard to ensure that I was ready and would be safe before I was released. Although I often argued and made their lives difficult, they continued to support me and look out for my best interests thanks to a tremendous effort on their part.

When I was released to Bruce House, the hospital's on site residential home, after my two-week in-patient stay to stabilize my condition, I was very happy to be less restricted and with more freedom. However, I was also very scared.

I was still symptomatic and the Bruce House staff was very caring, understanding and patient. They continually reassured me and made me feel as if I was at home.

A combination of support and new medications helped my condition rapidly improve but eventually my insurance would no longer support my stay at Bruce House. I was very frustrated about this but at the same time happy and appreciative of the care that I had received during my critical time of need.

While I did not want to leave, the staff at Bruce House found me a wonderful place to live, run by Human Development Services of Westchester (formerly Futura House).

In this new apartment situation I was to live with eight other people for the next two years. During this time I was still very slow, depressed and symptomatic.

I often did not shave or brush my hair and I dressed in a very disheveled manner. However, during this period the staff at HDSW's residential home taught me how to do many

see Residential on page 57

A Home For Our Son A Parent's Account

Schizophrenia, I know it well. My mother was schizophrenic. My husband and I did everything possible to protect our son from this affliction--everything but change his genes. Once the illness struck, we saw few options. It was necessary to find a residence in good shape with a caring, patient and knowledgeable staff where he would be safe. Mistakes made at our son's first halfway house and past experience with my mother proved invaluable in our search for a good residence.

We learned residents must feel they're involved in running the home. Community meetings to discuss future plans and changes are important. While having their own living space is essential, group activities such as trips and communal dinners strengthen the feeling of community. Participation in preparing meals and group dining create a feeling of belonging. Residents can rotate cooking, shopping for food, and dishwashing.

It is essential to make attendance at rehabilitation programs mandatory rather than a matter of choice. A rule that no resident is allowed to remain in the building after a certain hour unless he/she is sick nullified our son's refusal to attend the "boring" program, and now he is an active participant. Transportation to programs and other activities should be available to combat apathy and inertia, major symptoms of mental illness.

The staff must protect residents from unscrupulous people who take advantage of people with mental illness. Our son was robbed of his SSD money when coming out of a check cashing establishment near his first residence. If he had been accompanied by a staff member, he would have been protected from petty thieves in the neighborhood who recognize the mentally ill and often know when they receive their monthly checks. When we spoke to the people in charge, they said they had told the residents to be careful. Did they call the police? No, our son was against it.

Staff members must be willing to help residents with practical tasks such as budgeting. In the past, our son spent his monthly allowance paying debts he had accumulated in the neighborhood during the previous month. The managers of these stores, familiar with the amount of the SSI allowances, allowed the mentally ill to buy

see Our Son on page 57

NYS Faces A Crisis In Housing For Mentally Ill

By Rena Finkelstein, President
NAMI-FAMILYA Rockland County

We are not interested in engaging in any finger pointing. We are deeply concerned, however, about the perilous plight of people with psychiatric disorders throughout the state and in our own community. Housing is basic to successfully providing any other service for people with psychiatric disorders. We are faced with the reality that New York State has a severe housing crisis affecting some of the most vulnerable citizens in our community.

In the aftermath of the NY Times expose of abuses and neglect in some of the state's privately operated adult homes, there have been more inspections of adult homes and more punitive measures taken against some of the abusers. The fact is that disciplinary action after problems have occurred is not the sole answer.

There are serious problems in all types of current residences for this population. It should also be noted that only 12% of New Yorkers with serious mental illness are currently receiving state supported housing (from NAMI-NYS Housing survey). It generally takes a minimum of two years to develop any new housing program. We can't wait. NOW is the time for New York State to take positive action on a comprehensive plan for a continuum of adequately funded residential options.

Also, in housing, as in other services for people with mental illness, one size does NOT fit all. We must ensure that people at all levels of functioning have homes appropriate to their individual needs. These programs must be adequately funded so that they can be properly staffed and provide necessary support services. Not everyone is able to successfully transition from community residences to supported apartments and independent living. There needs to be some decent permanent housing available with appropriate supports for those who need it.

ADULT HOMES UNDERFUNDED

As discussed in an earlier issue of FAMILYA flyer, those adult homes that are trying to run a decent operation are hampered by inadequate funding. Supplemental security income (SSI) pays $857 per month for residents' room and board in an adult home. Operators indicate that this stipend, which translates to $28 per day, is not sufficient for basic services, let alone to hire adequate, trained staff for security, medication control, personal assistance to clients, etc. In 2003 SSI benefits will increase $2 for the residents and $5 for the adult home, certainly not enough to make a difference.

JOSEPH'S HOME TO CLOSE

On November 19, after a Board meeting convened on November 14, Joseph's Home Inc. (a non profit corporation begun under the auspices of Loeb House, Inc.) announced its plans to close an 87-bed adult home in Spring Valley. A letter sent to interested parties by John Murphy, President of the Board, stated the reason for closing as being: "... it is not personal, intimate, family modeled enough, to guarantee a serene, safe, and healing milieu that meets our standards. We are driven by our mission to provide safe, dignified, enlightened care. We will not compromise that of our residents by perpetuating a model of care that does not work. It's like flying a plane that has not passed every safety check."

The facility plans on working with a task force and the County Department of Mental Health to develop a closing plan, so that "not one of our residents will be made homeless by what we are doing. Their care is our core mission and our passion. Their lives will be improved."

Ingrid Watzka, Chief Operating Officer of Joseph's Home in an article in a Journal News article (11/26/02) is quoted as saying: "What we're finding is a lot of people need a lot of attention around their mental illness that we can't provide." It would cost $2 million to make repairs, fix the walls, and add central air conditioning, the Journal News article states. The NYS Health Department, which licenses adult homes, mandates only one direct-care staff person for every 40 residents. At Joseph's Home, 3 workers are on call for 68 residents.

see NYS Faces on page 57

MHA of Westchester Selected To Provide Assertive Community Treatment

Staff Writer
Mental Health News

The Mental Health Association of Westchester is one of only four institutions selected by the New York State Office of Mental Health and the Westchester County Department of Community Mental Health to direct an Assertive Community Treatment Program in the County. The ACT Program is designed to deliver comprehensive and effective services to individuals diagnosed with serious mental illnesses whose needs have not been well met by more traditional service delivery approaches.

MHA's ACT Program is directed by Tish Fitzpatrick, C.S.W., a certified social worker who has extensive experience in program development and has earned post-graduate certificates in family therapy, divorce mediation, substance abuse counseling and psychoanalytic psychotherapy. She will lead a professional and experienced team of nine that includes the team leader, psychiatrist, nurse, family specialist, employment specialist, life skills specialist/peer counselor, program assistant and substance abuse assistant.

Using a mobile, community-based, multi-disciplinary treatment model, the ACT team will provide comprehensive, clinical, case management, rehabilitation and support services to adult residents, 18 years and older who reside in central Westchester County, and who have been diagnosed with a serious mental illness. This central Westchester region includes Hastings, Irvington, Scarsdale, Dobbs Ferry, Ardsley, Tarrytown, Elmsford, Greenburgh and White Plains. Among the services and supports are: Empowerment and self-help, family life and social relationships, daily activities, employment, school and training opportunities, housing, integrated treatment for substance abuse, wellness self-management and relapse prevention, money management and entitlements, problem solving, health screening, education and referrals, medication support, service planning and coordination.

These extensive services will be delivered in the recipient's natural environment, rather than in an office or clinic setting. ACT supports recovery through a highly individualized approach designed to provide recipients with the tools to obtain and maintain housing, employment, relationships, and relief from symptoms and medication side effects. ACT-MHA has a maximum client to staff ratio of 1:9, with direct client contact available seven days a week with social and recreational activities available on Saturdays and Sundays.

For additional information about ACT services in central Westchester please contact Tish Fitzpatrick at (914) 347-4290, ext. 17, or by e-mail to: fitzpatp@mhawestchester.org.

Finding and Keeping a Roof Over Your Head

Staff Writer
Mental Health News

Last summer "Mr. and Mrs. B" were behind in their mortgage in part because they were victims of predatory lending, paying over 9.4% interest on a first mortgage, and 12.5% on a second loan. With help from Westchester Residential Opportunities (WRO), they were accepted into the Consumer Rescue Fund which provided a new, very low interest mortgage with no closing costs whatsoever.

"Maria C" is a Spanish speaking senior citizen who couldn't find a place to live when she was in danger of losing her White Plains apartment. WRO's bi-lingual senior housing counselor helped her secure a Section 8 certificate, locate a unit that would accept Section 8, and negotiat with the Department of Social Services for an advance of rent, security and broker's fee.

"John D" has bi-polar disease and is living in one of WRO's apartments, paying 30% of his income on rent. Through a special foundation grant, WRO was able to purchase a new bed and a sofa to furnish his apartment.

These three examples provide a brief snapshot of how WRO helps low and moderate income families every day.

Westchester Residential Opportunities, Inc. has been assisting Westchester households for nearly 35 years. WRO is a not for profit organization funded by United Way, the Department of Community Mental Health, and many other funding sources to address a wide variety of housing problems.

WRO provides housing and case management for the mentally ill, prevents homelessness through eviction prevention grants, fights housing discrimination, and helps low income families, the elderly, and disabled maintain or improve their housing. For an elderly person, this may mean counseling and helping the client secure a reverse equity mortgage, enabling the elderly homeowner to stay in their house for as long as they'll need it. Others come to the agency for market rate apartment listings and guidance as they struggle with the difficult task of finding affordable rental housing.

Many people recognize WRO as a provider of rental housing for persons living with mental illness, as the agency has over 70 units of affordable rental housing through Shelter Plus Care, Supported Housing and Supported Single Room Occupancy Programs. But WRO helps others as well. For example, domestic violence victims who are employed but who face budget crises when the abuser leaves the home may be eligible for a temporary rent subsidy for up to one year. WRO also helps first time homebuyers locate sources of down payment assistance to purchase first homes. Disabled adults, sometimes with the help of supportive family members, have used the first- time homebuyer counseling program to secure a decent housing future through the purchase of co-ops and condos with special mortgage products geared for this population.

Each year the agency helps over 2000 people through its offices in White Plains, Mt. Vernon and a soon to be opened location at 45 Ludlow Street in Yonkers. The best place to start is to visit their website at www.wroinc.org. Or give them a call at (914) 428-4507. For persons living with mental illness, call the Independent Living Program at ext 309; for the elderly call ext. 312; for those experiencing housing discrimination or interested in first-time homebuying call ext. 307; and to prevent eviction or get help with predatory mortgages, dial Ext. 305.

Prevention is the Best Cure for Homelessness

Staff Writer
Mental Health News

"Barbara" is a middle-aged woman who has lived independently her entire adult life, although she has several mental diagnoses. She came to The Bridge Fund of Westchester facing eviction from her apartment because she owed over 4 months rent to her landlord. Barbara's mental illness advanced, and she was not able to manage her finances any longer nor manage her daily living affairs. Her landlord liked her and wanted to keep her as a tenant, but needed to have the rent paid or would be forced to evict her. The Bridge Fund connected Barbara to case management services, who assisted her with managing her finances and affairs. They also offered financial help to prevent her from becoming homeless. She currently remains stable in her apartment.

Since 1991, The Bridge Fund of Westchester has been helping individuals and families like this remain in their housing. The purpose of The Bridge Fund is to prevent homelessness through a combination of financial assistance (interest-free loans of up to $2,500 or grants) and budget counseling. The Bridge Fund receives referrals through a wide network of social service agencies, non-profit and religious organizations. The program is supported by private donations, not by government, which allows us to be very flexible in resolving housing crises. Since the fund's only purpose is to prevent homelessness, they can respond quickly to a housing crisis and expedite a solution.

In order to remain in stabilized housing, there are many factors to take into consideration, such as affordability, access to transportation, and meeting special needs of disadvantaged and disabled people. While there are programs and sometimes special funding available, most people in need are not aware of the resources offered in the community. The Bridge Fund is well networked in the community, aware of these programs and how they work. Many times The Bridge Fund will work cooperatively with other programs and resources to create a solution to keep a family in stabilized housing.

Last year The Bridge Fund loaned out over $253,000 to help 277 individuals and families. In addition to utilizing their own private funds, The Bridge Fund collaborates with other funding sources, such as the Department of Social Services and other local non-profit and religious organizations. By networking with other agencies, about $150,000 more was made available to prevent these families from becoming homeless. We received over $58,000 in client repayments. The Bridge Fund also has a small food pantry, furnished by the Congregation Kol Ami. In emergency situations, they assist clients with food staples, which enables them to use their monies for rent. Last year, they helped 166 families with food from their pantry.

As part of each case review, The Bridge Fund provides budget counseling. This helps reveal a family's money management capabilities and allows The Bridge Fund the opportunity to offer advice on budgeting skills and bill prioritization. This ensures a stable housing situation and begins to educate the family on how to handle their finances. In addition, they follow up on families helped in the past to find out how successful their efforts were. We contact each family at six- and twelve-month intervals after our involvement. The results of this program have shown that through 2002, 95% of the families helped remain in the housing preserved for them for at least twelve months.

For further information about The Bridge Fund of Westchester, please contact Veronica Parks, Director at (914) 949-8146.

Orange County's Home to Stay Program Works

By Liz Mehnert, CSW
Director, Home-to-Stay

The Mental Health Association in Orange County, Inc., Rehabilitation Support Services and National Alliance for the Mentally Ill in Orange County have in the true sense of collaboration developed a supported housing program for six seriously and persistently mentally ill individuals who have been unsuccessful in traditional mental health residential programs because of challenging behaviors.

Due to the multiple needs of the individuals in this program, services are offered on-site from the hours of 8:00 a.m. through 9:00 p.m. seven days a week and on call for overnight crisis. Individuals live in their own individual apartments in one building where staff has an office. This type of service approach assists in achieving positive outcomes for the individuals in the program by providing intensive services, which are available and convenient for participants, while maintaining the participants sense of autonomy and community living.

Services include subsidized furnished apartments, community integration, budgeting/ financial planning, vocational/ educational support, transportation, life skills training, medication supervision, recreational activities and advocacy and support. For many of these individuals, this program will provide a last alternative to long-term inpatient psychiatric care, prison or homelessness.

The participants in the program make up a diverse population of individuals. Several of the referrals to the program have come from Middletown Psychiatric Center (local state operated psychiatric hospital) and have been there for long periods of time due to inappropriate or lack of community placement options. Other referrals have come from local homeless shelters, community residences, outpatient mental health clinics, Department of Mental Health and other community not-for-profit agencies.

Many of the individuals entering the program have been involved with the mental health system for many years with little or no success resulting in long-term in-patient psychiatric stays, homelessness and involvement with the legal system. By virtue of their histories, existing mental health residential programs were unable to meet their special needs resulting in the inpatient psychiatric hospitals acting as makeshift shelters for individuals ready for discharge. None of the traditional residential program models have been able to effectively meet the multiple service needs of the individuals being served at Home-to-stay nor are they as cost effective. Home-to-stay has found the right formula for providing the means for persons with serious and persistent mental illness to maintain their recovery and become productive members of their community.

The most telling outcome of this program has been the significant decrease in the number of hospitalization days and use of crisis services for individuals residing in the program. The benefit of being able to maintain community living for a significant period of time is immeasurable to the participants. The total number of decreased hospitalization days after a one-year admission to Home-to-stay compared to one-year prior admission to Home-to-stay equals over 1,400 days with a cost savings of over $448,000.00. It should be noted that a day in a local community hospital costs $1,022.00, a NYS psychiatric facility costs $430.00 and a day at Home-to-stay costs $105.00. Moreover, the quality of life for program participants has significantly improved creating a stable and productive environment for the individuals in the program.

The participants in this special program have shown tremendous progress in areas of socialization, daily living activities, improved self esteem, and they are truly happy. This has obvious tremendous emotional value for program participants and their families as well as economic savings for the community.

After our second operating year, we feel confident we are able to bring positive results to the table related to both cost effectiveness as well as quality of life outcomes including housing stability, greater self determination, increased independence and decreased need for crisis intervention. We are hopeful that this innovative program will serve as a national model in providing creative and flexible services to those most in need of mental health residential services.

National Coalition for the Homeless Testifies at President's Mental Health Commission

By Mary Elizabeth May
National Coalition for the Homeless

Testimony Given December 6, 2002

Good morning. My name is Mary Elizabeth May. I am here representing the National Coalition for the Homeless, a national advocacy organization composed of a network of people who are or who have been homeless, activists and advocates, community- and faith-based service providers, and others committed to the mission of ending homelessness.

Homelessness presents many barriers to those receiving mental health and other health services. People experiencing homelessness are impoverished, uninsured, or underinsured, and alone. People with a mental illness encounter greater barriers to employment and housing and tend to have complicated health problems. Approximately one-third of homeless adults have a history of mental illness, most of whom have co-occurring addiction disorders.

The need for mental health services among people experiencing homelessness with mental illnesses is greatly magnified because of their unique needs and life circumstances and the increased barriers they face to receiving these services. People experiencing homelessness ultimately desire the opportunity to access services in correspondence with housed people. Targeted programs such as the Projects for Assistance in Transition from Homelessness (PATH) program are valuable and provide much needed services, but in order to adequately meet the needs of homeless and low-income people, it is essential to ensure access to and accountability of mainstream mental health services. Many mainstream mental health service providers are not equipped at this time to accommodate the complexities presented by homelessness, including a full range of health, housing and social services. As a result, many mainstream providers provide insufficient or ineffective care to persons experiencing homelessness.

The federal government has supported a "mainstream" safety net system, in lieu of universal health care, for people without health insurance coverage, including those who are experiencing, at-risk of, or in transition from homelessness. The Community Mental Health Services Block grant program and various state programs form the core of a safety net system of mental health services. Current funding for these programs is not adequate to enable states to provide adequate mental health services to people without health insurance. We urge Congress and the Administration to greatly increase funding for these programs and to take statutory, regulatory, and programmatic actions to ensure access to mental health services within mainstream systems.

The role of ineffective discharges from mental health institutions in generating homelessness has been widely recognized. Large numbers of people become homeless upon discharge from hospitals and treatment facilities, representing a massive failure of publicly operated or regulated institutions to fulfill their responsibilities to persons in their care. This also signifies the lack of community resources to meet the housing, health care and other support needs of individuals with mental illness, and demonstrates the responsibility of institutions to work to increase community resources. All publicly funded institutions providing residential care, treatment, or custody should adopt and implement policies that prohibit discharges into homelessness. This must include access to appropriate housing and health care services for these individuals.

Mental health treatment programs are not the only ones who see a large number of mentally ill homeless individuals. Unfortunately the criminalization of homelessness is increasing, leading to the increasing incarceration of people experiencing homelessness, many of whom are struggling with mental illness. People with mental illness are 64% more likely to be arrested than those without a mental illness for committing the same crime (1) and 16% of prisoners in state prisons and local jails have a mental illness, which is four times the number of Americans in state mental hospitals.(2) Not only are homeless people increasingly incarcerated, but incarceration often results in homelessness. People leave jails and prisons without a destination, bereft of the resources necessary to secure housing or health care. Their homelessness is then exacerbated by criminal records, which can interfere with access to subsidized housing, public benefits, and employment. This often creates a cycle from which it becomes difficult to escape. The availability of mental health treatment upon request ("on demand"), ensured continuity of mental health services, and housing and health care services available upon discharge are vital in helping people escape this cycle.

People experiencing homelessness, and particularly those with mental illness have a complex set of needs often requiring an array of health and support services. The establishment of a universal health care system would ensure that the entire U.S. population—including people without homes, with disabilities, and with low or fixed incomes—has the same opportunity for accessing quality and comprehensive health services.

This system should ensure quality, affordable and comprehensive services for all, including mental health services. Ultimately, in order to end homelessness for all people, including those with mental illness, Congress and the Administration will need to enact public policies that eliminate extreme poverty in our nation, including guarantees of affordable housing, livable incomes, and health care for all Americans.

I thank you for the opportunity to be here today, and appreciate your taking these comments into consideration as you work to improve mental health services for all in our country.

I am including in my written comments our recommendations on Addiction, Mental Health and Homelessness; Incarceration, Homelessness, and Health; and Institutional Discharge and Homelessness.

NAMI Corner

Providing support to families and friends of individuals with mental illness and working to improve the quality of life for individuals with mental illness. Helpline: 1 800-950-3228 (NY Only) - www.naminys.org - Families Helping Families

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

J. David Seay, J.D.

When you are lost and don't have a map, any direction you take is OK. Unfortunately that is the case in New York regarding our mental health system and the Pataki administration. They are lost with no map and continue to propose budgets and set policy for New Yorkers with serious mental illness by lurching about with short-term fixes, short-sighted horizons and knee-jerk cost cutting and downsizing. That is what inevitably happens in the absence of planning. The map that is so desperately needed in New York is a serious, fair and balanced long-term plan for mental health facilities and services. Such a logical and rational planning process is long overdue.

Governor Pataki recently released his Executive Budget for 2003-2004, and it included some drastic cuts for the Office of Mental Health. Under the proposal, the world-class mental health research facility, the Nathan S. Kline Institute in Rockland County, would close as would three state psychiatric centers -- Elmira, Hutchings and Middletown. Two more Centers, Bronx Psychiatric and Children's Centers, would be shut down in 2005. The budget plan would also eliminate another 90 beds from the ever dwindling number of intermediate and long-term beds available to the seriously ill New Yorkers who need them.

The Governor's proposed budget underscores the need for the state to uphold its obligation to address the real needs of people with mental illness, including adults with serious and persistent mental illness and children with emotional and behavioral disabilities. The state must set budget priorities that provide for a comprehensive and efficient system of mental health care achieved through a fair and balanced long-term plan that assesses the needs of New Yorkers with psychiatric disabilities, evaluates existing system and service capacity and determines specific steps, numbers and timetables for implementation.

New York already has an ideal model for reforming its mental health system in its own Office of Mental Retardation and Developmental Disabilities (OMRDD). In the OMRDD system the state agency administers a diverse and complementary community-based network of not-for-profit providers and publicly-operated facilities. The agency assesses needs and works to fill service gaps while ensuring appropriate placement of individuals. OMRDD also works to maximize federal reimbursement and seeks the best use of available resources.

NAMI-New York State calls for the establishment of a long-term mental health planning process with appropriate input from all stakeholders, including families, consumers, providers and government.

In my last *NAMI Corner* I noted that the top three issues for NAMI-New York State this year are *housing, housing* and *housing*. Given the theme of this issue of *Mental Health News*, I again stress our deep commitment to advocating for adequate levels of safe, affordable housing with supports and services for all New Yorkers with serious mental illness who need them. The *Interim Report to the President* by the President's New Freedom Commission on Mental Health, which was presented last fall, states unequivocally that the U.S. mental health system "is in disarray" and is not "oriented to the single most important goal of the people it serves—the hope of recovery." The Report says that 5 - 7% of adults and 5 - 9% of children in the United States have "a serious mental illness" or emotional disturbance that affects functioning at work, school, home or in social situations.

"The reality is that the mental health system looks more like a maze than a coordinated system of care," according to the report. And nowhere is that maze more perplexing and difficult to navigate than when someone is trying to locate housing for a loved one. The facts speak loud and clear. The President's Commission observes that "While there are 40,000 beds in state psychiatric hospitals today, there are hundreds of thousands of people with serious mental illness in other settings not tailored to meet their needs -- in nursing homes, jails and homeless shelters." As I reported in the last issue, in New York there are 10,000 adults with serious mental illness in jails and prisons (most of whom are serving time for crimes committed as a result of their untreated illness), 12,000 in adult homes (many of which are in deplorable condition), and another 10,000 on any given night in homeless shelters in New York City alone. These numbers do not even include the countless thousands others living at home with aging parents who will not be able to take care of them much longer. All of these people are where they are due to the lack of appropriate housing and support services.

NAMI-NYS is working with the *New York Campaign for Mental Health Housing Reform* and others to fight for more housing in our state. While it is true that the Pataki administration has supported the development of vast numbers of such housing -- 31,000 units built or in the pipeline -- and that is highly commendable, much more needs to be done, as the above numbers indicate. This must be done for at least two reasons. First, for cost: It's not cheap to house people in prisons (where psychiatric care is all but nonexistent); in fact, supported housing or living at home with an Assertive Community Treatment (ACT) team as back-up is less expensive; and keeping people homeless costs more than you might think (a University of Pennsylvania study found that it only costs around $900 a year more to provide appropriate supported housing than the cumulative costs of homelessness -- emergency room, shelter, police and others associated costs). But secondly, and far more important: it is the *right thing to do* as a caring and compassionate society.

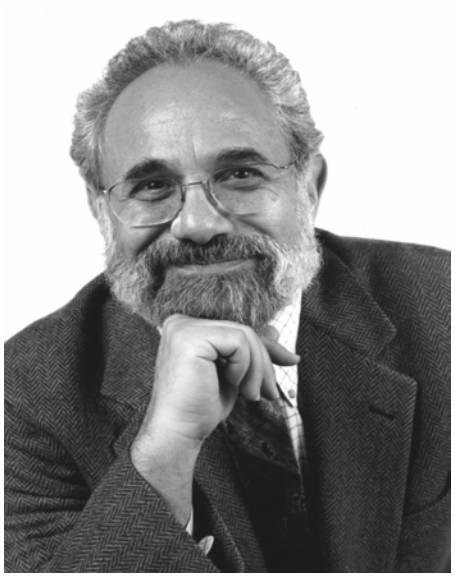
NAMI-NYS will fight for housing, research and a long-term plan. But we have not forgotten our other major concerns of adequate funding for ACT, mental health parity legislation, adult home reform, presumptive Medicaid eligibility, access to medications, employment opportunities, and banning the use of "special housing units" in prisons, or "the box," for persons with serious mental illness.

I am proud to join our NAMI-NYS leadership in this fight for care and housing. NAMI members have big hearts and loud voices. Together, we will prevail.

Point of View

Mental Health System Not In "Shambles"—Yet

By Michael B. Friedman, CSW



Michael B. Friedman

According to the "Interim Report" of The President's Commission on Mental Health, the mental health system in the United States is "in shambles." I do not agree. "In shambles" is what it was before the Community Mental Health Centers Act of 1963, when hundreds of thousands of people were warehoused in state institutions where the conditions were shameful. "In shambles" is what it was after the inception of deinstitutionalization when tens of thousands of people were discharged from, or denied access to, state institutions with no services or supports in the community.

But since the Community Support Program was initiated in 1978, the mental health system has improved considerably. Over the past 25 years, there has been significant expansion, even creation, of housing programs, outpatient services, rehabilitation, case management, peer support, inpatient care in local general hospitals, etc. In addition, state psychiatric centers have also improved dramatically. In New York State they now offer a mix of inpatient, residential, rehabilitation, and outpatient services which are often of very high quality.

It is offensive to those of us who have advocated—with considerable success—for community mental health services for the past quarter century to characterize the mental health system in a way that appears to dismiss all that has been achieved.

That is not to deny that there are many inadequacies with the current system, some of which are documented in the "Interim Report." The current mental health system may be as fragmented today as it was in 1978 when the last President's Commission called for the creation of integrated mental health systems. The current mental health system frequently fails to respond to the needs of people with severe, recurrent mental illnesses who reject traditional treatment. Large numbers of adults with serious mental illnesses are housed in adult homes, facilities designed for poor people who cannot care for themselves adequately but not for people with marked disabilities. Far too many people with mental illnesses are in jails and prisons because of inadequate efforts to divert them to appropriate treatment. Children and adolescents with serious emotional disturbances are often abysmally treated because services are not available, because they are outmoded, and because of failures to integrate the efforts of the mental health system with those of the schools, the child welfare system, and juvenile justice. Minorities, a rapidly growing part of the American people, are generally not adequately served despite calls for "cultural competence." And the explosion of the population of older adults is just beginning to be mentioned in policy discussions; plans and services lag way behind.

But it would be unfortunate to let the many inadequacies still to be overcome blind us to the progress that has been made over the past quarter century—to the progress we now may have to fight to preserve. I don't think our current mental health system is in shambles now, but it could be in shambles soon.

This thought will come as no surprise to those historians of mental health policy (such as Gerald Grob and David Rochefort) who believe that the history of the treatment of people with mental illness in America is characterized not by progress but by cycles of improvement and decline. Their core observation is that periods of progress in the care and treatment of people with mental illnesses come to a crashing halt during times of economic crisis. Thus, the asylums of the early 19th century built on the philosophy known as "*traitement morale*" (French for "humane treatment") gave way to a philosophy of custodial care during and after the Civil War. Similarly some gains in the humanization of institutions after World War I gave way to the degradation of asylums during the Depression and World War II.

Will the slow and limited gains of the second half of the 20th century similarly give way to a loss of moral concern about people with serious mental illnesses and children with serious emotional disturbances and to a period of rapid decline in both the amount and quality of mental health services?

At the moment the signs are mixed. Despite a growing federal deficit, President Bush has announced his intention to propose $1.75 billion to aid people with disabilities over five years beginning October 2003, though there may also be cuts for some mental health programs and to Medicaid—the major source of federal funding for mental health. In New York Governor Pataki's budget request promises some improvements in future years and *appears* to preserve most community mental health services. However, preservation of current funding depends on proposals that are far from being done deals, including closing underutilized state psychiatric centers, bed reductions, consolidation of the state's two research centers, and the substitution of federal Medicaid dollars for state dollars. In addition The Governor's budget request would result in funding problems for inpatient and outpatient services at general hospitals.

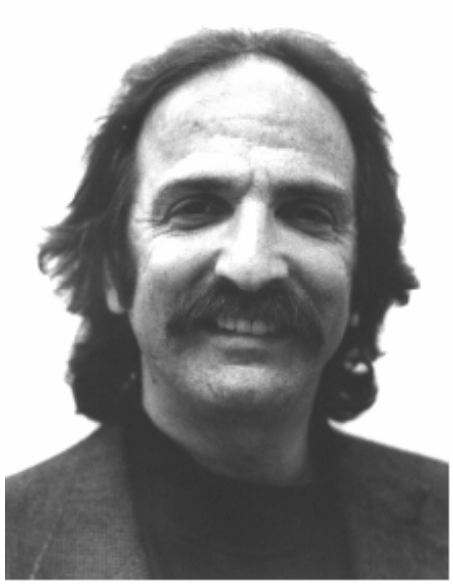
Although current funding and policy plans leave the future uncertain, the lesson of history is clear. In bad economic times, people with mental illnesses fall off the political radar screen. Political promises are just as good as the American economy. If the economy does not rebound soon, we will have to fight very hard to preserve the gains of the past 25 years. That will require us all to be clear that a system has been created which, for all its inadequacies, is worth defending.

And that is why it is worthwhile saying again: the current mental health system is not "in shambles"—yet.

Michael B. Friedman is the Director of The Metropolitan Center for Mental Health Policy and Advocacy, a collaboration of the Mental Health Association of New York City and The Mental Health Association of Westchester County. The opinions expressed in this column are his own and not necessarily the positions of the Mental Health Associations.

THE NYAPRS ADVOCACY WATCH

By Harvey Rosenthal, Executive Director NYAPRS



Harvey Rosenthal

Testimony Before the Joint NYS Legislative Mental Hygiene Budget Hearing February 5, 2003 by the New York Association of Psychiatric Rehabilitation Services

Thank you for the opportunity to present to you the reactions and concerns to this year's Executive Budget mental health budget proposal on the part of the thousands of New Yorkers represented by the New York Association of Psychiatric Rehabilitation Services, a unique statewide partnership of New Yorkers with psychiatric disabilities and the community mental health professionals who support them in community mental health service settings from every corner of the state.

NYAPRS members join together every day in efforts aimed at moving state and local mental health policy and practices to those that have as a central goal the promotion of the recovery, rehabilitation and rights of New Yorkers with psychiatric disabilities.

This testimony incorporates the direct input of almost a thousand NYAPRS members who gathered at local forums in New York City, Binghamton, Long Island, the lower Hudson River Valley, Westchester, Syracuse, Watertown, Glens Falls and Buffalo during the last three months.

Over the past year, a series of media stories have powerfully demonstrated the crucial importance and impact of our state and local mental health service systems, and, sadly, the tragic outcomes when New York's mental health policies and practices fail to adequately serve and protect the needs, basic rights and very lives of its citizens with psychiatric disabilities.

The terrible scandals that resulted from the wholesale discharge of thousands of New Yorkers from state hospitals to deplorable conditions in adult homes, the state's failure to provide adequate oversight, surveillance and enforcement and the resultant tales of dehumanization and death are tragic legacies we must all see end, once and for all, this year.

The growing number of tens of thousands more New Yorkers with psychiatric disabilities who have come to populate our nursing homes, streets and prisons and jails are further terrible reminders that New York must, now more than ever, firmly take up its responsibility to offer us all an effective, responsive community mental health service system that promotes hope, recovery, dignity and a productive life in the most integrated setting of each New Yorkers' own personal choice.

In the wake of recent tragedies and clear demonstrations of unmet need, New York must responsibly take up the charge to properly reform and make responsive our community mental health system of care. In doing so, our state must not only preserve but expand and wisely direct its public mental health dollars.

In that spirit, NYAPRS is grateful to see that the Executive Budget proposal appropriately does not exact cuts and preserves the basic community mental health services safety net that tens of thousands of New Yorkers rely on each day. Included here too is some recognition of the great inadequacy in community housing and supports that contributes prominently to the great tragedies that you've learned have occurred in our adult homes and the ones you must come to learn exist in our prisons and jails and on our streets.

As you will see, mental health advocates view these small increases in housing for some groups and community supports for adult home residents as down payments on a broader investment New York must make this year, and in the years to come, to repair and reform the care we provide our friends, neighbors and family members with severe psychiatric disabilities.

The Executive Budget makes savings in several areas in its mental health budget this year, and we'd like to comment on two of those.

First, it proposes the closure of 5 state hospitals over the next few years. From the beginnings of our involvement in state mental health public policy as a major member of the campaign to win passage of the Community Reinvestment Act of 1993, NYAPRS has supported the downsizing of our very large state hospital system and the re-direction of those funds to address our most urgent community service needs.

Individualized Discharge Planning for Individuals in Hospitals to be Closed

While we continue to support state hospital closures, we wish to express a deep concern about the treatment of those individuals who currently reside in those facilities targeted for closing. While current proposals would automatically move every individual to a nearby state hospital in another community, lessons painfully learned from poor state hospital discharge policies should inform us to work with each individual, their friends and their families to fashion a personalized service plan that prioritizes each inpatient's own personal needs, rights and choices.

In that spirit, OMH must provide for every individual in a hospital slated for closure the option of remaining in that home community, close to their families and friend, with an appropriate array of 'step down' community housing, services and supports. As we hope OMH moves to improve the way it develops its statewide comprehensive plan, it must start with affording proper person-centered discharge planning for each individual affected by the closures.

Restore Reinvestment This Year

As a member of the state's Mental Health Action Network (MHAN), we join our fellow advocates' appreciation of the Governor's proposal to restore the landmark Reinvestment program and are disappointed, however, in the current plan to delay the actual start date of Reinvestment until FY 2004-5.

Urgent community needs remain unaddressed by the current budget proposal (see below); we urge the Legislature to restore Reinvestment this year, effective January 1, 2003, and to include within it ALL savings, including the net proceeds associated with the sale of properties as well as generated from the fringe benefits portion of the general budget.

Further, we urge the Legislature to reject the Budget's incorporation of $180 million of previously authorized Reinvestment funds into the mental health base budget; Reinvestment must remain separately lined out so we can continue to track and protect this priority community mental health funding stream.

Trended Medicaid Rate Increase Built into New 'PROS' License

A second major source of savings proposed in OMH's budget proposal is the conversion to Medicaid of over $50 million of mental health rehabilitation, employment and support programs through the introduction of a new Medicaid outpatient license called 'PROS.' As many of the programs affected are NYAPRS member agencies, we have been very actively involved in advocating with OMH that the spirit and integrity of these pioneering programs in promoting recovery and rights be fully preserved.

While we are hopeful that 'PROS' will improve service delivery with its emphasis on recovery outcomes and individual service planning, we urge the Legislature to ensure that the funding for these programs continues to keep pace with growing demands and pressures. Accordingly, we strongly urge you to ensure that a trended rate increase be incorporated into the program's design from the outset. The state 'Medicaided' housing programs some years ago and its failure to build in a trended rate increase is largely responsible for the erosion in those programs that have helped create the tremendous housing crisis I spoke of earlier.

While we welcome the budget's proposal to provide capital funding for 1,000 new state funded community housing beds to come online in future years, we want to emphasize that these beds are committed to a diverse group of individuals and do not adequately address the Governor's Adult Home Work Group's recommendations to develop 6,000 new alternative housing sites for New Yorkers with psychiatric disabilities currently forced to live in deplorably inadequate and inappropriate settings in New York's adult homes.

Further, the Executive Budget continues to ignore the crisis that threatens to jeopardize New York's existing mental health housing services; years of drastic under funding leaves thousands of community residence and scattered site housing units vulnerable to closing as community providers are no longer able to endure years of rising costs and negligible state relief.

A Comprehensive Package of Community Housing and Adult Home Reform

In concert with our colleagues in the Mental Health Action Network and the NYS Coalition for Adult Home Reform, we urge the Legislature, therefore, to:

- work with us over the next few years to assure the funding of 5400 additional units beginning this year with $7 million for 1000 scattered site units and intensive case management slots for those ready to leave adult homes beginning in October.

- support the creation of a demonstration program aimed at producing 1,000 units of this housing in the coming years (no initial state cost)

- provide an appropriation of $500,000 to fund the creation of an independent non-profit housing application assistance office to help residents of adult homes in the preparation of housing assistance applications

- maintain the state's commitment to address the unmet housing needs of currently homeless individuals with psychiatric disabilities by approving full first-year funding for a New York/New York III Agreement (Capital appropriations of $125 million in the OMH budget and $37.5 in the OTDA budget for the first 1,500 state units.)

- prevent the loss of existing mental health housing beds by providing a $20 million infusion to strengthen staffing at over 20,000 community residence and scattered site units.

- savings realized from the legislature's immediate restoration of the Community Reinvestment program should be directed to both boost funding for existing housing mentioned in the previous bullet, and to provide a "one for one" new community bed for every state hospital bed closed in this and subsequent years.

- establish a statutory requirement that OMH maintain a community housing waiting list identifying those New Yorkers with psychiatric disabilities who have applied for but not received supported, supportive, supervised or congregate housing. This would be similar to the OMRDD waiting list.

Reject Proposal to Deny a COLA to SSI Recipients

Governor Pataki's Executive Budget proposal for Fiscal Year 2003-04 includes a plan to take $25.7 million in federal SSI funds away from over 600,000 impoverished elderly, blind and disabled New Yorkers in the coming year. NYAPRS joins our fellow disability advocates from around the state in mobilizing to seek a rejection of this disastrous proposal to make savings at the expense of our most vulnerable citizens.

A federal cost-of-living increase would provide about $13 a month in additional aid to SSI recipients, a significant amount when you're budgeting down to the last dime. Individual SSI benefits are currently $639 per month, but most beneficiaries are forced to direct the bulk of their benefits to housing and health-related costs, leaving them little or nothing for personal needs. We urge the Legislature to promptly reject this proposal.

Open Medicaid Access to Medications

NYAPRS has a long tradition of working to guarantee strong individual consumer rights and choice protections. Accordingly, we have joined over the past few years with other groups to jointly fight against proposals to limit access to medications many in our community rely on in a misguided effort to reduce costs. We very much support the Executive Budget's proposal to exclude psychiatric drugs from plans to limit drug access. On the other hand, we are very worried that those same individuals' physical health will be put at risk unless access to those medications is equally protected.

NYAPRS' Non-Budget Legislative Agenda

NYAPRS members have prioritized a number of non-budget items this year that we will be pursing with the members of the Legislature and the Administration this year, including:

- passage of electroshock rights protection and state oversight legislation

- passage of mental health insurance parity legislation

- passage of prison reform legislation excluding most state inmates with psychiatric disabilities from confinement in solitary 'Special Housing Units'

- passage of mental health 'right-to-treatment' legislation

NYAPRS members look forward to working closely with our state legislators this year to continue our long mutual tradition of working to improve services and social conditions for New Yorkers with psychiatric disabilities. Thank you again for the opportunity to present our concerns to you today.

The MHA Connection

Mental Health Association in New York State, Inc.

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By Joseph A. Glazer
President & CEO, MHANYS

Joseph A. Glazer

No singular issue in recent memory has brought together Republican Senators, Democratic Assemblymembers, private sector organizations and public employee unions like the need for a comprehensive system of community-based mental health services.

When Governor Pataki introduced his 2003-04 Executive Budget in January, he proposed closing three state psychiatric hospitals this year--Elmira, Middletown and Hutchings; and two next year--Bronx and Bronx Children's.

Beyond the usual opposition to closings, which has long been seen as a territorial battle over bricks and mortar, a different clarion is being heard. After two years of working with NAMI, Families Together, the Civil Service Employees Association and Public Employees Federation, MHANYS is helping to lead an effort to bring planning mechanisms and development to our state's mental health delivery system.

For many years, even before the present administration, the governor's proposed budget has annually moved tens of millions of dollars around, closed hundreds of psychiatric inpatient hospital beds, started and terminated programs, all in the absence of an over-arching, and statutorily required plan. MHANYS believes that the purpose of the state budget is to implement a plan. Without a plan, the governor and the legislature makes decisions regarding the public mental health system that are based only on numbers and dollars and not on the priority of a system of care.

In 1978, Governor Carey, as part of the settlement of the Willowbrook lawsuits, called for creation of two comprehensive systems of community-based care—one for mental retardation and developmental disabilities and another for mental health. Yet, 25 years later, while an overall good system of care, coordination and funding exists in OMRDD, there is nothing of the sort for OMH.

In December 2002, the NYS Office of Mental Health released a document it calls a "Five-Year Statewide Comprehensive Plan." As pointed out in a response by the former Assembly Mental Health Committee Chair, that document clearly fails to meet the structural requirements of Section 5.07 of the Mental Hygiene Law.

Following the release of the OMH document, MHANYS did a survey of our 33 affiliates and our colleagues, asking whether they had been involved in the OMH planning process.

There were 85 responses to that survey. Eighty percent had not participated nor been asked to participate in the development of statewide goals and objectives, the underpinnings of the statewide plan during the last two years. Interestingly, one respondent thought that the Assembly hearings on compliance with the 5.07 requirements last year was the planning input session.

Six weeks after the release of that OMH document, Governor Pataki introduced his 2003-04 Executive Budget. His budget includes closing five psychiatric hospitals, further bed reductions, moving existing programs from the state OMH funding stream into Medicaid, restricting access to medications under Medicaid, staffing reductions and other major changes to the system.

The law requires a three-year capital plan, yet the OMH document contains nothing about the proposed closure of Elmira, Hutchings or Middletown Psychiatric Center this year nor the proposed closings in 2005 of the Adult and Children's Psychiatric Centers in the Bronx.

The lack of a plan leads to other concerns, particularly related to coordination of services, programming and protection of the funding stream.

The Governor's proposed budget reduces Medicaid spending by a billion dollars, albeit in the Department of Health Budget. Family Health Plus is cut, Child Health Plus is cut, Medicaid services and medications are cut.

At the same time, the State Office of Mental Health is promoting the Personalized Recovery Oriented Services (PROS) program, which moves many state funded vocational and employment programs into Medicaid.

This idea raises major concerns for our organization. First, how secure is the Medicaid funding stream these programs are being moved into? Are we jeopardizing those programs, moving them from statutorily secure funding streams into a funding stream targeted for cuts? Would this be the strategy we'd use if we had a plan?

Reinvestment is also a high priority issue for us. The legislature passed a Reinvestment bill last year, which the Governor vetoed in late December. MHANYS is urging the legislature to fix the technical flaws identified by the Governor, and the legislation repassed. With Reinvestment now expired for 18 months, and millions of dollars lost, we join with many of our colleagues in urging that the capture of savings be made effective as of January 1, 2003. Another year's delay would result in a loss total nearing $50 million. This year's savings from downsizing should not be used to pay for last year's budgetary commitment of a much needed COLA and Medicaid fee increase.

We also urge that Reinvestment dollars be treated like any other dedicated fund--identified separately in the budget, and used specifically for the original intent of the law. Just because the law capturing those dollars has expired doesn't mean that the promise can be broken for those dollars already in the fund. If OMH wants to replace Reinvestment dollars with Medicaid dollars, and the legislature concurs, we would urge that the Reinvestment dollars taken out be used to expand community-based services, and not poured into the general fund.

Debt relief is temporary—history has shown that the loss of Reinvestment dollars is forever.

As stated in our 2003 legislative program, New York State's system of mental health care is greatly in need of a far-reaching plan. Together, we must: improve children's mental health services; provide safe, quality housing; assess the need for services and; ensure proper capacity provided by a qualified and appropriately paid workforce. MHANYS calls for the creation of an inclusive plan to develop a comprehensive system of community-based mental health care that includes the following components: (1) Consumers' right to live in the community, (2) Having a broad range of assessments, services and supports, (3) A choice of multiple providers, (4) That services must meet individual needs and desires, and (5) Appropriate coordination and sufficient funding.

Every day, thousands of New Yorkers living with mental illnesses remain homeless, incarcerated, or in settings that are not appropriate to their needs. Every year, we see a budget proposal and resultant debate that fails to recognize that all people living with mental illnesses have both the ability, and the right, to a full recovery.

Certainly, we applaud the focus on the adult homes and nursing homes that for so long have been an area of underservice in our state. But a plan should identify all those who have needs, assess those needs, develop mechanisms and services to meet those needs, properly staff the programs that address those needs, with input from all stakeholders on how to fully fund the system.

As has been the case for more than 25 years, this proposed budget does not do that. And, although the legislative budget process has reviewed and approved budgets each year, it has not undertaken the statutory mandate of requiring a plan before adopting a budget.

This year, the Mental Health Association in New York State is taking a position that is somewhat unique. Faced with proposed hospital closures, proposed cuts and at the same time adds to mental health services in Medicaid, MHANYS states the following position: "MHANYS cannot support any psychiatric hospital closings or major changes to the mental health delivery system in this state in the absence of a statewide plan for comprehensive community-based services."

Recognizing that many colleagues and state legislators are taking the same position, maybe it isn't so unique.

the NARSAD *report*

The National Alliance for Research on Schizophrenia and Depression

By Constance Lieber, President NARSAD

Constance Lieber

Mental illness is one of the most difficult challenges an individual and family can face. I would like to devote this column to talking about why the new year brings hope that we are moving closer to conquering the devastating brain disorders. Many researchers who are on the front lines say we have entered a "golden age" of neuroscience.

Psychiatry is one of the last frontiers of medicine, largely because the brain has been so difficult to study. But now researchers have new tools and insights that will help them elucidate the underlying mechanisms of brain disorders. This became clear at NARSAD's most recent scientific symposium in New York City. The event turned the spotlight on the extraordinary research of 15 Young Investigators who have received NARSAD grants. Three members of NARSAD's Scientific Council served as commentators for the two-day event. Dr. Francine Benes of Harvard Medical School, Dr. Lewis Judd of the University of California, San Diego, and Dr. Carol Tamminga of the University of Maryland School of Medicine provided valuable commentary on the research presented.

The Young Investigators, who had each received a NARSAD grant of $60,000, discussed their leading-edge studies in basic science, affective disorders and schizophrenia. Several hundred people braved the pouring rain to attend the symposium.

Researchers like Dr. Dane Chetkovich of Northwestern University are using sophisticated cellular and molecular biology techniques to gain a better understanding of the complex mechanisms involved in brain disorders. Dr. Chetkovich's research focuses on schizophrenia and the role of chemicals called neurotransmitters that help brain cells to communicate. He believes a glitch in the communication mechanism may contribute to the development of schizophrenia.

Other presenters discussed their use of brain imaging techniques, such as PET scans and magnetic resonance imaging. The latest imaging technologies allow scientists to see brain structure, blood flow, chemistry, receptors and neural development. These tools are allowing researchers to identify brain regions that may be impaired in people with a psychiatric illness.

Dr. Kristin Haga of the University of Edinburgh presented her research on the relationship between stroke and the development of major depression. She is using magnetic resonance imaging (MRI) and spectroscopy (MRS) to study chemical changes in the brain to see who may be vulnerable to depression following stroke. Stroke patients who develop major depression more than triple their risk of dying over the next two years.

Dr. Roy Perliss of Harvard Medical School discussed his search for genes that may characterize a type of major depression that includes anger attacks. He and his colleagues are collecting DNA samples from 300 people for their study.

Dr. Lisa Monteggia of the University of Texas Southwestern Medical Center at Dallas presented a groundbreaking study to determine if a shortage of a protein called brain-derived neurotrophic factor (BDNF) leads to depression. The study was especially noteworthy because she and her colleagues developed a new technique that enables them to delete the gene that makes BDNF in the brains of mice at various stages of development. Commenting on her ability to knock out the gene in adult mice, Dr. Lewis Judd said, "I can't tell you the number of times people have tried this, hundreds and hundreds, and they have failed. This is really a stupendous technical piece of work."

Studies like Dr. Monteggia's have scientists predicting tremendous discoveries about the underlying causes of mental illness over the next 10 years. At the symposium, moderator Dr. Robert M.A. Hirschfeld, a member of NARSAD's Scientific Council, said "NARSAD has attracted the best and the brightest, and enabled them to get started with these really visionary ideas, innovative ideas that hopefully will lead to a true breakthrough in terms of our understanding, and, more importantly, a treatment, and hopefully, a way to prevent the illness."

For more information about NARSAD and upcoming events, or to show your support, please call our office: (516) 829-0091 or visit our Web site: www.narsad.org.

National Artists for Mental Health

365 Main Street, Catskill, NY 12414 • 518-943-2450 • www.namh.org

By Franklin Marquit
CEO & Founder

Franklin Marquit

WHOLE HEALING THROUGH ART A MODEL FOR RECOVERY

The essence of this article is on the creative healing aspects as they relate to psychiatric disabilities. At the core of this article, I believe creative expression is a medicine that can heal and transform the human soul back from the pits of hell. The following is only a sample of my personal viewpoint.

This paper will draw from a number of authors and experts in the creative arts area. I will weave my own experiences through it to help ground you as the reader and myself to what I believe has always allowed humans from the beginning of time to nurture oneself, ones spirit, using the creative process through reflection and ultimately to heal.

Take a moment, reflect and imagine a world without music, poetry, dance, movement, theater, writing and imagination. What would you conjure up in your mind? For me, it is too frightening to even imagine, a place without the creative spirit of humans, where one cannot express the ultimate human soul. The following is a sample of an expressive poem:

Utopia

I am returning to the powerful
blue-green waters where I feel life
had its beginning.

I can see the glowing volcanic
red sun as it slowly begins to set
far way above the mountain's horizon.

I can hear the heartbeat of the crystal
waves as they pound against the
glacial remains. My essence begins to
drift among this soothing feeling.

A sea gull dives towards me then
glides over the ocean disappearing
into infinity. I suddenly felt at peace!
Was this an omen?

I face the ocean and I feel a gentle
warm breeze caress my face. As I walk
along the wet sandy beach, tips of
the ocean's tide massages my waiting
feet. Suddenly, I'm face to face
with my beginning.

Looking now at the fading sun as it
sinks, I feel deep within my soul a
power stronger than I, pulling. I now
begin to taste and smell the sweet salty
waters ever so good!

A mystic silence moves softly through
the air, engulfing me as it grows:
I am part of the universe, no worries, no
cares, only tranquil dreams as I blend
into Life itself for eternity.

Franklin A. J. Marquit

How did this poem make you feel? Could you feel, see and smell the ocean? What was the essence or meaning of these words?

Now, come with me and we will explore the creative healing aspects of art as medicine and how expressive arts can restore an individual's whole life (mind, body, and spirit) so that within a continuous process one can self-transform to a place of positive health.

Art and Healing

The art and healing process provides an alternative to art oriented individuals or organizations who want to work with recipients of mental health services. This modality is different than art therapy. The idea is for our peers who want to make art, but not do art therapy, opens up new possibilities.

The basic belief of art and healing is that an artist or creative individual can be with another person just to create art and that the process is healing in itself. There is no diagnosis, classification, treatment or outcome measurement other than the individual experience of the process as meaningful. The art and healing process involves characteristics of both art therapy and the peer process. Art therapy today also can be art and healing without therapy or interpretation or psychotherapy, depending on the person and the program, especially as it relates to the self-help modality.

NAMH, Inc. believes that there is no need for licenses to certify artists helping artists or other creative individuals in art and healing. The only license you need is to be with another human being in a time of suffering, to be present, and to have the intention to be healing. The most effective work is done by a peer, whose intention is to heal, to be a witness to the creative process, to be clear, and to allow the individual the space to be creative without imposing an opinion – without any criticism at all. The intention to heal is critical. The merging of the two people's spirits is profound and magical. One person has the intent to be healed, one person the intention to heal, but the key is mutual self-help like Alcoholic Anonymous (AA). You join and create a caring encounter. Peers helping peers is the glue that creates the healing bond. Art is the vehicle for love, for joining. The artist embraces the person's painting as the finest expression of the individual's life. It is art at its finest because it is taken as something we do together with another person in a new level of meaningfulness.

The New Field of Art and Healing

Art and healing is quickly becoming a new field in the world of healing and the world of making art. Art and healing has brought the creative arts, including painting, sculpture, music dance, storytelling and poetry into clinical healthcare settings. In art and healing, the creative arts are used for their own healing power rather than for interpretation or therapy. This new innovative approach is being integrated into the health care settings. By opening the scientific paradigm of the medical institutions, art and healing will revolutionize preconceived conventions of health care. Expressive arts are finding its way into the medical model and are becoming integrated utilizing both for healing and recovery.

Expressive arts are being born as we speak. The concept is growing every day as more awareness about the healing aspects unfolds. The healing concept is involved at two levels: art, artists, musicians and dancers are realizing that their imagery has meaning. They are understanding that their imagery heals them, others, their community and ultimately the world. When artists make a healing image they feel such energy around them that they want to produce more. Their lives are changed, their world is changed.

The second vision comes from the realm of the healer. Art used in psychiatric therapy is a moving experience. It becomes the doorway for recovery. It becomes the vehicle for transformation. It is integral to healing.

The healing arts heal by freeing the artists' own healing energy and resonating their body, mind and spirit. Next, the artists can make a piece of art to heal another person. The artist can do it for specifically one person or for a group of people. This is transpersonal and transformational healing. It connects one to another. It is an art of interconnection.

All human beings journey throughout their lifetime on widely varied paths. No matter what an individual's background, assets, or specific circumstances are, we all seek to find happiness and satisfaction in our day-to-day experiences and throughout our lifetime.

Inevitably, conflict and emotional issues arise from an almost infinite pool of circumstances that challenge us all to face our truest self, the dark and tormented side, and art meets the conflict head-on and works toward resolution and growth. Some people have the psychological and genetic structure to traverse their journey without much, if any, professional help at all. Others require intervention when their resources of self, family and community cannot provide the necessary supports.

Peer Self-Help

The self healing goals based in the peer self-help model place the responsibility on ones self, though within the peer model you have support from others in this group. This supported partnership truly creates the recovery process. Based on this model, participants have the opportunity to experience the power of expressive arts as a self-help (recovery) therapeutic tool. The main idea is to give individuals an opportunity to design their own personal choices of recovery modalities. This allows and opens avenues for the individual to go down specific healing paths that may be more in tune with the individual. The individual may choose to utilize journal writing, dance, poetry and/or painting to enhance the healing process.

I firmly believe that recovery is possible through self-help peer groups that work with creative arts. I also strongly believe in working alone on artistic exploration. Such examples are: the fine arts, journalizing, poetry, deep clay work and experiencing oneself through dance and movement. This in itself is healing.

Since many of my peers have experienced the medical model of psychiatric treatment, I want to foster linkages between creative arts approaches and traditional mental health therapies, bridging the two, and strengthening the whole recovery process.

The NYSPA Report

By Dr. Barry Perlman, President of the New York State Psychiatric Association

Barry Perlman, M.D.

ECT
The Myth and The Reality

The following has been adapted from Testimony presented on behalf of the the New York State Psychiatric Association and the American Psychiatric Association by Laura J. Fochtmann, M.D before the New York State Assembly Mental Health Committee during 2002.

No psychiatric treatment has been the subject of more controversy, confusion and misinformation than Electro-Convulsive Therapy (ECT). Public perception fostered by the media - movies, novels and television - is that ECT is a dangerous treatment that is forced upon patients against their wills, often used as a form of punishment for socially unacceptable behavior and, even when used appropriately, causes irreversible brain damage. Like much of what regrettably passes for "common knowledge" regarding mental illness in our culture, these canards about ECT are untrue and without any scientific basis in fact. This article presents a balanced and scientifically based overview of ECT - its uses, benefits and risks.

WHAT IS ECT?

Electroconvulsive therapy (ECT) is the administration of an electrical impulse to the brain by means of electrodes typically placed on each side of the skull in order to induce a convulsion. Patients are administered a short-acting general anesthetic (comparable to a simple surgical procedure) and a muscle relaxant. Oxygen is also given by mask and blood pressure, heart rhythm and blood concentrations of oxygen are monitored throughout the procedure.

WHEN IS ECT USED?

ECT remains the most rapid and effective treatment of major depression despite an ever-increasing number of treatment options. Furthermore, ECT is also efficacious in the treatment of selected individuals with mania and schizophrenia. Given the demonstrably high rates of mortality and morbidity with these psychiatric disorders, the effectiveness and speed of action of ECT are particularly important. Mortality and morbidity from mental illness occur, not only from direct effects of the mental illness (e.g., suicide, anorexia, inanition, and general debilitation), but also from medical disorders. Many types of medical illness, including cardiovascular disease, are significantly more likely and more severe in individuals suffering from these mental illnesses. At the same time, the presence of a mental illness is often an impediment to getting needed medical care. Consequently, serious mental illnesses, particularly of the type and severity that typically leads to a referral for ECT, are bad for one's health and may shorten one's lifespan. These risks can be minimized with effective psychiatric treatment.

HOW EFFECTIVE IS ECT?

A large number of controlled research studies show a high efficacy for ECT, making it one of the most well established treatments in medical practice. Meta-analytic studies, which statistically combine results of controlled research investigations, have indicated that ECT is more effective than antidepressant medication in major depression with a statistical certainty of 99.9999%. One of the largest individual studies investigating the effectiveness of ECT involved first assigning 284 patients with major depression to antidepressant medication, with 60%-70% of them responding. When patients who failed to respond to this regimen were referred for ECT, 85% responded to treatment. Thus, in the treatment of major depression, no other therapeutic strategy has proven superior to ECT.

Although the majority of patients treated with ECT are experiencing depression, ECT is also effective in treating the manic episodes of bipolar disorder, a condition marked by dramatic mood swings that wreak havoc upon the lives of the afflicted and their families. In a recent published review of the medical literature on mania, ECT was shown to be associated with clinical remission or marked improvement in 80% of 589 individuals. This response rate is higher than that reported for any other type of anti-manic medication.

Although it is used less commonly in schizophrenia and schizoaffective disorder than in mood disorders, ECT remains an important alternative to treat acute episodes in those individuals who do not tolerate or respond to antipsychotic medications. In addition, ample controlled data indicate that combining ECT with such medications is more effective than either treatment alone.

WHAT ARE THE RISKS OF ECT?

In choosing any medical intervention for a given individual, the potential benefits of the treatment must always be weighed against the potential for adverse effects. Like virtually all effective medical therapies, ECT has risks as well as benefits, but the medical morbidity and mortality of ECT is low. The risk of death with ECT, about 0.01% (one in ten thousand) of patients, is comparable to the risks with general anesthesia alone and much lower than other typical surgical procedures. Additional evidence from longitudinal follow-up studies suggests that mortality rates following hospitalization may be lower among elderly depressed patients who received ECT than in those who received other treatments or no treatment at all. When complications do occur with ECT, they are typically seen immediately after the treatment or during the recovery period while the individual is still extensively monitored. Although most arrhythmias and cardiovascular changes with ECT are benign and resolve spontaneously, treatment team members are experienced in the rapid recognition and management of such abnormalities.

WHAT ARE THE SIDE EFFECTS OF ECT?

Some patients do experience nausea, headache, or muscle pain following ECT, but these resolve spontaneously and respond to pain relievers or antiemetic agents. Following each ECT, almost all patients experience a period of confusion that may be brief or, less commonly, extends between treatments. During and shortly after an ECT course, patients will also experience anterograde amnesia, which is characterized by the rapid forgetting of newly learned information. Studies consistently show that this effect resolves in the days to weeks after ECT.

Retrograde amnesia, characterized by the forgetting of past events, also occurs and is most prominent for events around the time of the ECT course. Although older memories are most likely to be preserved, occasional patients note permanent gaps in recalling specific past events. In rare individuals, more profound amnesia is reported. The effects of ECT on memory are often confounded by the effects of the individual's underlying psychiatric disorder. For example, there is substantial evidence that schizophrenia is associated with clear neuropsychological deficits over the course of the illness. More recently, patients with depressive disorders have been found to have decreases in the size of the hippocampus, a brain structure that mediates memory.

It is also important to recognize that technical advances in ECT administration have been associated with decreases in the cognitive effects of ECT. For example, the use of brief pulse electrical waveforms rather than sine waveforms for the electrical stimulus results in fewer memory difficulties. It is also clear that the cognitive effects that do occur are not caused by nerve cell death or other damage to the brain.

see *ECT* on page 55

10 Secrets For A Speedier Recovery

By Donald M. Fitch, M.S., Founder
The Center for Career Freedom

Donald M. Fitch

The "Ten Secrets for a Speedier Recovery" came about from The Center's case management efforts to relieve the suffering and deplorable conditions of many of our members. The "secrets" come from personal experience rather than the classroom. They're expedient solutions to painful problems designed to bring real differences in one's life by making lasting changes through visible empowerment.

We hope these secrets stimulate consumer/survivors to forge their own personal recovery plan and strategies.

1) OUR FIRST SECRET IS THAT IT TAKES A "VILLAGE" TO EFFECT FASTER RECOVERY. A very smart, tough and caring village that's up on the latest research, prescriptions, talk therapies, entitlements, eligibility requirements, appeal tactics, debt negotiations, "trick" application questions, system code and more. Search and screen for the best psychiatrist, talk therapist, case manger, lawyer and peer advocate. If they're not actively helping you in your recovery, replace them.

2) THE SECOND SECRET: COOPERATE WITH YOUR TREATMENT PLAN. When visiting my friends in the inpatient units I ask "What happened-how come you're back?" Almost everyone says it's because they stopped taking their meds either because of the side effects or they felt better and thought they were "cured." Contrary to some peer groups, our experience is that the right combination of psychotropic medication is the cornerstone to recovery. Then talk therapy, housing, money/food/clothing, family, friends and lastly; skills acquisition, internship and competitive employment. Each new area seems to build upon the successful processing and stabilization of the previous one. At the Center, recovery appears to be a steady path with occasional detours.

3) BELIEVE IT OR NOT, SOME OF US CHOOSE TO BE HELPLESS VICTIMS OF OUR DISABILITY RATHER THAN FIGHT FOR RECOVERY. Fear of failure or success can paralyze us just as much as deep depression or overmedication. While most of our members check off "to learn computer skills" on their applications as an objective, about one third never make it to the training room. So our Clinical Advisor, Dr. Steven Smith, Psy.D started a short-term cognitive-behavioral program to help members cope with the anxiety associated with acquiring computer skills (Cyberphobia). The program has been a total success. Another "threshold point" is when a student passes the Microsoft practice test but is reluctant to take the similar final exam on-line. It's not that they don't know the material; it's that; they're afraid of failure or the responsibilities that success may bring i.e. "Now I'll have to go out and get a job and go off disability." Our solution is to recognize this powerful fear of change and to deal with it, a day at a time.

4) LEARN EVERYTHING YOU CAN ABOUT YOUR DISABILITY. Go to the library, get the latest "DSM" and read up on your diagnosis, visit relevant web sites of professional organizations, e.g. the American Psychiatric Association, NARSAD, NAMI, etc. for the latest research trials, results and conferences. Look up your meds in the latest "Physician's Desk Reference". Read "Mental Health News." This research will help you communicate better with your therapeutic partners.

5) REPLACE ANY CO-DEPENDENTS ON YOUR THERAPEUTIC TEAM. Melody Beattie defines a co-dependent as "one who lets another person's behavior affect them and is obsessed with controlling that person's behavior." The populations which attract co-dependents are usually the needy and helpless; e.g. the physically or mentally ill patients or the elderly. A co-dependent feels compelled to help people solve "their problems" and are often domineering and manipulative. They are a danger to us because consciously or unconsciously, they do not want us to recover, to become strong and independent, to say "goodbye." Co-dependents won't encourage you to grow, to leave the nest, to move on.

6) QUESTION AUTHORITY. But be nice about it. Keep repeating your questions until you get a definitive answer. Listen critically; does the advice make sense to you? Does it correspond to what other "experts" are saying? Is the person speaking from experience? What kind of world do they work in: government, institutional, community agency or for-profit? We find a better quality of care/ information comes from the relevant environment. For cutting edge information on the latest psychotropic medication, I'd want to consult several psychiatrists who specialize in my diagnosis and are affiliated with a teaching hospital. For low stress entry level job opportunities in office

see Ten Secrets on page 56

Saint Vincent's Westchester Opens New Latino Mental Health Program in White Plains

Staff Writer
Mental Health News

The Latino Treatment Service of Saint Vincent's Hospital Westchester opened a new office at 199 Main Street in White Plains near the Galleria shopping center to provide bilingual adult and adolescent outpatient mental health services.

"We felt that it was important to provide our clients who travel by public transportation with a more convenient location," said Dr. Leo Leiderman, coordinator of the Latino program at Saint Vincent's. "The new office will provide the same high level of bilingual, bicultural mental health services for adolescents and adults that clients receive at Saint Vincent's Hospital Westchester."

Staff from the Latino program recently hosted a reception at the new office, which was attended by area mental health and school officials, including Dr. Jennifer Schaffer, Westchester County Commissioner of Mental Health, and representatives from Hispanic organizations.

Patients interested in more information about the Latino Treatment Service or to make an appointment can call 914-925-5123.

Saint Vincent's Hospital Westchester offers comprehensive inpatient and outpatient mental health and chemical dependency services to adults, adolescents, children and their families.

Left to right: Dr. Leo Leiderman, Coordinator of the Latino Treatment Service, Dr. Jennifer Schaffer, Commissioner of Mental Health for Westchester County, and Dr. Adolph Soto, Clinical Chief of Latino Treatment Service.

Lisa Rattenni Named Vice President of Behavioral Health Services at Westchester Medical Center

Staff Writer
Mental Health News

Lisa Rattenni, R.N., M.S.N, C.N.A., of Mahopac, has been named Vice President of Behavioral Health Services at Westchester Medical Center. Her responsibilities include overseeing the Behavioral Health Center's inpatient and outpatient psychiatric services, including crisis intervention and alcoholism treatment services.

Rattenni joined Westchester Medical Center in 2001 as Deputy Director of Nursing, overseeing administrative and clinical operations for Ambulatory Care Services, Behavioral Health and Correctional Health.

Prior to joining Westchester Medical Center, Rattenni served as Program Director of Quality Assurance, Risk Management, Nursing Standards and Hospital Education at New York-Presbyterian Hospital, Westchester Division. She joined New York-Presbyterian as a staff nurse in 1985 and held a number of positions of increasing responsibility including Nurse Manager, Associate Director of Nursing, and Associate Director of Patient Care Services.

Rattenni holds a Bachelor of Science degree in Nursing and a Master of Science degree in Nursing Administration from the College of New Rochelle.

She is a member of the American Psychiatric Nurses Association and Sigma Theta Tau: Zeta Omega Chapter.

She has presented at the Psychiatric Nurses Association Annual Conference and at Medical Grand Rounds at New York-Presbyterian, Westchester Division. In addition, she is co-author of an article, "Training Hospitalized Patients with Schizophrenia in Community Reintegration Skills," which appeared in the journal Psychiatric Services.

Lisa Rattenni, R.N., M.S.N

Thomas Sanders Named President of New York State Association for Family Service Agencies

Staff Writer
Mental Health News

Family Services of Westchester President and CEO, Tom Sanders, was recently elected President of the New York State Association for Family Service Agencies, a statewide organization of about twenty family agencies.

NYSAFSA's principle purpose is to improve, advance and promote services to children and families around New York State. Members of the organization meet quarterly to research the needs of children and families within New York State and to share the programs developed to meet those needs. Since 1951, NYSAFSA has sought to ensure that the needs of the local agencies it represents are met. Each year it meets with state legislators in Albany to discuss ways in which the state can help local family service agencies to better serve their communities.

Tom Sanders

"NYSAFSA allows local agencies to come together and share what we are doing, and then present our needs with creative solutions to the state as a unified front," comments Sanders.

As President, Sanders brings much to the NYSAFSA, including nearly ten years of experience as President and CEO of Family Services of Westchester. Sanders is responsible for fiscal management, program development and program operations of FSW. He also brings insight from a national level to the state organization, as FSW is a member of the Alliance for Children and Families, a national organization of family service agencies based in Wisconsin. He began his term in July 2002, and will serve as president for two years.

Sanders holds a Masters degree from the Columbia University School of Social Work and a Bachelor's degree from Trinity College. Sanders has worked in family service for more than thirty years. Prior to his service at FSW, where he has served as president and CEO since 1993 (and previously as Vice President for Programs since 1990), Sanders worked at Westchester Jewish Community Services for more than a decade, as well as the Jewish Family Service of New York and the Bureau of Child Welfare of New York. In addition to his work at FSW, he currently serves as the President of Westchester Association of Voluntary Services for Mental Health, Mental Retardation, Alcoholism and Drug Abuse, Inc., as well as the Vice President of Westchester Association of Family Service agencies. He also is on the Board of Directors of Putnam Family and Community Services, Inc.

Edythe Schwartz Named NYAPRS Co-President

Staff Writer
Mental Health News

Edythe S. Schwartz, ACSW, Executive Director of Putnam Family and Community Services has been selected to become Co-President of NYAPRS (The New York State Association of Psychiatric Rehabilitation Services).

Schwartz mutually shares this position with David Lehmann, Executive Director of Venture House, a clubhouse program located in Jamaica, Queens. NYAPSRS is a statewide coalition of people who use and/or provide recovery-oriented community based services. It is dedicated to improving services and social conditions for people with psychiatric disabilities or diagnoses as well as those with trauma-related conditions, by promoting their recovery, rehabilitation and rights. Schwartz received her Master's Degree from Hunter College School of Social Work in 1980, has been an active member of NYAPRS for the past 10 years and an avid advocate of Mental Health, Recovery Rehabilitation and Consumer Rights for the past 23 years.

Edythe S. Schwartz

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Key Factors Influencing the Treatment of Latinos: A Culturally Competent Approach for Mental Health Providers

By Ofelia Rodriguez-Srednicki, Ph.D., Upper Montclair Psychological Associates, LLC

Dr. Ofelia Rodriguez-Srednicki

By the year 2020 it is estimated that the number of U.S. residents who are Hispanic or non-white will have more than doubled to nearly 115 million. The ability to provide effective, quality care to clients from different cultures is essential if people from culturally diverse groups are to receive proper mental health care.

Cultural competence refers to a set of cultural behaviors and attitudes integrated into the practice methods of a system, agency, or its professionals, that enables them to work effectively in cross cultural situations. When mental health practitioners are culturally competent they establish positive helping relationships, engage the client, and improve the quality of services they provide. An agency or professional working with a culturally diverse population should strive to develop cultural competence with those populations being served.

Foremost in the development of working in a culturally competent manner, the mental health practitioner must begin by developing a personnel awareness of their own culture as well as an understanding of their experiences and attitudes toward people from diverse groups. A clinician should consider the following questions in developing personal awareness:

- What ethnic group, socioeconomic class, religion, age group, and community does the clinician belong to?
- What experiences has the clinician had with people from various ethnic groups, socioeconomic classes, religions, age groups, or communities different from their own?
- What were those experiences like? How did the clinician feel about them?
- When the clinician was growing up, what did their parents and significant others say about people who were different from their family?
- What sociocultural factors in the clinician's background might contribute to being rejected by members of other cultures?
- What personal qualities does the clinician have that will help establish interpersonal relationships with persons from other cultural groups? What personal qualities may be detrimental?

Again, in order to be culturally competent one must understand one's own cultural beliefs and values. Then one needs to approach clients with empathy, respect, genuineness, and understanding which are fundamental to establishing any counseling relationship. Remember, evaluating and treating patients in a culturally competent manner is a process that can be learned and one that can be integrated into an existing practice.

Understanding how one identifies themselves within the culture may reveal a rich body of clinical information. Whether or not one refers to themselves as a Hispanic or Latino is important to know. Both terms describe people who come from different countries with different histories and cultures with a wide variety of differences. The most important thing to understand is that both terms were designed to create unity. These terms would not be used in a country of origin. The term Hispanic is an English term and does not denote gender whereas Latino (a) is a Spanish term, denotes gender and is considered more politically progressive then Hispanic. For the clinician, having a client proclaim their nationality is very important within the Latino culture. Listening to the client's story of immigration helps the therapist learn about those the client left behind, the culture, and the reasons for leaving. For many immigrants and refugees, adaptation may occur but may never be complete. They may express feelings of being *a part and apart* from the new group.

Although Latinos are from different cultural heritages, when they arrive in this country what is most apparent to others are their similarities. They speak Spanish except for Brazilians, who speak Portuguese. Most are Roman Catholics, and they have common values and beliefs rooted in a history of conquest and colonization. However, there is within-group conflict evidenced by competition among the different Latino groups. Conflicts are frequently related to a history of war between the countries of origin, distinct sociopolitical histories, and different ties to the US which have affected their entrance and acceptance into this country; leading to resentment and distrust amongst the various groups.

When conceptualizing such a diverse population as the Latinos, mental health workers need to understand the client's level of acculturation and or enculturation and development. Acculturation is the willing or

see Key Factors on page 32

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

Four Winds Hosptal and Foundation
Spring 2003 Professional and Community Education Calendar of Events

April

Grand Rounds ~ Friday, April 4th ~ 9:30 – 11:00 am

"Creativity and Mental Illness: Schumann"

Richard Kogan, MD

Would some artists have been as creative if they were not mentally ill? Focusing on the music and composition of composer Robert Schumann to illustrate the point, Dr. Kogan, a psychiatrist and virtuoso pianist, will offer a lecture/performance demonstration on the emotional lives of great composers, and the ways their psychological problems influenced their art and creativity.

Fee: $10.00 payable to Four Winds Hospital
Location: Four Winds Hospital Conference Center
800 Cross River Road, Katonah, New York 10539
Registration Required: Please call 1-800-546-1754 ext 2413

Special Conference ~ Friday, April 11th

"Differential Diagnosis and Treatment of Trauma"

Bessel van der Kolk, M.D. and Sandra Bloom, M.D.

Learn from the masters how to improve the efficacy of trauma treatment through gaining an understanding of differential diagnosis and treatment alternatives. There will be twenty informational workshops.

Location: Holiday Inn Conference Center, Fishkill, NY
Co-sponsored by: Four Winds Hospital
Putnam Family and Community Services, and other co-sponsors.
Fee: $75.00 Application for CME and CEU Credits has been made.
For additional information and a brochure, please call Allison Fowler at 845-225-2700 ext. 118. Registration is Required.

Grand Rounds ~ Friday, April 25th ~ 9:30 – 11:00 am

"The Relational Trauma of Incest: A Family-Based Approach to Treatment"

Fiona P. True, Family Therapist
Associate Director for International and Community Training
Ackerman Institute for the Family and Private Practice, Stamford, CT.

This workshop presents a novel family-based approach to the treatment of incestuously abused children and their families. Via in-depth exploration of cases, the presenter will demonstrate how clinicians and child protection workers can promote a sense of personal empowerment in the child, help family members to re-establish a connection while protecting the child from further abuse, and how to develop a safety plan in collaboration with the family.

Fee: $10.00 payable to Four Winds Hospital
Location: Four Winds Hospital Conference Center
800 Cross River Road, Katonah, New York 10536
Registration Required: Please call 1-800-546-1754 ext. 2413

May

May is Mental Health Month

May 4th–10th is Children's Mental Health Week

Wednesday, May 7th ~ 1:00 – 4:00 pm

"National Anxiety Disorders Screening Day"

A Program for Consumers designed to provide an anonymous screening and educational information about anxiety and depressive illnesses.

Free of Charge. Open to the Public. Confidential.
For information, or to schedule a confidential appointment, please call 1-800-546-1754, ext. 2413.
Location: Four Winds Hospital, 800 Cross River Road, Katonah, New York 10536

Special Training ~ Thursday, May 8th ~ 2:00 – 4:30 pm

"Child Abuse Identification and Reporting"

Valerie Saltz, CSW, Four Winds Hospital

This course is required by all licensed professionals involved in reporting child abuse and neglect. A State Education Department Certificate of Completion will be given at the end of the class.

Fee: $40.00 payable to the Four Winds Foundation, a non-profit organization
Location: Four Winds Hospital Conference Center
800 Cross River Road, Katonah, New York 10536
Registration Required: Please call 1-800-546-1754 ext. 2413

Nursing Career Day ~ May 14th ~ 4:00 – 7:00 pm

Experience Four Winds Firsthand during this Informal Event. Come and join a team that uses a multidisciplinary approach to treatment! Your Voice Will make A Difference. Refreshments, Tours. Competitive Salaries/Benefits
RSVP by Friday, May 9th at 1-800-546-1754 ext. 2413

Grand Rounds ~ Friday, May 30th ~ 9:30 – 11:00 am

"Beyond Suffering: An Artist's Journey through Mental Illness"

Presented by: Susan Weinreich, Artist and Lecturer, Mount Kisco, NY

Artist Susan Weinreich examines her struggle with Schizophrenia. Diagnosed at age nineteen while at the Rhode Island School of Design, Ms. Weinreich, fourty-seven and an accomplished painter, allows us a unique view into the world of this devastating illness. By examining her struggle, Susan takes us from the deterioration of her past, to the role of art in human relations and recovery, to her ideas about treatment and eventually to what lies before us above and beyond suffering.

Join the artist at the opening of her one-woman show on June 13th at The Northern Westchester Center for the Arts in Mount Kisco, New York.

Fee: $20.00 payable to the Four Winds Foundation, a non-profit organization
Location: Four Winds Hospital Conference Center
800 Cross River Road, Katonah, New York 10536
Reservations Required: Please call 1-800-546-1754 ext. 2413

June

Grand Rounds ~ Friday, June 13th ~ 9:30 – 11:00 am

"Managing The Unexpected in a Structured Setting"

Carolyn Grosso, Psy.D., Director, Child Partial Hospitalization Program Four Winds Hospital and Private Practice, Katonah, Bedford Hills and Sleepy Hollow, NY and **Lynne Kellner, Psy.D.,** Director, Adolescent Partial Hospitalization Program, Four Winds Hospital and Private Practice, Katonah and Bedford Hills, NY

Children in a regular education class, inclusion class, day treatment setting, or partial hospitalization program, from early childhood through the upper grades, each have individual needs. Learn techniques and tools to manage children with different types of behavioral needs, and how to create a structured day that is flexible enough to accommodate the individual ways in which each child can cope.

Fee: $10.00 payable to Four Winds Hospital
Location: Four Winds Hospital Conference Center
800 Cross River Road, Katonah, New York 10536
Registration Required: Please call 1-800-546-1754 ext. 2413

Beyond Suffering: An Artist's Journey Through Mental Illness

By Fran Walsh, Executive Director
Four Winds Foundation

"Beyond Suffering: An Artist's Journey Through Mental Illness," a special community event featuring renowned artist Susan Weinreich, is slated for May 30, 2003 on the Four Winds Professional and Community Education Calendar. Ms. Weinreich will come to the Four Winds Hospital Conference Center and share with the audience the story of her incredible transformation from the dark days of psychotic paranoid delusion to the place of light and balance in which she lives her life today.

Diagnosed as a paranoid schizophrenic, but never actually diagnosed for years, Ms. Weinreich recalls the day in 1979 when Dr. Samuel Klagsbrun, the Executive Medical Director at Four Winds Hospital, told her that there was a name associated with the pain that she had been suffering. But only when she heard the words, "and you can recover," did her dreams of hope and a promise of a restored life begin to trickle into her mind. Thus, began her slow, strenuous journey

"PAUL" Charcoal on paper

"out of hell," and a twenty-five year process of restorative treatment and therapy.

Weinreich was a talented Rhode Island School of Design student whose psychosis began unfolding during adolescence. A creative artist who, instead of blossoming outward during those formative years, Susan began an inward spiral, moving further and further from the outer world, to a complex and frightening inner world, taking her art deeper and deeper into the vortex. When Susan's mother moved her into RISD to begin her college career, she helped her daughter move into her new apartment with the usual amenities including a new set of dishes from Bloomingdale's. Those dishes were used once and remained in the sink with food on them, growing moldy for four years only to be discovered when Susan's brother went to move her out. Skillfully hiding her psychosis, Susan had managed to keep her family and friends away for a long time.

Finally, in 1979, those desperate, confusing years in Rhode Island were over. Had years and years of painful psychotic delusion actually consumed her? Had RISD actually asked Ms. Weinreich to leave the school? How had she survived? Come and hear Susan Weinreich tell her incredible, compelling story, through words and pictures on May 30th from 9:30 – 11:00 a.m. at Four Winds Hospital.

MEET THE ARTIST!
Don't miss the opportunity to spend an evening with this amazing artist and view her work firsthand! Join Susan Weinreich on Opening Night at her One-Woman Show at The Northern Westchester Center for the Arts, Friday, June 13, 2003. Log on to www.nwcaonline.org for further information. All are invited.

Key Factors from page 25

unwilling process of psychosocial changes and cultural learning that occurs as a result of contact between members of two or more cultural groups. Enculturation is the socialization process by which we develop a sense of our own cultural group. Understanding these concepts may lead to more effective treatment planning and clinical interventions. Other important commonalities that may impact on treatment are as follows:

- Language: Spanish is the common language although there are differences in idioms and phrases.

- Religion: Catholicism as well as a combination of spiritual and folk religions such as santeria, espiritismo, brujeria.

- Emphasis on Spiritual Values: Expressed willingness to sacrifice material possessions or growth for spiritual goals.

- Personalism: Importance of establishing meaningful personal relationships within families. For example family bonds are more important than independence.

- Familism: Emphasis is on the family rather than on separation/individuation. Extended family as well as non-relatives are included in this concept of "families or familismo".

- Machismo: The self-respect and responsibility of the male to protect and provide for his family. This concept may encompass the paradox that the macho must protect his female relatives from the sexual advances of other men while constantly signally his sexual availability and power.

- Marianismo: The counterpart of machismo is based on the Catholic worship of the Mother Mary. It predicates that women are spiritually superior to men and therefore capable of enduring all suffering inflicted by men and others. Women are expected to sacrifice for their children, spouses and families.

- Respeto: Similar to respect but it is more like deference to authority figures or those perceived in positions of power.

Within the Latino culture the following syndromes are found, and it is important for the clinician to be aware of: Somatization, which refers to when one converts psychological symptoms into physical complaints, Nervios, which refers to a variety of symptoms expressing both feelings of anxiety and restlessness and tends to be a long term syndrome; Mal de Ojo, which typically means the evil eye, which is a belief in the power that one human being can cause negative things to occur in another; this may be a willful attempt or an unwillful attempt to cause negativity on part of that person seen as the one giving the evil eye; children and females tend to be more vulnerable to mal de ojo than males; and Ataques de Nervios, which is often reported as a sense of being out of control, which may include symptoms such as crying, shouting, trembling, and fainting that usually occurs as a direct result of a stressful event relating to a family member.

Regarding children, Latino youth appear to be at greater risk than White children for mental health problems. Consider the following:

Research has found that Latino children were more likely to experience separation anxiety disorder and to be rated by their parents as "fearful."

Studies of depressive symptoms and disorders also revealed more distress among Hispanic children and adolescents.

The National Coalition of Hispanic Health and Human Services reported that Latino youth were the ethnic group most likely to have attempted suicide. They were also more likely to report suicidal thoughts.

Although no significant differences were found amongst Latino, White, and African youth aged 12-17 in their use of alcohol and illicit drugs, Latinos represent 23% of all drug abuse deaths among young men 10-19 years of age.

The frequency of school dropout for the general population ranges from 5-30%. Puerto Rican youth dropout rate in New York City ranges from 42-80%.

Research indicates that Hispanic females are the least knowledgeable of all ethnic groups regarding sexuality and contraception. This may relate to the concept of "Marianismo."

A larger proportion of Hispanic Americans compared to White Americans are incarcerated. Hispanic youth make up 18% of juvenile offenders in residential placements.

Treatment strategies can be targeted to Latino clients in a manner consistent with culturally competent practice. Currently, there is no consensus as to which modality of therapy best fits Latinos. Traditional therapies may be used, but they must be adapted to meet the needs of a Latino population. Here is what we know regarding best treatment strategies in working with this group:

Latino clients may need more introduction to the process of therapy.

Engaging the family is essential when treating a child or adolescent. Lack of engagement is the primary cause of premature termination.

With adolescents and young adults it is essential to explore the "bicultural competence" or the "cultural identity conflicts" of the patient.

In family therapy, the therapist needs to acknowledge their own ethnicity and explore the process of acculturation within the family.

In couple's therapy help the couple reflect on cultural contrasts; what do they want to take from the old and from the new.

Latino patients often expect the therapist to initiate and maintain dialogue. This is because a therapist is viewed as an authority figure.

Confusion, reluctance, hesitation, mistrust, skepticism or suspicion initially displayed by the Latino patient may be confused with resistance.

Therapists must begin with the external reality aspects before attacking the refractory internal resistances.

Therapists must first treat their own racism before they can well serve their patients in interracial psychotherapy.

The existence of therapist unconscious stereotypes may interfere with effective treatments.

Unconscious racist derogations can be as insidious as calling patients by their first names without authorizing the patient to return the favor.

Practicing in a culturally competent manner will help you build a better and more beneficial therapeutic relationship with your client or those you help.

Ofelia Rodriguez-Srednicki, Ph.D. is the director of the Graduate School Psychology Training Program at Montclair State University in Montclair New Jersey. She is also the clinical director of Upper Montclair Psychological Associates LLC in Upper Montclair New Jersey where she maintains a private practice. She may be emailed at the following address: Rodriguezo@montclair.edu

The Mental Health News

New York City Section

Bronx Assemblyman Peter Rivera Named Mental Health Committee Chairman of NYS Assembly

Staff Writer
Mental Health News

Assemblyman Peter M. Rivera has been named Chair of the New York State Assembly Standing Committee on Mental Health, Mental Retardation and Developmental Disabilities. In a statement released to Mental Health News, Assemblyman Rivera promises to work with our mental health delivery system and advocacy groups to improve the lives of recipients of mental health services.

"I am eager to begin working on the many important issues of concern to the recipients of mental health services in our state. I am also humbled by the magnitude and complexity of the issues that the Committee on Mental Health, Mental Retardation and Developmental Disabilities will be working on," stated Assemblyman Peter M. Rivera.

"In a year that has begun with much anxiety and unknowns due to the weak economic condition of our nation and state, mental health advocates and mental health service recipients should know that they will continue to have a dedicated voice that will work diligently and tirelessly on their behalf," continued Rivera.

Rivera added, "I am looking forward to working with the mental health community to help prioritize the most pressing issues facing the sector and look forward to their input on bringing about improvements to the mental health system."

From addressing the Governor's veto of the Community Mental Health and Workforce Reinvestment legislation, passed by both houses of the New York State Legislature last year, to working on assuring access to prescription drugs without having to deal with preferred drug lists and dispensing limits to providing a rigid inspection of the Governor's bonding proposals for providing additional beds in the system, Rivera will move quickly to examine key issues needing committee action.

"I would also like to thank Assembly Speaker Sheldon Silver for allowing me with this tremendous opportunity to work on issues of importance to so many of my fellow New Yorkers," concluded Rivera.

Rivera, is the most recent Chair of the Assembly Standing Committee on Cities and is the present Chairman of the New York Sate Assembly Puerto Rican/Hispanic Task Force.

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Peter M. Rivera

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New York City NewsDesk

New York City Agrees to Provide Services for Released Jail Inmates with Mental Illness

By Heather Barr, Staff Attorney
Urban Justice Center
Mental Health Project

Heather Barr

On January 8, lawyers for New York City and lawyers representing jail inmates with mental illness reached a proposed settlement in a class action lawsuit called Brad H. v. City of NY. This settlement, if finalized, will give jail inmates who receive mental health treatment while they are in New York City jails improved access upon their release to medications, Medicaid, treatment and services in the community, public benefits, housing or shelter, and transportation.

Three and a half years ago, the Urban Justice Center, the law firm of Debevoise & Plimpton, and New York Lawyers for the Public Interest filed the Brad H. lawsuit. The defendants in the lawsuit are the mayor, the city, the Department of Correction, the Department of Health and Mental Hygiene, the Health and Hospitals Corporation, the Human Resources Administration, and Prison Health Services. The lawsuit, brought on behalf of the class of approximately 25,000 people with mental illness released from New York City jails, alleged that the Department of Correction's practice of dropping released inmates with mental illness at Queens Plaza between 2 and 6 AM with $1.50 in cash and a $3 Metrocard violated these inmates rights under New York State laws and regulations that require that mental health treatment providers offer discharge planning to all patients. "Discharge planning" is the process of planning with a patient in a treatment program how s/he will obtain services s/he needs and wants after leaving the current treatment provider.

The court ruled for the jail inmates in the Brad H. case, issuing a temporary restraining order on behalf of several named plaintiffs, then a preliminary injunction on behalf of the whole class. The city appealed the preliminary injunction, lost unanimously in the Appellate Division, sought leave to appeal again, and was denied. The lawyers representing the jail inmates later filed a contempt motion against the city, challenging the city's failure, under the Giuliani administration, to comply with the preliminary injunction.

Three weeks ago, lawyers for the City and lawyers for the jail inmates reached a proposed settlement in the Brad H. case. The settlement provides for class members to receive--prior to or upon release from jail--medications, prescriptions, discharge summaries, appointments for aftercare, Medicaid (and, if necessary, access to the Medication Grants Program), assistance obtaining Public Assistance and Food Stamp benefits, placement in housing or shelter with on-site mental health services (for those class members who are homeless), and transportation. It also provides that all Brad H. class members will be released during daylight hours, rather than in the middle of the night, as they were previously.

Class members have the right to refuse all discharge planning services if they wish to and also have the option to accept some discharge planning services but refuse others. Class members also have the right to refuse discharge planning services initially and then change their mind and accept services later. The Brad H. agreement will not change how long anyone will spend in jail; class members have the right to receive discharge planning services prior to whenever their release date is, and the agreement specifically provides that no one will be held in jail for longer because s/he is a Brad H. class member. Finally, the agreement provides that if a class member wishes, s/he has the right to have family members and/or significant others involved in the discharge planning process.

Some provisions of the agreement apply only to class members who are designated as "seriously and persistently mentally ill." Only inmates with this designation will be eligible for transportation, and only inmates with this designation will have the right to file an application for Public Assistance and have it processed while they are in jail, so that their Public Assistance benefits will be available as soon as possible after they are released. Class members will be designated as "seriously and persistently mentally ill" or not based on criteria for "serious and persistent mental illness" created by the New York State Office of Mental Health that look at how well a person is able to function in day-to-day life. Class members who are treated with antipsychotic or mood-stabilizing medications while they are in jail will be presumed to be "seriously and persistently mentally ill" and thus eligible for the additional services.

The settlement also provides that class members who are released from a courthouse can receive the same services available to people being released directly from a jail, by going to a SPAN Office. SPAN Offices, which are operated by the Bowery Residents Committee, are located in each borough within close walking distance of the courthouse and are available for class members to walk into and receive services immediately during business hours. Class members who have difficulty following through with their discharge plan can also go to a SPAN Office to get help.

For the next 60 days, lawyers for the jail inmates are gathering comments from class members regarding the proposed settlement. On April 2, 2003, Judge Richard Braun will hold a fairness hearing regarding the proposed settlement. He will review the comments from class members and others and, based on these comments, decide whether the settlement seems fair and whether he should approve it. If the settlement is approved and ordered by the court, the city will have 60 days to implement the provisions of the settlement. The city and the plaintiffs will each hire a compliance monitor, and these two compliance monitors will monitor the city's compliance with the agreement after the implementation phase ends. The agreement will bind the city, and the monitoring will continue for a minimum of five years; if the city does not comply well with the agreement, the monitoring will go on for longer.

Brad H. v. City of New York is the first class action lawsuit ever brought against a correctional facility demanding discharge planning for mental health consumers. It is tragic that so many mental health consumers are now incarcerated. As one of the lawyers representing the jail inmates, I have always wished we could instead find a way to prevent people with mental illness from being sent to jail in the first place. Until we can accomplish that, however, I hope that this agreement will at least give class members the right to benefits, housing, services, and support which can help them lead full lives in the community and avoid returning to jail.

People wishing to read the entire settlement agreement (it is 76 pages long!) may request that a copy be emailed to them by calling Heather Barr at (646) 602-5671.

New York City NewsDesk

A Conversation with Dr. Lloyd Sederer, NYC's First Executive Deputy Commissioner for Mental Hygiene

Staff Writer
Mental Health News

Lloyd I. Sederer, M.D.

New York City is charting a new course in its efforts to promote and protect the well-being -- both psychological and physical -- of its residents.

In July, the former Department of Mental Health, Mental Retardation and Alcoholism Services joined forces with the former health department in a merger that created a new entity: the New York City Department of Health and Mental Hygiene. I joined the new agency shortly thereafter, quite pleased that its two roles had been given equal billing on the New York City health marquee.

As former Surgeon General David Satcher was fond of saying that, "There is no health without mental health." I believe our new agency reflects that reality, in both its name and its mandate.

As head of the Department's Division of Mental Hygiene, I oversee the provision of services in three areas: mental health; mental retardation and developmental disabilities; and chemical dependencies.

In a time of expanding needs but shrinking resources, our division has great challenges ahead. As always, we are striving to meet the needs of New Yorkers by offering high-quality and effective services. But we are working toward that goal with an increased emphasis on improving our division's data-gathering and analytic capabilities and making them the foundation for all else that we do.

We have undertaken an initiative to give us a clearer picture of the mental hygiene needs of New York City -- to gain a better understanding of who it is we serve, what their needs are, what treatments they are receiving, what outcomes they are achieving, and whether those outcomes reflect what consumers and their families value. Gaining answers to these questions is an important step forward in achieving our Division's goals.

My staff and I have identified nine priority areas in which we will focus our efforts:

- Data-driven planning and policy. As we build a reliable and informative database of knowledge -- about the people we serve, their disorders and disabilities, and outcomes -- we will make it the foundation of our decision-making process about programs and capacity planning.
- Culture of Quality. We will work to ensure that New Yorkers are receiving quality care that reflects the best clinical and epidemiological scientific evidence available as well as expert consensus and data about best practices and outcome assessment.
- Housing. Because adequate housing is crucial to recovery, we will leverage our influence with the relevant city, state, and federal agencies to pursue expanded housing opportunities for people with mental illness and chemical dependency and to achieve and sustain appropriate housing allocations for people with developmental disabilities.
- Early Intervention Program. We will examine alternate models of service delivery and reimbursement for this program, which now serves about 18,000 children annually.
- Medicaid parity. We will work to achieve parity in Medicaid benefits for people with mental illness and chemical dependency via the elimination of the Medicaid neutrality cap, a discriminatory benefit that inhibits the provision of appropriate clinical services.
- Project Liberty. Thanks to the $112 million federal (FEMA) grant we received in June, we have the opportunity to do new kinds of outreach, education, and intervention in this program, which has been an extraordinary response to the City's post-9/11 mental health needs.
- Primary Care. We will collaborate with primary-care providers to help them in detecting and treating mental hygiene disorders, focusing first on depression.
- Disaster preparedness. We will work to enhance community and family readiness and increase resilience against potential terrorist attacks.
- Prevention and health promotion. We will foster and implement mental health and substance abuse prevention and promotion strategies within the community. We will promote self-help and peer support efforts and work toward destigmatizing mental and substance abuse disorders

This is indeed an ambitious agenda, and we undertake it at a difficult time, when there are more health and mental hygiene needs and more effective interventions than ever, yet fewer resources available. To enable us to do more with less, the Division of Mental Hygiene is determined to ensure that its programs are sound -- based on clinical and epidemiological scientific evidence, expert consensus, best practices, and the assessment of outcomes. In this way, we will best fulfill our mandate and best serve the residents of New York City.

Lloyd I. Sederer, M.D., is New York City's first Executive Deputy Commissioner for Mental Hygiene in the newly created Department of Health and Mental Hygiene. For the past two years, Dr. Sederer served as director of clinical services at the American Psychiatric Association in Washington, D.C. He is also the former Medical Director and Executive Vice President of McLean Hospital in Boston.

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JBFCS Offers Range of Housing Solutions for Persons with Mental Illness

Staff Writer
Mental Health News

In New York State during the late 1970's, the deinstitutionalization of the mentally ill was a movement just under way. It was recognized that with the creation of adequate service support systems, many individuals living in state psychiatric hospitals could live more independently in the community. While some of those individuals could return to their families, many could not. To meet the emerging needs of those people who could live outside of a hospital, a network of services began to be developed. The Jewish Board of Family and Children's Services was one of the lead agencies in the development of what today is a diverse system of support and housing for individuals living with severe and persistent mental illness.

The first stage of programs created by JBFCS were its REAL programs (Rehabilitation and Education in the Art of Living). Today, programs in the Bronx and Brooklyn offer a rich array of services including group therapy, medication management, life skills, and vocational workshops. These programs include Continuing Day Treatment and Intensive Psychiatric Rehabilitation and Treatment.

In the early years of the shift to living in the community, a major challenge was to develop adequate housing options for this population. Here too, JBFCS has been at the forefront in creating viable and supportive housing alternatives. The agency's housing programs began with the opening of a community residence in the Boro Park section of Brooklyn. This provided a supportive environment with 24-hour staff available. Residents were expected to attend day programs or to participate in work-related activities. From there, JBFCS opened a range of supported apartment programs, and following that, two residences funded by the New York/New York agreement between New York State and New York City.

Today, JBFCS operates 138 beds in four facilities for extended stay in Community Residences/Single Room Occupancy. These provide individual studio apartments for formerly homeless men and women with psychiatric disabilities. On-site rehabilitative services support residents' reintegration into the community; staff is available 24 hours a day. In addition, JBFCS runs four Treatment Apartment Programs for mentally ill adults who can benefit from an intermediate form of supervision. Typically, there are three residents to each apartment who participate in structured programs and are closely monitored by trained staff. JBFCS also runs two Graduate Apartment Programs for adults with mental illness who live independently and are able to benefit from minimal supervision.

In 1994, JBFCS developed another type of housing for mentally ill adults by designing Supported Housing. The goal of Supported Housing is to be a viable form of permanent housing that furthers the rehabilitative goals of residents which may include education and employment achievements, lower and/or discontinued reliance on medication, and to establish their independence in daily life skills such as money management, maintaining a household, negotiating with landlords, and living with neighbors and roommates.

The intent of Supported Housing is to ensure that individuals who are seriously and persistently mentally ill may exercise their right to choose where they are going to live. This takes into consideration the consumer's functional skills, the range of affordable housing options available, and the type and extent of services and resources residents require to reside within the community. Rather than a program, this type of housing is considered an approach which creates housing opportunities for individuals ready to leave certified community residences, individuals discharged from psychiatric centers, and individuals who are currently homeless living in shelters. These housing options include community support services, rental stipends, advocacy, and psychiatric rehabilitation.

JBFCS' Supported Housing provides services to seriously and persistently mentally ill adults that promotes community integration through stable permanent housing. It also links housing to formal and informal supportive services in the community and provides support, assistance, consultation and education to landlords, employers and community agencies who provide opportunities to residents. JBFCS receives weekly calls from hospitals who want to place inpatient adults in our Intensive Supportive Apartment Program or the Supported Housing service. Upon acceptance, residents receive comprehensive care which includes assistance to help them live independently in the community and continuing day treatment program to also help prevent re-hospitalization. For those residents who have substance abuse histories, another on-site service is the Recovery Consumer Self-Help service.

Jewish Board of Family & Children's Services (JBFCS) was a pioneer in developing a full spectrum of housing and social services for the mentally ill in the New York City metropolitan area. With a strong network of services throughout the five boroughs and Westchester County, today JBFCS provides mental health and social services to more than 65,000 individuals and families on an annual basis. Located in 185 community-based, residential and day treatment programs, social workers, psychiatrists, teachers, doctors, nurses, direct care staff, support staff and volunteers work tirelessly to provide timely appropriate and effective services designed to ease the burdens that strain and disrupt the lives of people with persistent and severe mental illness.

The agency's ability to respond to the emerging needs of the mentally ill grew out of its longstanding expertise in serving the needs of adults and children with serious emotional problems and facing other life crises. JBFCS is proud of its leadership role in providing housing and support services for the mentally ill throughout New York City. All of these services reflect the agency's belief that, with the proper level and quality of supportive services, adults living with mental illness can lead productive and satisfying lives.

The Larry Brown Project

An Essay About My Successful Navigation and Negotiation of the Shelter System, Rehabilitation, and Therapeutic Environments

By Larry Brown and Neil McAuliffe, Vice President, FEGS

From the window of his apartment, Larry Brown, 48 years old, has a view of the Bronx River Parkway and behind it, the Woodlawn Cemetery. Often, as he prepares for his day, as a Direct Care Worker for Best Care or as a volunteer at the V.A., Mr. Brown reflects on that view and on the memories it engenders.

Fifteen years ago, Mr. Brown sat in a room at Montefiore Hospital with his dying mother. During her last days Mr. Brown recalls they would often look out the window at Woodlawn Cemetery and remark about how beautiful the trees were and how peaceful the scene was.

Up to that point, Mr. Brown and his family had managed to hold things together. After high school Larry entered the Air Force. It was during his tour of duty that he had his first psychiatric hospitalization at age 20. Mr. Brown was discharged from the Air Force with a service connected disability. He remained connected with the military through a job with the Veteran's Administration and volunteer work.

The death of his mother led to the difficult period in an already troubled life for Mr. Brown.

"During those last two weeks with her, I learned more about my mother than I did in a few life times of loving her. From her hospital bedroom window we would look out at the beautiful grounds of the Woodlawn Cemetery. One day while focusing just upon the trees, (there were many different types) moms just began to recite the textbook name of each tree. In essence she was saying good-bye, and with more effort than ever before, I would now have to take care of myself.

I was facing head-on my two greatest fears, the death of moms, and becoming homeless. I never made any plans for life beyond my mother's death. And although I was receiving substantial income from two sources, I found myself on the street. People began to notice, on the job, that there was more wrong than just the usual. I was close with one of the nurses at work who I knew from the Air Force. She helped me apply for a disability leave. She got me into the Bellevue Men's shelter on a nightly basis until my leave was approved. When that came through I was set up with a Post Office box to receive my checks. Between Mom's death and my substance abuse, I was not able to keep up. I just took the money and ran.

Eventually I found myself in the Vets shelter at Bordens Ave. in Long Island City Queens. My treatment and therapy began there. It was my very first MICA program and attendance was a must to hold your bed.

After two years, I was admitted to the Bowery Residence Community's Fulton House in East New York, Brooklyn. By this time much pain and sorrow had diminished and I began my "road less traveled" once again.

As part of my treatment plan at Fulton House, I traveled to Community Access where I attended a group called "Double Trouble." This was designed for the population of "consumers" who suffered from mental illness and substance abuse. There I met Mr. Howie Vogle and Mr. Howie The Harp. They were instrumental in starting a Peer Advocacy movement for the "dually diagnosed," or "MICA" consumer. That was eight years ago. I was one of the consumers who was selected for the first class of the Howie T. Harp Peer Specialist Training Center.

Today, Mr. Brown is a resident of the F·E·G·S White Plains Road CR/SRO. With support form FEGS he was employed at Best Care, a home health agency, as a Direct Care Worker. He is a 15-year volunteer at the Brooklyn V.A. Center. Mr. Brown is a veteran of the Air Force. He was in the first graduating class of the Howie T. Harp Peer Advocacy Training Program. Mr. Brown, in this article, reflects on his struggles and successes in dealing with mental illness, substance abuse, and life.

In 2000 I moved to F.E.G.S. White Plains Road CR/SRO. My first year at F.E.G.S, I kept relapsing. Every time I would start over, I would relapse. I had two very close friends here. We wrote and were active in the self-help and peer advocacy arena. They knew my plight. At this point, I made a pact that if I relapsed one more time that I would have to go away for rehabilitation. I made a pact with Bobby and Tyler, that if any one of us were aware that the other was using, we would tell staff, without even confronting each other first.

I used drugs and went away to rehab. I went away, came back and completed my VA/MICA day treatment program and started being invited to speak to my fellow veteran consumers, and civilian consumers. In this war, we are all on the front line. So I'm beyond two years clean and by actively pursuing my dreams and bringing along who ever else wanted to come. That's the way it goes, you see.

The team at White Plains Road provided me with resources regarding employment opportunities, and one opportunity that existed was to become a per-diem worker with an agency called Best Care, where I could work in the human services field and give back to the community. I turned it down two times because I was afraid. On the third go around, I reconsidered and took the job and haven't looked back since.

After that I made a commitment to God, myself, my peers, and F.E.G.S…. a common cause to humanity and society. "If you are not part of the solution, then you are part of the problem". No matter what may happen during the course of a day, just don't pick up a drink or a drug…take your medication, do a group or two, and it would be a successful day (come whatever may).

Finally, I have to be a little patriotic here for the Air Force, my first love. Serving this government was and still is an honor. Serving God is an even greater honor. Many of my peers here thank God every day, for organizations such as F.E.G.S. and the VA."

Promoting Excellence in the Field is Goal of Association of Behavioral Healthcare Management

Staff Writer
Mental Health News

Members of the Association of Behavioral Healthcare Management (ABHM) are management executives in the fields of mental health and addictive disease services who have joined together to promote high standards and quality in their profession. Each year, the New York Chapter of ABHM produces a one-day conference in Poughkeepsie (NY) to address that purpose.

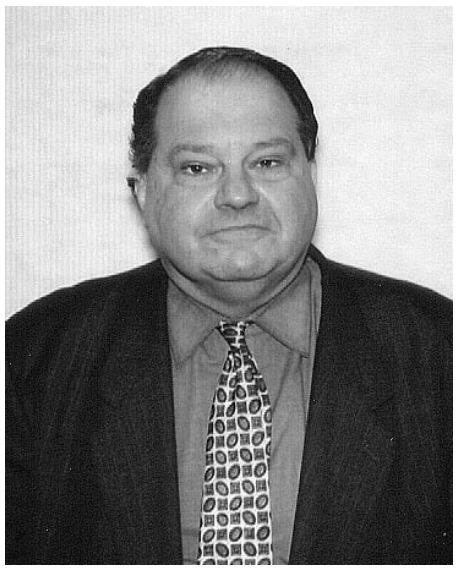
The man behind these conferences is Mark Gustin, senior associate director at Kings County Hospital Center, Brooklyn, and the president since 1999 of ABHM's New York chapter. Mark is himself the embodiment of the high standard of professionalism that is evident in the quality of the conferences. Wrote one conference attendee, "I attend many conferences, but ABHM provides some of the best and useful subject matter. The conference is thoughtfully planned and coherently presented."

It is no coincidence that the conferences are so well received, as Mark undertakes their production with the same thoroughness and dedication that has characterized his pursuit of a career in health care. In the beginning, he was trained as an accountant. "But I didn't want to do tax returns for the rest of my life," he once told me. He left the accounting profession to earn a Master's of Professional Studies in Healthcare Administration degree at C.W. Post Long Island University. But his accounting skills have served him well as his career advanced through several management positions in health care from 1978 to the present. His responsibilities at Kings County Hospital Center includes directing caregivers, securing regulatory compliance, developing budgets and expense controls. At the same time, he has enhanced his career credentials by becoming a Certified Behavioral Healthcare Executive and Board Certified in Healthcare Management. Mark has served on association boards including the National Council for Community Behavioral Healthcare. Presently, he serves on the board of the Mental Health Association in New York State and the Community Health Charities of New York.

Active networking among his peers has enabled Mark to draw from a pool of top state and national leaders in mental healthcare for presenters at the Poughkeepsie conferences and to give the conferences an exceptional level of prestige. This year at the "Behavioral Healthcare Management Institute," held on September 20, the keynote speaker was Joseph A. Glazer Esq., the President and CEO of the Mental Health Association in New York State. Keynoters in prior years have been Charles G. Ray, president/CEO of the National Council for Community Behavioral Healthcare; James L. Stone, Commissioner of the New York State Office of Mental Health; and Ann M. Boughtin, Executive Director/COO of Merit Behavioral Care of Tennessee (and former New York Office Mental Health executive).

While Mark sees to it that the executives who attend the annual ABHM conferences get an update and an overview of state and national behavioral healthcare delivery, he also provides them with expert professional guidance they can take back to their clients and put into practice the next day. Consultant Ron North, for example, at this year's conference offered customer relations management advice, ways of improving patient satisfaction and compliance. Harry M. Shallcross, a behavioral health consultant, described building an effective system for delivering mental health care services to children.

Attendees to th ABHM conferences earn Continuing Education credits, and this also attracts new members. Each year, newcomers pick up an application form and realize that ABHM membership, with such benefits as professional publications and certification programs, is key to their ongoing growth and professional success. Moreover, the merger of ABMH with the National Council for Community Behavioral Healthcare puts them in touch with a nationwide community of behavioral healthcare colleagues.



Mark Gustin

For ABHM membership applications and information, contact Mark Gustin, President ABHM, New York Chapter, 32 Jasmine Lane, Valley Stream NY 11581, tel: 718-245-2764

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Source: NYAPRS
Mental Health E-news

New York State Assembly Speaker Sheldon Silver has named the new Assembly Mental Health Committee Chair to replace recently retired Marty Luster from Ithaca.

He is Assemblyman Peter M. Rivera from the 76th Assembly District in the Bronx. covering Fordham, West Farms, Parkchester and Castle Hill. His district is to the west of the Hutchinson River Parkway and extends to within a couple of blocks of the Bronx Psychiatric Center, which has been targeted by the Pataki Administration for closure next year.

Following are details of Mr. Rivera's biography, taken from the Assembly website and from other sources:

Peter M. Rivera was born in Ponce, Puerto Rico on November 12, 1946. He migrated to New York City at an early age along with his mother, Candita; his father, Victor Manuel; and his sister, Lucy. A graduate of New York City public schools, Peter was awarded a Baccalaureate degree in Business Administration from Pace College in 1968, and, in 1974, was conferred a Juris Doctor from St. John's Law School. He was admitted to practice law in March of 1975.

His career in public service began in the late 1960s as a police officer in the South Bronx. From a street patrolman, he quickly rose to the rank of detective. As a detective, his duties included serving as the Department's radio and television spokesperson on issues pertinent to the Hispanic community. He became a Federal Agent with the Drug Enforcement Agency (D.E.A.), where he distinguished himself in Operation Eagle, at the time the largest federal narcotics operation in the United States. Shortly thereafter, upon graduating from law school, he joined the Bronx District Attorney's Office working as an Assistant District Attorney in the Homicide Bureau. While in the Homicide Bureau, he tried the first Co-Op City homicide. Since 1978, he has been in private law practice, where he has handled several highly publicized cases.

His involvement in community activities has been varied. His tireless efforts as President of the Puerto Rican Bar Association resulted in the doubling of the number of Hispanic judges in the state. He has worked in such diverse organizations as the Mayor's Committee on City Marshals, the Gateway National Recreational Area Commission, the Spanish Progress Foundation, El Comité de la Providencia, the Governor's Committee on the Judiciary, and the Board of Directors of OTB, to name a few.

Elected to serve as a member of the New York State Assembly in November of 1992, Peter M. Rivera represents the areas more popularly known in Bronx County as Fordham, West Farms, Parkchester and Castle Hill.

Assemblyman Rivera is presently the Chairman of the Assembly Standing Committee on Cities. He also sits on the powerful New York State Assembly Committee on Rules and was the most recent past Chairman of the New York State Assembly Committee on Real Property Taxation.

Assemblyman Rivera is also the Chairman of the Assembly Puerto Rican/Hispanic Task Force. Over the last 14 years, the New York State Assembly Puerto Rican/Hispanic Task Force has used its annual legislative conference to focus attention to critical issues facing our state's growing Hispanic population. This conference also serves as a tool that allows for the presentation of proposed legislative remedies by workshop panelists and conference attendees. It is a unique networking conference for this segment of New York's population as thousands of community leaders, government officials, members of the corporate sector and nonprofit sector attend this important event.

see Rivera on page 44

The Coalition of Voluntary Mental Health Agencies, Inc.

The Coalition Report

"The crumbling infrastructure of OMH's Supported Housing"

By David M. Bergman
Senior Policy Associate

David M. Bergman

At a time when the state budget is facing major shortfalls and deficits, it is important to note that Governor Pataki has presented a creative proposal to ensure that vital mental health services have remained relatively intact. In fact, while other programs will likely experience major cuts, the Governor's proposal promotes some vital program development, including historically under-funded children's services and the addition of scarce community housing.

In the mental health community, it is axiomatic that a stable residence is an indispensable component of rehabilitation and recovery. This is true along all levels of housing—from more intensive models like Community Residences to scattered-site apartments like Supported Housing. The 1000 community mental health beds which are funded in the Governor's proposal, the 600 which are earmarked for creation in '05 through a new Reinvestment proposal, and another 1000 which are called for in '06 will help to address the rapidly expanding need for housing among people with mental illnesses.

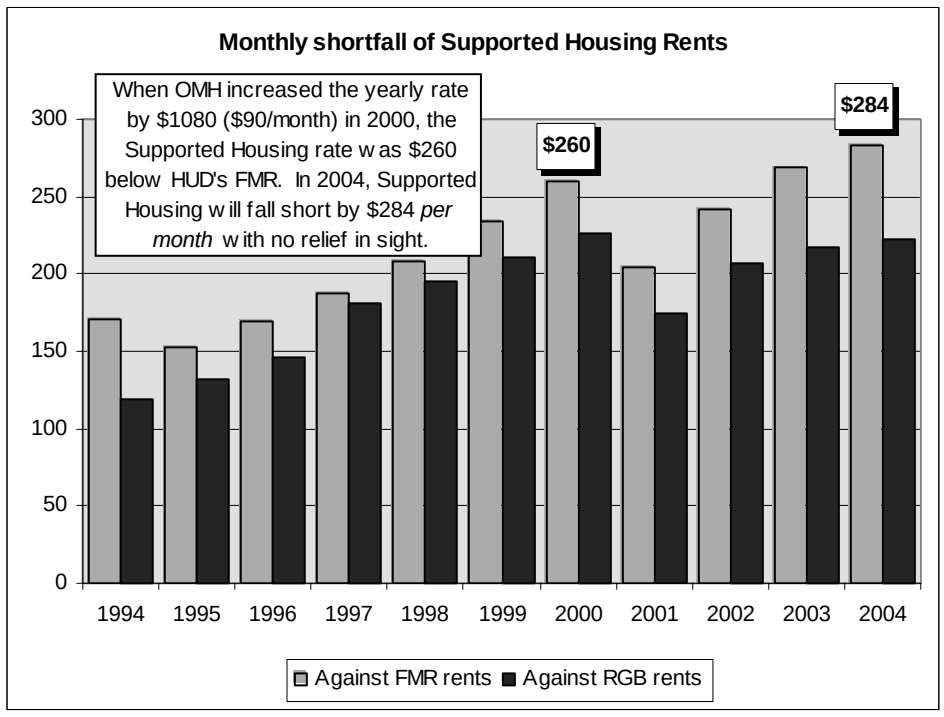
But the critical need for community housing is not fully met with the creation of these 2600 beds. Current budget deficits should not deter us from seeking long-term satisfaction of this vital human need. It has been reported here and elsewhere that homeless shelter use in New York City has sky-rocketed past its previous all-time high; thousands of adult home residents with mental illness, warehoused in inappropriate settings for far too long, should be discharged to more appropriate community settings; the on-going release of prison inmates with mental illness and the discharge of psychiatric hospital residents—all these factors call additional attention to the incredible shortage of appropriate community-based residential options for people with mental illness.

As the state's primary community program for housing people with mental illness, Supported Housing has the greatest potential for helping to solve this shortage—but only if adequately funded. Begun in 1990, Supported Housing combines funding for supportive services with rent subsidies for scattered-site apartments that are rented on the open market. The program, by and large, has been a great success–both as a low-cost alternative to more intensive housing programs, and in terms of the independence and stability it provides to consumers seeking long-term housing.

Yet, the rates for existing Supported Housing apartments—more than 4,500 in New York City alone—are far from adequate, taking into account the rapidly escalating costs of rent alone. When created in 1990, Supported Housing assumed that $550 was an adequate rent. This was in comportment with the Federal Department of Housing and Urban Development's (HUD) estimated Fair Market Rent (FMR).

Since that time, the contract rate for Supported Housing has failed to keep pace with the real cost of rent in New York City.

The one set of increases for Supported Housing came in the Fall of 2000 when Supported Housing residents were faced with eviction notices because the subsidies were too low to cover the rent costs. At that time, HUD put Fair Market Rent for a one -bedroom apartment at approximately $810 per month. Supported Housing, meanwhile, still had rent payments of $550 per month for a difference of $260 each and every month. The City's Rent Guidelines Board (RGB), which authorizes small allowable increases for rent controlled and rent stabilized apartments, has risen much more quickly than the rate for Supported Housing. If rents had gone up in the conservative increments recommended by the RGB, an apartment would have cost $712 per month in 2000—exceeding the allowed reimbursement for Supported Housing by more than $160 per month.



The increase of $90 per month in 2000 was seen as a renewal of the state's commitment to the needs of Supported Housing residents. It ensured, for a short time, the continued viability of this important program.

But since 2000, rents and other costs have continued to rise. The difference between Supported Housing rent allocations and the Fair Market rents is now even larger than it was in 2000, even taking into account the projected pay-out of the 3% Cost of Living Adjustment which began on December 1, 2002. It is clear that Supported Housing is, once again, in jeopardy.

With his Executive Budget Proposal which was released late last month, Governor Pataki has done a great deal to hold the line on existing mental health services and addressing capacity deficiencies for needy populations. For that, he deserves a great deal of credit. Regrettably, the system was inadequately funded even before this budget crunch was even upon us.

In addition to capacity building in residential community mental health programs, Governor Pataki and legislative leaders must also resolve the structural deficit in funding for Supported Housing before it, too, evolves into a new crisis. Without some adjustment, it is only a matter of time before residents begin to see those troubling eviction notices. For their sake, a fix is in order.

For more than 30 years, The Coalition of Voluntary Mental Health Agencies has been the umbrella advocacy organization for more than 100 not for profit, community-based providers of mental health services in New York City. Our member agencies provide every manner of service—from clubhouses to clinics to residences—to more than 300,000 consumers annually. For more information, call (212) 742-1600.

Asian-American Mental Health: Substance Abuse and Service Utilization

By Aman Nakagawa, M.S.
Director, Central Access
Institute for Community Living
and K. Loan Mai, M.A.

Early studies on substance abuse ignored Asian populations or failed to identify them by grouping them as "other," for example, Drug Abuse Warning Network (DAWN), an epidemiological national study, coded ethnicity as Black, White, and other. In a study cited by Ja and Aoki (1993), the National Household Survey on Drug Abuse in 1988-89 excluded Alaska and Hawaii from the survey population. However, these two states constitute large numbers of Asians, and Hawaii is the primary geographical location for Asian and Pacific Islanders. This methodological approach is an example contributing to a systematic underestimation of Asian and Pacific Islander substance abuse rates.

Culture-specific research on Asian, Pacific Islanders, and substance abuse present conflicting theories of use and inaccurate assumptions of sociocultural variables. Research on Asian and Pacific Islanders and substance abuse focused on alcohol consumption. Several studies proposed that individuals of Chinese ancestry consume less often and less quantities of alcohol than Caucasians, which led to an investigation of these conclusions. One of the first studies by Wolff (1972) scrutinized biological response patterns of Chinese and what become known as the "flushing response." He concluded that lower rates of drug use and dependency in Asian communities was due to metabolic differences.

Other studies focused on this biological deficit model, which proposed that Asians in comparison to Caucasians, lack the ability to metabolize alcohol due to a missing liver enzyme, hence reduced rates of drug and alcohol use. Contrary to the biological deficit model, Wilson, McClearn & Johnson (1978) found no difference of physical symptoms between Caucasians and Chinese drinkers. Recent research examined a sociocultural perspective, which considers acculturation factors as being strongly correlated with drinking patterns: "…cultural norms are predictive of a person's alcohol consumption patterns in both ethnic groups (Chinese and Caucasian) whereas reported physical symptoms fail to predict alcohol consumption patterns…there is a significant correlation between variables measuring acculturation and drinking status among Chinese subjects. Chinese who are more assimilated to Western culture are more likely to be current drinkers…Lastly, for both ethnic groups, the correlations between personal belief about alcohol use and drinking status are significant. This provides further support for the cultural explanation" (Li & Rosenblood, 1993, p. 431).

Cheung (1993) contended that using a one-dimensional categorization of ethnicity in research is not a guarantee that one is dealing with a homogeneous group. Ethnicity is a multidimensional construct. In using only one dimension, prior alcohol and drug abuse research were inadequate and lacked clarity in understanding the interplay of culture, ethnicity and substance abuse. For instance, the term 'race' in prior research as a quantifier of ethnicity does not adequately capture specific cultural patterns regarding alcohol and drug abuse existing between and within diverse ethnic groups.

Mediating variables such as 'place of origin' as an indictor of ethnicity is insufficient in providing a cultural context of a person's drinking pattern (e.g., immigration resulting in varying degrees of acculturation). United States-born children of immigrant parents do not necessarily share the same cultural context of drinking and substance use. Ethnic identification also fails as an indicator of ethnicity in alcohol and substance abuse literature due to there being a lack of one single ethnic group or heritage with one identify. This is especially true for bicultural children or those in conflict about their identify.

In developing an accurate understanding of culture and its connection to ethnicity, alcohol and drinking, Cheung proposed that a study of the members of a community be conducted to explore natal, symbolic and cultural aspects of ethnicity and their interactions with demographic variables insofar as examining patterns of alcohol and substance use.

Critics have explained low rates of reported substance use in Asian communities as being linked to problematic data collection and sampling. The majority of the studies on Asian-American drug use and abuse obtained their samples from drug arrest and commensurate representations of Asian Americans in drug abuse treatment "programs," hospital settings and/or used face value surveys as a primary source of data collection. This is problematic in that reporting biases of admitting to potentially embarrassing or socially disapproved behaviors are found to be high in Asian populations due to cultural values such as 'losing face.'

These sampling methods have proven to be inadequate predictors of prevalence and incidence of users in Asian communities because Asians utilize public services less frequently than other groups. Therefore, it is inherently problematic to employ such methodologies to collect data and to pool sampling groups. Alternative culturally sensitive methods for collecting data and improving sampling pools include face-to-face structured interviews and self-report surveys. Other methods would be to incorporate community-based surveys, which tend to broaden the perspective of patterns of use and addictive behaviors and verify drug usage in the Asian communities.

Prior studies failed to give appropriate language translations of the original English measures, have adequate controls or adequate sample sizes to compare for significance. Previous research based erroneous assumptions on the stereotypes of Asians as "model minorities" with no social or psychological difficulties. Current research is engaged in ameliorating these methodologies by directly investigating patterns within specific Asian groups rather than making global assumptions.

As a result of the awareness raised to improve research and understand low service utilization rates by Asian groups, more culturally sensitive and appropriate models of service delivery are being developed to address the needs of diverse populations. Several effective treatment considerations include the need to match service providers by ethnicity and/or who speak the client's mother language if English is a second language. Family involvement has demonstrated to be helpful for the client during and after treatment. A peer group emphasis is also suggested in establishing positive support for the Asian client.

Cheung (1993) addressed the need for service providers to be equipped with the knowledge and the sensitivity to issues specific to individual groups. According to Yee, (1995), a number of important considerations in serving diverse populations at risk for substance abuse include culturally relevant health education, social supports and family resources, adaptive coping skills and social role. Implementation of sensitivity service models and appropriate research methodologies will increase the reliability and accuracy of substance use and abuse patterns.

Specific treatment models for these groups are still in the early stages of development and must incorporate knowledge of transition, acculturation, and community. While research about substance use and abuse patterns in the Asian communities is currently limited--endeavors to understand, investigate, and serve those communities appear positive.

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A Behavioral Healthcare Network

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ICL's agency-wide program information:
1-866-ICL-ACCESS

OUTPATIENT PROGRAMS

ICL EAST NY CLINIC

Carmen Blanco, C.S.W.
Acting Director
2581 Atlantic Avenue
Brooklyn, NY 11207
(718) 495-6700

Satellite locations at P.S. 159, P.S. 174 & P.S. 213

Outpatient mental health services for adults, children, and families. Mental health services on site for public school children. Evidence-based and culturally appropriate individual and family treatment and specialized trauma services.

ICL JEROME STREET CENTER

971 Jerome Street
Brooklyn, NY 11207
(718) 272-3300

Outpatient mental health services for adults, children, and families. Home-based treatment for clients with impaired mobility. Evidence-based and culturally appropriate individual and family treatment and specialized trauma services.

ICL/P.S. 13 SCHOOL-BASED MENTAL HEALTH PROGRAM

Sharon Sorrentino, Ph.D., Director
557 Pennsylvania Avenue
Brooklyn, NY 11207
(718) 922-7098

Individual, group, family, and school-wide interventions. Parent library open to the community. Other community activities.

Matteo Capaccio, A.C.S.W., Director
1743 81st Street
Brooklyn, NY 11214
(718) 256-8600

THE GUIDANCE CENTER OF BROOKLYN

A member of the ICL Behavioral Healthcare Network

Evidence-based and culturally appropriate mental health services for adults, children, and families. Outpatient medically supervised substance abuse treatment for adults

Rainer Orth, C.S.W., Associate Director
Outpatient MICA clinic services.

828 Washington Ave.
Brooklyn, NY 11238
(718) 399-7107

The Center for Students, Teachers & Families at I.S. 220

A program of The Guidance Center of Brooklyn
Diane Milio, A.C.S.W., B.C.D., Director
4812 - 9th Avenue
Brooklyn, NY 11220
(718) 436-8692

Individual, group, family, and school wide interventions and community activities

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Robert Feferman,C.S.W.,
Clinical Coordinator
2581 Atlantic Avenue
Brooklyn, NY 11207
(718) 290-8100 ext. 120

PROJECT LIBERTY

A project of The Guidance Center of Brooklyn

Crisis counseling and public education in response to September 11th.

RESIDENTIAL PROGRAMS

EMERSON/DAVIS FAMILY CENTER

Dennies Wharton, B.S., Acting Director
161 Emerson Place
Brooklyn, NY 11205
(718) 636-1463

Housing, rehabilitation, family reunification and support services for individuals and single parents with a history of homelessness and mental illness.

Novelett Ross, M.S.W., Director
2581 Atlantic Avenue
Brooklyn, NY 11207
(718) 290-8100 ext. 136

ICL HOPWA

Housing, rehabilitation, and support services for HIV+ women with a history of homelessness and mental illness, serving both single adults and families.

JUVENILE JUSTICE DIVERSION PROGRAM

ICL MENTAL HEALTH/ JUVENILE JUSTICE DIVERSION PROGRAM

Catherine MacRae, M.S. Ed.
Director
408 Jay St., Suite 201,
Brooklyn, NY 11201
(718) 694-9776

Assessment, linkage and referrals to divert youth from the juvenile justice system and keep them in their homes and communities.

FAMILY SUPPORT PROGRAM AND BROOKLYN PARENT RESOURCE CENTER

2581 Atlantic Avenue
Brooklyn, NY 11207
(718) 290-8100

Information, support, training, advocacy, referral and linkage for parents of children with mental health needs.

2581 Atlantic Avenue
Brooklyn, NY 11207
(718) 290-8100 ext. 150

CHILD & FAMILY BLENDED CASE MANAGEMENT TEAM

Multi-systems approach brokering medical, mental health and other supportive services to families and individuals.

In The New York City Leadership Spotlight

Staff Writer
Mental Health News

The Human Services Council of New York City, Inc., held its 7th Annual Leadership Awards Reception this November and honored three of New York City's best.

For their outstanding leadership to the human service community, their commitment to New York City and to New Yorkers, awards were bestowed to Jack Rosenthal, President of The New York Times Company Foundation, Donald H. Layton, Vice Chairman of J.P. Morgan Chase & Co., and Hon. Helen Marshall, Queens Borough President.

To bring you closer to the event, Mental Health News has the heart-felt remarks made by Jack Rosenthal, which give us a special glimpse into how The New York Times Company Foundation responded to the tragic events of September 11th. *Here they are:*

Scotty Reston, editor, columnist and childhood hero, once wrote that Washington is a city full of people who think they are what they merely represent. There's no such danger here tonight.

For one thing, I understand clearly that in accepting this award, I merely represent all the staff and soul of The Times Foundation – notably Clare Salvaggio, Randy Becker, Barbara Casalino and Rita Wnuk.

For another thing, all of us merely represent the trust that the public reposes in The New York Times. Yes, we raised almost $62 million for 9/11 relief – but it was other people's money.

Finally, we understand that much of the good done by these millions was done by people like Phil Coltoff and many of you in this room tonight – among the smartest, warmest social service experts in the country. That makes us all the more touched by this tribute, and we give you our thanks.

Jack Rosenthal

Let me also offer what we found to be 9/11's two most important lessons for philanthropies. *The first lesson is speed.* Everyone's instinctive reaction in an emergency is to respond to instant needs – flashlights, blankets, bottled water – and to defer what are traditionally thought to be long-term needs. Jobs, for instance. Or post-traumatic stress.

This short-term/long-term distinction may apply to an earthquake or a flood, but in post-9/11 New York, it failed dramatically. Seeing lives disappear on TV that day shocked us to our core. But maybe 50,000 people also saw their livelihoods evaporate. For people making $12 an hour in a pizzeria or Sam's Hat Shop, what's long-term about suddenly losing your entire, hand-to-mouth income?

We were determined to err, if at all, on the side of speed, accepting the risk of later embarrassment if someone took the money and ran. I freely acknowledge that we were well-situated to move quickly. Our instant new fund had none of the rules and policies that constrain many charities. Instead of due diligence, we could just do. For instance, we worked out procedures with our Neediest Cases agencies from the first days after the disaster for their case workers to make on-the-spot awards of $2,000 per family and then come to us for weekly reimbursement.

I'm pleased to report that in 14 months, we've heard of not one case of fraud. Let me also say that even if there had been, it would have been worth it for the sake of quickly getting millions in help into the hands of people who needed it.

The second lesson might be called "categories." Our Neediest agencies, like many of you here, performed magnificently getting case-by-case assistance to perhaps 20,000 individuals and families. Initially, we assumed that the agencies would distribute all our funds that way, in what might be called a retail approach. But the money poured in so fast we were compelled to look for another way. What we discovered was the importance of a wholesale approach, providing help to whole categories of victims.

We identified four major categories for assistance, what we call Job Rescue, School Support, Legal Assistance and Trauma Treatment for 9/11 shock. To illustrate, we worked with the After-School Corporation to quickly create special after-school programs for 15 schools in the disaster zone providing thousands of children with safety, security and regained class time. That program is now well into its second year.

Probably the most challenging effort has been to respond to 9/11 shock. We have launched 12 trauma treatment programs. Let me tell you briefly about one that illustrates both lessons, speed and categories, our trauma treatment program.

How many victims were there in 9/11? Start with the families of the 3,000 people lost: that's probably 10,000. Then 25,000 people who escaped and their families: that's probably 100,000. Then 10,000 school children and their families. That's another 40,000. Then probably 50,000 people whose jobs evaporated, and their families. You very quickly get over 200,000 without stretching the definition of victim one little bit.

Now no one thought that all 200,000 would suffer from 9/11 shock, but some proportion would. To judge by the Oklahoma experience, the figure would be about 15 percent. So the question we put to ourselves was, even in New York, the shrink capital of the world, are there enough therapists trained in sophisticated trauma treatment to deal with 30,000 new patients? We asked around and not only was the answer, No, but we were told that what many therapists know is in fact toxic.

So we set out to start, immediately, to provide the most sophisticated trauma training possible. We managed to get the four university-based trauma treatment centers to form a consortium, paid $225,000 to create immediate trainings for 60 clinicians, 15 from each institution, and we put up $2 million to pay half their salaries for a year. In exchange, they agreed then to teach others, as well as treat. We're now up to 200 who have had the training, and counting. It's a good thing, too, considering the time bombs still going off in the minds of many New Yorkers, as we all discovered at the anniversary.

Now, the anniversary has come and gone. Some of the cloud has lifted. The rebuilding is about to begin. Yet the lives of many people remain shadowed and so, together, our work goes on. We treasure your award and your friendship and we, all of us, give you admiring thanks, from head and heart.

mha mental health association of new york city

The September 11th Training Initiative for Mental Health Professionals

By Giselle Stolper
Executive Director

Giselle Stolper

The Mental Health Association of New York City (MHA) and The September 11th Fund are collaborating to offer free trainings in trauma and bereavement therapy to licensed mental health and substance abuse professionals in the Greater New York area. The trainings will provide thousands of New York area clinicians with new and improved skills for diagnosing and treating problems related to trauma and bereavement.

"Posttraumatic stress syndrome has similar symptoms to other disorders, a large number of people were affected, and people are likely to continue to seek help for years to come," said Carol Kellermann, CEO of The September 11th Fund. "We need to be sure that there are enough trained professionals to help them get the accurate diagnosis and treatment they need."

Numerous studies after 9/11 indicate that significant, long-term mental health needs exist across a wide range of affected groups, which will likely challenge the existing mental health and chemical dependency treatment systems. MHA and The September 11th Fund established a goal of training over 5000 clinicians in a continuum of trauma treatment interventions.

"The ability to treat trauma was once seen as a specialty; now it is considered a necessity," said Giselle Stolper, Executive Director of MHA. "This initiative is an unprecedented effort to prepare New York mental health professionals to work with 9/11 affected populations to prepare for future traumatic events and to provide an opportunity to enhance trauma skills in a wide variety of ways through cognitive behavioral interventions working with families, groups, children and adults."

The training workshops are based on evidence based practice and will focus on assessment, diagnosis and the provision of effective frontline interventions for adults and children exposed to disasters and other major traumatic events; Cognitive behavioral treatment of posttraumatic stress disorder (PTSD); treatment of traumatic grief; group interventions for treatment of psychological trauma; and family therapy interventions for problems related to trauma. In addition, continuing education credits are available for all training programs.

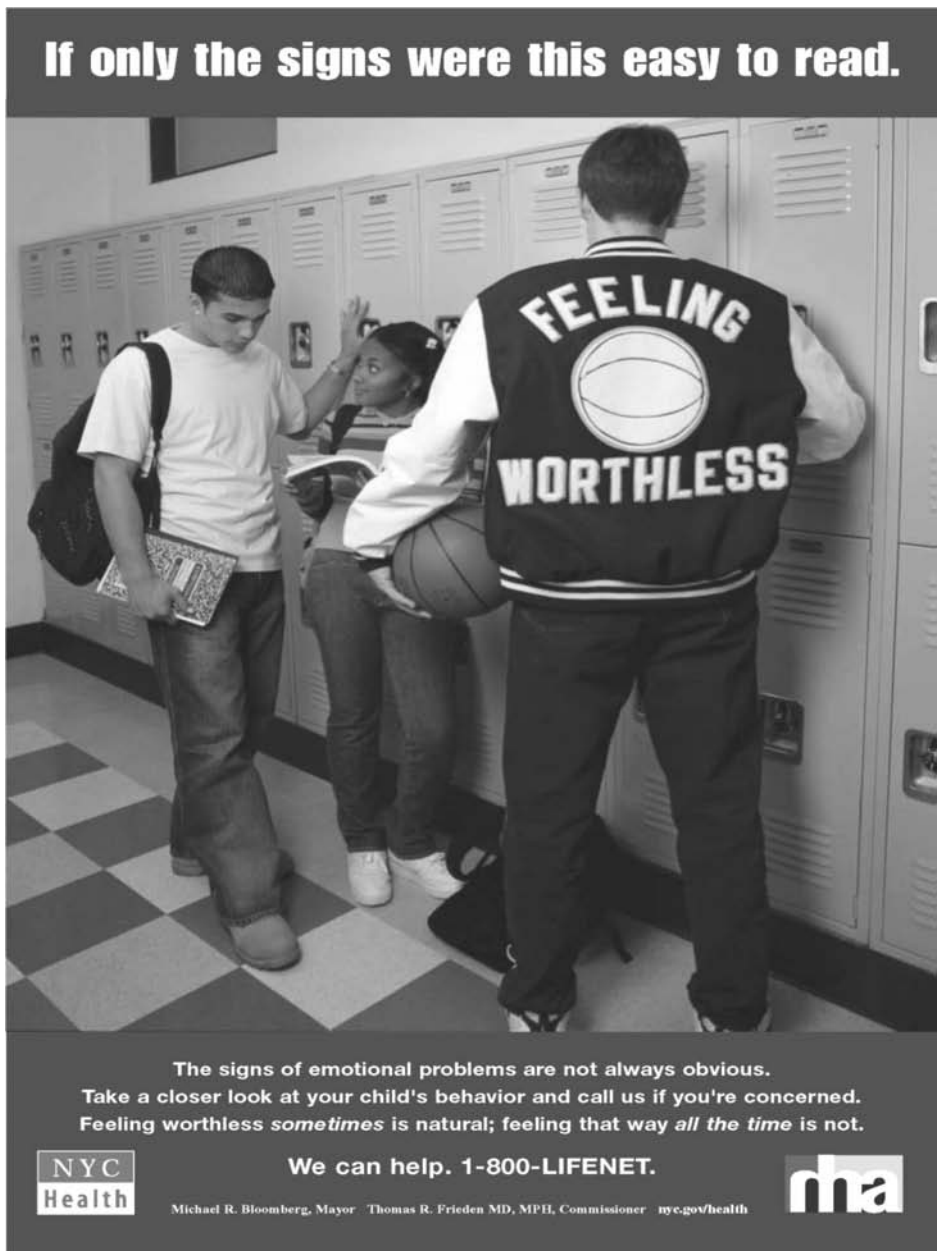
These trainings will be available to psychiatrists, psychologists, nurse practitioners, certified social workers, certified alcohol substance abuse counselors (CASAC), certified rehabilitation counselors, and student interns in the above disciplines in the Greater New York area. The training sessions will take place throughout New York City and are also available on site at provider agencies.

Richard Schaedle, DSW, Director of MHA's Crisis Resource Center, said, "We have gathered the latest information from leading academic institutions to develop these trainings. These evidence based curriculums are designed for clinicians to provide front line assistance to individuals, children, groups and families who experience common reactions to disasters as well as more pathological responses related to PTSD."

The key individuals from these institutions include Carol North, M.D., from the Washington University School of Medicine and Betty Pfefferbaum, M.D., from the University of Oklahoma School of Medicine; Edna B. Foa, Ph.D., from the Medical College of Pennsylvania at Hahnemann University; Katherine Shear, M.D., from the University of Pittsburgh; Peter Fraenkel, Ph.D. and Kenneth V. Hardy, Ph.D., from the Ackerman Institute for the Family; and information developed by the American Group Psychotherapy Association.

Recognizing that this work itself is tasking for providers, the program makes available consultation and support groups for professionals working with victims of trauma. The main goal is to assist professionals in managing the toll of working with traumatized clients by receiving help from their peers. Groups will provide participants with the consultation and support they need to continue their efforts without suffering professional burnout. Groups will be available throughout the five boroughs of New York and will be run by the American Group Psychotherapy Association.

For information regarding trainings, registration dates, or consultation and support group registration, contact the Training Hotline of MHA's Crisis Resource Center at (212) 614-6395 or crctraining@mhaofnyc.org, or call 1 (800) LIFENET.



Saint Vincent Catholic Medical Centers' Residential Services: Small Steps Toward Independence

Staff Writer
Mental Health News

Saint Vincent Catholic Medical Centers' (SVCMC) behavioral health residential program operates 284 beds in New York City and Westchester County. Multiple levels of services are offered for people with mental illness and/or chemical dependency, ranging from closely supervised programs to supported apartments in the community. In the next few years, SVCMC will open approximately 200 new beds in Brooklyn, Queens and Westchester County.

For each client in the SVCMC residential program, says Director of Residential Services, Marianne DiTommaso, "Our goal is to help people move into independent living as quickly as possible."

"Many of our clients are people who would have been given up on," said Roni Zarbiv, Division Manager for Residential Services. "We ask them to commit themselves to a new, healthier life and leave their old street life behind. Then we nurture them to take slow, small steps toward independence..."

The clients of Chait Residence, one of SVCMC's many residential programs in Staten Island, tell stories that are both heartbreaking and hopeful. Most come to Chait, a closely supervised program for persons with a serious mental illness and chemical dependency, feeling that they may have run out of chances, but many move from this program into SVCMC's supported apartment program, having taken important steps toward independence and a better life.

For one of those clients, "Robert," the structure and support the staff gave him, he said, "helped me understand it wasn't a bad thing to have a mental illness." By getting the right medication and learning the importance of taking it regularly, "I learned how to deal with others assertively, not aggressively," he said.

"Robert" spent more than a year in the Chait Residence, then moved into SVCMC's supportive apartment program. He has completed vocational training and internships and expects to have a paid job soon. "Before I came (to Chait), I couldn't see anything," he said. "Now my future looks brighter."

"Debbie" suffered from depression most of her life and began abusing drugs and alcohol as a teenager. She married a man who abused her and had two children, and eventually her mental illness and substance abuse problems led to her losing her children and becoming homeless.

"I had a lot of relapses and was in and out of a lot of programs, but nothing worked," she said. "I blamed everybody but myself for my problems." She reached a point where she called EMS, saying she wanted to kill herself. When she was admitted to the Chait program, she said, "As soon as I walked in, I could feel the warmth."

While in Chait, Debbie said, "I started to get serious." She graduated from Chait in under a year and moved into the apartment program. She is beginning to develop a better relationship with one of her daughters and is waiting to go into vocational training.

"I learned that when you set your mind to do something, you can do it," she said. "Thank God for (the Chait staff) tough love."

Eric first came to Chait not long after being released from prison, but at that point he "wasn't too keen" about the program and was not accepted. He was accepted after a second interview, but after a few days, he said " I wanted to leave."

"I wasn't able to grasp I had a mental illness," Eric said. "I had to learn that medication is important and let it work for me." He describes himself as "one of those stubborn ones, but I became teachable. I'm waiting for my turn to show I can do it."

For more information about SVCMC's residential programs, please call 718-818-5055.

Rivera from page 38

The highest-ranking Latino elected official in the New York State Assembly, Peter M. Rivera has maintained close ties to the community by fighting for quality in education and for strengthening bilingual education, by promoting access to health care and AIDS-related funding, and by working for the establishment of a Puerto Rican heritage center at a newly renovated Bronx office of the New York Public Library.

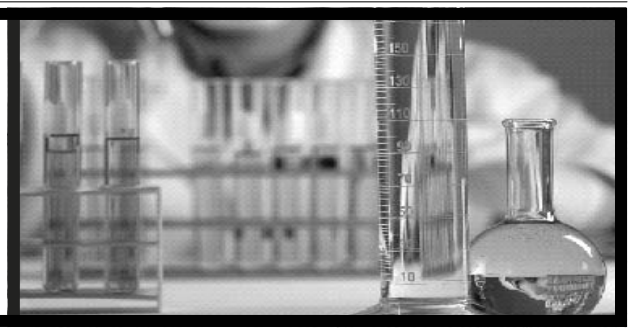
Assemblyman Rivera is a member of the following standing committees: Agriculture, Consumer Affairs and Protection, Judiciary, Libraries and Education Technology, and Rules. Along with these are his subcommittee assignments that include the Task Force on: Constitutional Amendments, Court Operations, Criminal Justice, Economic Development, High Speed Rail, New Americans, Workers' Compensation, and the Subcommittee on Estates and Trusts.

Most of the legislation he has cosponsored relates to bread & butter issues--banks cashing Social Security checks, whether or not the payee has an account, deferral of home mortgage payments, emergency contraception for college students, exemption from standard statewide Regents exams, permitting arrestees to fail to list arrests where charges were terminated in their favor; directing school districts to operate in jails, regulation of public housing playgrounds, motor vehicle emission controls, credit card interest rates, low cost rentals, minority business enterprises, protection of lobster traps, sustainable development, registration of landlords, discrimination by hospitals, prescriptions for seniors, and privatization of city hospitals.

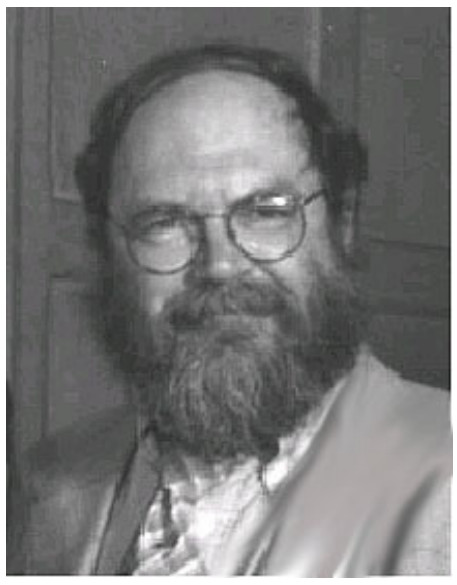
WORKING WITH MEDICATIONS

How Physicians Choose Medications? Part 2.

The Properties of the Medication



By Richard H. McCarthy M.D., C.M., Ph.D. ComprehensiveNeuroScience White Plains, New York



Dr. Richard H. McCarthy

Fortunately, there are a wide variety of medications that can be used to treat psychiatric illnesses. These medications differ with respect to how well they work and their adverse effect profile. How is it that physicians choose one medication rather than another? The last column discussed two sets of factors that enter into the selection of a specific medication for a patient. The first set of considerations are those related to the patient and his personal characteristics. The second set are those that are concerned with the problem the patient has, i.e., the symptoms or illness being treated. Today's column will focus on the factors related to the medication itself.

If we want to understand the particular medication there are two general classes of information that we need to know about, pharmacodynamics and pharmacokinetics. Pharmacodynamics refers to how the pill acts in the body to change how organs function. In psychiatry, discussions of pharmacodynamics typically focus on the medication's interaction with receptors. Most of modern psychopharmacology has evolved out of what we have learned about the receptors and their physiology. We will discuss this very large topic in another article at a later date. Pharmacokinetics concerns itself with what the body does to the medication: how it is absorbed into the body, distributed throughout the body, metabolized and finally how the body gets rid of the medication. While these topics may seem to be somewhat esoteric and irrelevant they are actually crucial to drug selection. Understanding these basic issues is critical to help us determine how, when, how often, and how much medication a person will need to take.

Absorption: getting the medication into the body. Even though pills are taken by mouth, they are usually absorbed in different areas of the GI (gastro-intestinal) tract. Pills must be broken down and dissolved before the active ingredients in them can be taken into the body. Some pills are better absorbed in an acidic environment like the stomach while others require a basic environment like the intestines. A pill is made up of the active ingredient, the actual medication or drug, and inactive ingredients, substances that have no medical value but give the pill bulk, color and consistency. The inert ingredients are necessary to make a pill but they must be removed before the medication can be released. While these inert ingredients may not have any therapeutic effect, they certainly influence the process of absorption. Moreover, the absorption of medications can be very much influenced by the presence or absence of food. Some medications such as ziprasidone (Geodone®) are absorbed better when they are taken with food. Others such as olanzapine (Zyprexa®) are not influenced by the presence of food and can be taken either with meals or on an empty stomach. It may well be that for some medications that presence or absence of food will determine the amount of the medication that will be available to help the patient. Likewise, taking two or more medications at the same time may alter medication absorption For example, carbamazapine (Tegretol®) and Chlorpromazine (Thorazine®) can interact when taken together such that neither drug is absorbed properly.

Understanding the mechanisms of absorption gives us a number of ways in which we can manipulate and control a medications absorption. For example, Controlled or Extended Release Medications dissolve in different parts of the GI tract and therefore slowly release the active ingredient over the course of a day. This allows the medication to be taken on a once or twice daily basis. Furthermore, the absorption step can be skipped entirely or partially. We skip absorption entirely when we inject a medication directly into the bloodstream. This is a good way to make a large amount of medication immediately available to the body. We are better able to manipulate absorption more subtly when we inject medications into muscles. Most intramuscular injections will be very rapidly available for the body to use. On the other hand, we can adjust our medications and make their rate of intra-muscular absorption extremely delayed as in medications such as the depot neuroleptics, for example haloperidol decanoate (Depot Haldol). These depot medications are injected into the muscles and slowly absorbed over the course of weeks into the bloodstream. Knowing something about how medication is absorbed will allow us to manipulate how much medication to use and how often it needs to be administered.

Distribution: moving medication around the body. Once a medication is absorbed into the body, it needs to be brought to the appropriate organ system for it to be effective. This process is referred to as distribution. Distribution largely depends on whether a medication dissolves better in water or oil. Usually a medication dissolves well in one but not the other. Medications that dissolve in oil are best absorbed by the brain. However, medications that dissolve in water are best absorbed into the blood stream. We have a dilemma, medications that will get into the blood stream must dissolve in water, but medications that will get into the brain must dissolve in oil. The body solves this problem by using proteins in the blood to carry oil-dissolving medications around the body. This allows the body to absorb and carry and release a medication in the necessary locations. If this protein is abnormal or absent in the bloodstream, medications will not get to where we need them to be. Fortunately, the amount of this protein is very closely controlled in the body. As a result distribution problems are somewhat uncommon. Once a medication has been carried to the brain it has to move from the protein in the bloodstream into the brain. That is to say, it has to be absorbed once again but this time into the brain. The brain is a highly isolated and well-protected organ. Absorption of chemicals into the brain is very tightly controlled. Sometimes medications can only get into the brain if special proteins actively carry them from the bloodstream directly into the brain itself, by a process known as active transport. You can think of this has been similar to a bus with a limited number of seats. In order to get from one place to another you must be in a seat. Problems can occur if there are too few buses, too few seats, the seats are already occupied or something prevents the medication from occupying the seats. All of these kinds of problems can occur with active transport dependant medication. Gabapentin (Neurontin®) is such a medication. Interestingly, if too much gabapentin is present it actually interferes with its own absorption, that is, it prevents itself from occupying the seat and therefore misses the bus. When this happens the available medication must take a later bus if it is to get into the brain at all. Since medications can not wait around all day for a bus, the body usually metabolizes and eliminates them. Thus, gabapentin is usually given in small, doses divided up over the course of the day. This allows more of the medication to be "catch the bus" and be transported into the brain. Simply increasing the dose one a day would not accomplish this.

Metabolism: how the body alters medications for use and elimination. Metabolism is the breaking down of a medication into its parts. While most medications are metabolized by the body, some are excreted unchanged. Most, however, are broken down and the step of metabolism is one area where problems are quite frequent. The major organ of metabolism in the body is the liver. All of the body's blood filters through the liver and, as a result, every thing that is carried in the blood is exposed to liver metabolism. The liver is rich in chemicals called enzymes that speed up or slow down the rate at which the body metabolizes a medication. If metabolism speeds up, we reduce the availability of medication that can work in the body. If metabolism is slowed we increase the availability of medication to do work. Metabolism can vary for quite a number of reasons. The biggest potential interfering factor in metabolism is the presence of other medications. These can either block entirely (quite rare), reduce, or increase the rate at which a medication is broken down. These are referred to as drug/drug interactions. These drug/drug interactions can be quite complex such that Drug A may reduce the concentration of Drug B, while Drug B is simultaneously increasing the concentration of Drug A. We have only begun to understand these complex interactions.

There are also a number of things that patients do that influence metabolism. Smoking and drinking alcohol almost always increase the enzymes in the liver and speed up metabolism, thereby reducing the amount of drug available to do work and increasing the amount of drug necessary for the patient to take. While smoking and drinking are not particularly good things to do in the first place, they are particularly bad for people taking medication. This is due to drug/drug interactions between the medications and alcohol as well as alterations of metabolism due to smoking and drinking. Thus, people who smoke will almost always need more medication than people who do not. This often means that smokers will have more or worse adverse effects than others because they will need more medication.

Excretion: removing mediations from the body. All medications must be eliminated from the body and the process by which this occurs is referred to as elimination. Typically, the medication and its metabolic byproducts are dissolved inside of water, solids, or air that the body is getting rid of. If the organs of elimination such as the kidney are not working properly, they will not be able to rid the body of medication fast enough. This can lead to an inappropriate accumulation of medication in the body which could cause a wide variety of problems including making the patient ill. This would obviously require dosage adjustments. Such dosage adjustments are typical for people who have kidney disease. This leads to an important concept, the elimination half-life of a medication. Usually referred to as half-life, this is defined as the amount of time necessary for the body to reduce the total amount of drug by 50 percent. Drugs with a long half-life will stay in the body for days or weeks. Drugs with a short half-life will leave the body and a matter of minutes or hours. If you wanted to make a medication to put people to sleep but that would not keep them asleep you would choose a medication with a short half-life. Likewise if you want to give someone a medication to help relieve anxiety all day, you would consider medications with a long half-life. Drugs with a short half-life need to be taken more frequently over the course of the day and drugs with a short half-life. Sometimes medications need to be taken three or four times a day because the body processes the medication so quickly.

There is one other factor that is of increasing importance in the modern era, cost. If two different companies make the same drug, both drugs should have almost the same pharmacokinetic and pharmacodynamic properties. It is important to note the word "almost" because there are technical reasons why both medications are not exactly the same even though the active ingredient in the pill is.

Brand Name versus Generic. Presently there is a good deal of discussion about the differences between brand name and generic drugs. The Brand Name is the name of the original version of the medication and is made by a specific manufacturer. Only the manufacturer can only use this name for the medication. All drugs also have a chemical (higly complicated and rarely even known much less used by most people) and a generic name. Any subsequent manufacturer of the medication can use the generic name. A generic drug is the same medication made by a different manufacturer. When a medication is new to the market, the original manufacturer receives a patent that allows it exclusive rights to make and sell the drug. This allows the company that discovered and developed the drug to make up its costs and to be rewarded for its efforts. When the patent expires, other companies are allowed to make and sell the drug using the generic name, as long as the generic versions are functionally equivalent to the original medication. This means that the generic medications function pretty much the same as the brand name, as determined by the FDA (Food and Drug Administration) .

Generic medications are typically cheaper than brand name drugs. In fact, with only one or two exceptions, I always order generic drugs. New York State Medicaid now has a mandatory generic drug program. This means that Medicaid will only pay for (the cheaper) generic drugs, unless there are very good reasons not to do so for a specific patient and prior approval is obligatory. Only nine medications are automatically exempted from these prior approval constraints. Of these, only two are routinely used in psychiatry, viz., Clozaril®, (clozapine is the generic name) and Tegretol® (carbamazapine is the generic name). Generally, physicians learn about and speak about medications using generic names. Patients almost always speak about medications using brand names. In this and future columns, I will typically use the generic name and will provide the brand name as well.

Taken together the pharmacokinetic properties of absorption, distribution, metabolism and elimination all influence how often and how much medication we need to take. This, after all, is the whole point of pharmacokinetics is to be able to use medications to help maximize the benefit to the patient with the least amount of interference to the patient's life.

Mental Health News

Fairfield County Section

Danbury BRIDGEPORT **Stamford** Ridgefield Norwalk

Spreading the Word on Mental Health

By Dr. David Brizer, Chairman
Department of Psychiatry
Norwalk Hospital

What do you do when funding for health care is heading south? What do you do when insurance premiums and restrictions make it harder than ever for people to get the mental health services they need?

Let me tell you what the outstanding providers of mental health care in Fairfield County have done.

Thirty individuals—mental health consumers, advocates, nurses, psychologists, social workers, therapists, administrators and psychiatrists met in January at Norwalk Hospital to kick off the premier edition of the Fairfield County Mental Health News.

Mental Health News, a 56-page wellspring of information about mental health, mental illness, and treatment resources, already appears in Westchester County. A New York City supplement to the publication was recently launched with great success. The periodical, with a readership of 75,000, is the brainchild of Ira Minot, a survivor of near-lethal depression.

As the newspaper's founder and publisher of Mental Health News, Minot's story is nothing short of remarkable.

Five years ago, his life had nearly ended; he was on a deadly tailspin, having struggled with severe depression for a literal decade. Following a period of homelessness and then psychiatric hospitalization, Minot literally resurrected himself by throwing all his energy into educating others about depression and related problems. A quick study, Minot taught himself desktop publishing, did what it took to write, edit and publish a broadside on the good news about psychiatric treatment (it's available; it works; there's no shame in needing the help). Pretty soon he was out there, hand delivering bundles of his newspaper to dozens of hospitals and agencies throughout Westchester and New York.

Minot's dedication and enthusiasm for what he does is direct, wonderful and contagious. He has lived in the eye of the hurricane and he has survived. He has emerged from that horrific time better for the experience. Helping others get through is now his source of joy.

The care providers of Fairfield are banding together and making sparks to get the word out.

Mental Health News will help to close a huge information gap. I have lost count of how many phone calls, e-mails and other queries we receive for specific types of help from people who have been in trouble for months and even years without knowing where to turn.

David Brizer, M.D.

Despite the ever more sophisticated array of interventions including safe yet powerful medications and synergistic behavioral therapies, too many people still know too little about how and where to get the professional or peer help they need. Many publications in the mental health and psychiatric field are intended for the professional and are often top heavy with jargon and editorial influence from the big pharmaceutical companies.

Mental Health News is unique in supplying detailed and comprehensive information about mental health treatment that is accessible to everyone. We hope you like the new Fairfield section.

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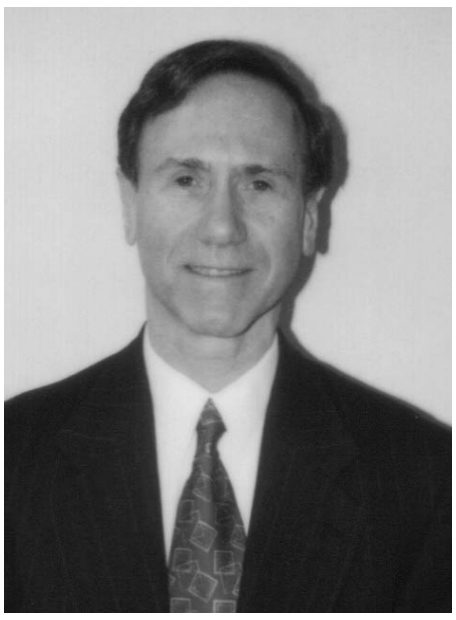
Southwest Connecticut's Mental Health System

By James M. Pisciotta, ACSW
Chief Executive Officer



James M. Pisciotta

The Southwest Connecticut Mental Health System (SWCMHS) is a Local Mental Health Authority in the state of Connecticut's Department of Mental Health and Addiction Services (DMHAS). It was created as an entity in 1999 upon the merger of the F.S. DuBois Center in Stamford and the Greater Bridgeport Community Mental Health Center in Bridgeport. Our mission is to provide and manage high quality, compassionate, and culturally competent mental health and substance abuse services to adults with behavioral health disorders who are indigent.

SWCMHS (also known as Region 1) is a blend of state-operated mental health and substance abuse programs and a rich variety of private non-profit (PNP) affiliate agencies providing a full range of services. The separate services offered by state employees and PNP employees are coordinated through a variety of interagency and communication activities on an ongoing basis.

The geographic coverage encompasses lower Fairfield County starting in Greenwich and includes communities heading easterly to Stratford. Included are Greenwich, Stamford, Darien, New Canaan, Wilton, Weston, Easton, Norwalk, Westport, Fairfield, Bridgeport, Stratford, Trumbull and Monroe. This is a region characterized by high density in three major cities and low density in their suburbs. The majority of our consumers tend to reside in the cities. It is also a region of economic contrasts, wherein the city with virtually the lowest per capita income in Connecticut (Bridgeport) is situated within the county (Fairfield) with the highest per capita income. The result is increased financial pressures on consumers who must live in a high-priced environment.

The population of these communities is characterized by a rich diversity of cultural, racial and ethnic groupings, and, of course, the composition of our consumer groups reflects this. For this reason we strive to have a workforce capable of displaying sensitivity, understanding and respect for consumers from all of these backgrounds.

This service system provides a full range of services to persons with serious types of mental illness and substance abuse. In the mental health continuum these range from hospitalization, community residences, Assertive Community Treatment, case management, vocational and social rehabilitation services, jail diversion, and outreach services to homeless mentally ill and substance abusers, to housing development services and supported

see Southwest on page 54

PILOT Addresses Housing in Connecticut

By Alex Berardi, Executive Director, Keystone House, Inc.

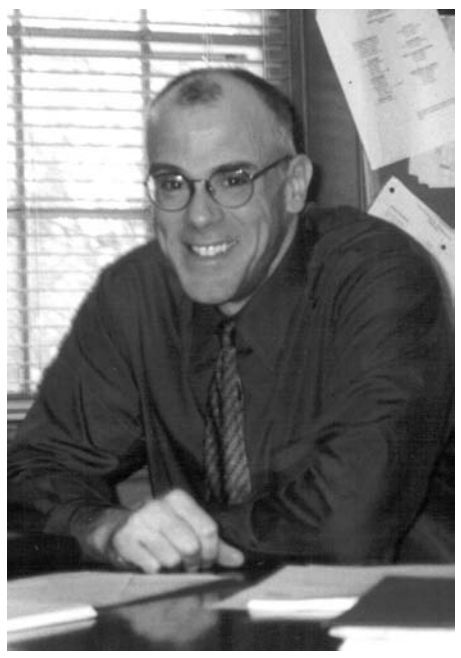
Psychiatric rehabilitation pioneer Bill Anthony tells a compelling story about the basic desire and goals of mental health service consumers. He met with a group and elicited their priorities for themselves. One reluctant participant did not speak up, so Dr. Anthony asked him directly, what is it he wants from his mental health program. "Chow," he said. "Chow? Is it better food that you want?" he asked. "No, chow," the consumer persisted. Finally Dr. Anthony asked what this meant. Another group member answered, "A car, a house, and work." The consumer nodded in agreement.

Dr. Anthony tells this story in the context of the recovery philosophy to illustrate that our clients value the same things as all citizens. These are core elements of independence the ability to travel at will, financial means, and a place to live. In Fairfield County the most daunting demand is safe, affordable housing. Most people who live in Fairfield County would agree.

For the past several years, Connecticut's Department of Mental Health and Addiction Services (DMHAS) has maintained an initiative to create affordable housing which includes support services to help homeless clients select, obtain, and maintain housing. The PILOTS initiative, an interesting statewide collaboration, spawned several local initiatives. The legislature, DMHAS, and the Corporation for Supportive Housing (CSH) lent statewide leadership to this effort. The legislature would appropriate the service dollars that DMHAS would manage and distribute to local partnerships while CSH would help access federal (HUD) subsidies through the local continuum of care collaboratives that exist in most communities. CSH would also provide technical assistance to help the local collaborations to develop housing where accessible and viable housing stock is limited or non-existent, such as in Fairfield County.

The PILOTS program that has been developed in Norwalk illustrates the success of this initiative. Gaining the necessary political support was not difficult. Norwalk's Senator Robert Genuario, the ranking Republican member of the Appropriation's Committee, was approached by the local partners. Senator Genurario readily acknowledged the need for housing and lent his support. Keystone House, Inc. and the Family and Children's Agency, with well-established track records for providing residential support, case management and homeless outreach services, would bring their accumulated expertise to the table. The Mid-Fairfield Human Services Council would lend its expertise and experience in housing development, and Interfaith Housing Associations of Westport--with experience in both service provision and housing development--would establish a PILOTS component in Westport. The Norwalk Housing Authority lent its expertise to administer the HUD subsidies (secured through Norwalk's continuum of care) which have netted millions of dollars in federal housing assistance over the years for the locality. The continuum of care, itself, is a collaborative effort that features the PILOTS partners and several other Norwalk agencies.

The Norwalk project is currently serving 20 of 43 clients projected to be served. The clients reside and are served in apartments throughout the city, reflecting a "scattered-site' model. While the integrative (i.e., the provider comes to the client, rather than vice versa) nature of the model is extremely desirable, the collaborative has been urged to develop housing rather than merely access marketplace housing, owing to the limited housing stock in the area. This year, as Phase II of the initiative begins. the Human Services Council and Interfaith Housing Association have begun housing development activities. Sites have been identified, and the development process is already underway.



Alex Berardi

Successful collaborations are difficult. The devils lie in the details. Both the Norwalk and statewide projects have demonstrated success. The involved agencies are true to their missions, can recognize and identify client need, and have the experience, expertise, track records, and existing services and infrastructure which can be leveraged and synergized collectively to achieve a common goal. Vocational service provision is a part of the service package the Norwalk group has developed. Once the project is fully implemented, all that will remain to be done is to renovate I-95 to facilitate access to clients and services!

They Call It The Hospital On The Hill

By David Brizer, M.D., Chairman
Department of Psychiatry
Norwalk Hospital

Norwalk Hospital has been serving Norwalk and the surrounding communities for over a century, building and changing to meet the needs of a dynamic and socioeconomically diverse population.

The hospitals' department of psychiatry has grown and changed with the times too.

Psychiatry at Norwalk has always been heavily weighted on the humanistic side. The current roster of therapists, nurses, nurse practitioners and psychiatrists are there because they want to be. Their compassion shines. People from all walks of life—policemen, parents, trustees, attorneys, even therapists—come in to talk, to grow…to glow. Each person under Norwalk psychiatry's umbrella of care gets a truly individualized helping of leading edge treatment. For some this means intensive counseling, for others it might be involvement in an anger management or adolescent group; some benefit from a combination of interventions that can include medication, mediation—or meditation.

If you get your care at Norwalk, you feel like you are taken into the heart of a loving and wise family.

We know that people with mood and other kinds of disorders are not only highly challenged but are highly gifted as well. The short list of extremely accomplished, hugely creative individuals who wrestled with the angel of mental illness includes Virginia Woolf, William Blake, William Styron, Irving Berlin…and perhaps, the person sitting next to you at the coffee counter.

Depression, anxiety and other psychiatric disorders are pandemic in this society. No family is spared from the challenge of emotional and addictive disorders.

Our patients are heroes. Not only do they master their problems but they live admirable, courageous lives, lives filled with dignity and achievement. And they allow us to take part in all this!

The field is growing, taking on ever more refined and sophisticated approaches to mind and brain.

Brain imaging has advanced to the point where feelings and thoughts can be photographed. Newer medications are shedding their side effects and becoming increasingly targeted at specific symptoms. Treatment is no longer whimsical or subject to the personal caprice of the clinician. Like our counterparts in medicine and surgery, we give the best that that science and compassion can offer.

It's a privilege to be part of this new venture. *Mental Health News*, already a success in Westchester County and New York City, has come to our neck of the woods. This project—getting the word out about mental health resources in the community and how to find them—is critically important. In this day and age I try not to be surprised at the number of requests we hear from people who cannot find the kind of help they need. *Mental Health News* is the living solution to that lack of information.

I would like to make some closing anecdotes.

We have all had our share of golden 'moments', times when we wonder why we're doing this crazy work at all. Moments illuminated by the dragon-fires of cost-cutting, of the criminalization of health care, of managed care woes.

But then a young woman comes in and tells you she wants to blow her brains out. You listen, you open your heart, you work with her. She is pregnant, but the prospect of motherhood—like everything else for her—is meaningless, empty, absolutely void.

Twelve months later she returns to the office, thanking you for your help—and healed.

Maybe you're still wondering why you're doing this…then you meet a family member of a patient who needs you. Or a child whose life you and her school and her parents have helped to glue back together. Or you meet Mental Health News founder and publisher Ira Minot, whose life and mission are a glowing example of the kind of personal and spiritual turnaround that we want for patients.

And you get a chance to be part of it, to tell your story.

Welcome to Mental Health News.

Treating Adolescent Addiction: An Ongoing Challenge

By Dr. Richard Frances
President and Medical Director
Silver Hill Hospital and
Dr. Avram Mack, Child Fellow
Columbia Presbyterian Hospital

The use and abuse and the treatment of substance abuse in children and adolescents has been a major focus of attention for parents, school personnel, law enforcement officers and mental health professions for many years. The prevalence of Substance Use Disorder in this age group is rising, the age of first usage is dropping, and the progression of the disease and the mortality rate is increasing. Substance abuse can interfere with natural growth, with normal interaction and development, relationships with peers, academic performance, attitudes toward law and authority and can have acute, chronic organic effects.

When does use become abuse and dependency in adolescents? Diagnosing dependence in adolescents is difficult due to reduced likelihood of signs and symptoms of withdrawal that frequently occur later in addiction.

Extent of the Problem

Statistics from the Substance Abuse and Mental Health Services Administration show that drug abuse by 12 to 17 year olds has climbed from a low of 5.3% in 1992 to a fluctuation between 9 and 11 % since 1995. Furthermore, the age of first usage of drugs or alcohol has dropped. More than 50 % of sixth graders have tried alcohol or other illicit substances.

Warning Signs

Signs of adolescent drug use include a drop in school performance, irritability, apathy, mood change (including depression) poor self-care, weight loss, over sensitivity to questions about drinking or drugs, and sudden changes in friends. Screening devices should include routine medical examinations and the use of urine analysis to confirm a diagnosis when necessary.

Contributing Factors

Peer group, school environment, age, geography, race, values, family attitudes, risk-seeking temperament and biological predisposition all contribute to adolescent substance abuse. Whereas non-users are more likely to describe close relationships with parents, users more frequently indicate they do not want to be like their parents and do not need their approval or affection. Frequently there is a positive family history of chemical dependency. Children of divorce have a greater risk of substance abuse.

Treatment

In the treatment of substance use disorders, the role of the family is more important to adolescents than to adults. However, parents and family members may resist involvement because they feel responsible for the adolescent's behavior, or guilty if they themselves are addicted. Inpatient or residential treatment is recommended for adolescents whose drug problem has interfered with functioning in school, work and home environments, and for those who could not maintain abstinence through outpatient treatment. Depression and suicide inclinations, hyperactivity, chemical dependence and drug overdoses all indicate need for inpatient treatment.

Complicating Factors

Intoxication with drugs and alcohol in adolescents or children may lead to a lack of inhibition, violence and medical complications. Although the risks vary by diagnosis, all childhood psychiatric disorders are associated with Substance Use Disorders. Most adolescents entering inpatient drug and alcohol treatment programs have additional mental health problems, such as attention-deficit disorder, anxiety disorder and eating disorders. Treating attention-deficit disorder in adolescents significantly reduces risk of developing substance abuse patterns in later life.

Suicide ideation and behavior is common in adolescents with substance use disorders and if there is family history of suicide or depression, the risk is increased. Increased alcohol and drug abuse in adolescents is often associated with risk-taking behavior linked to the spread of HIV infection. Parents should be interviewed on family history and the adolescent's behavior, and the clinician should be aware of the possibility of denial.

Treatment Issues

The treatment of adolescents requires both structure and flexibility. Most programs rely heavily on a therapeutic environment with individualized treatment planning. A warm, supportive environment with organized structure increases motivation and maximizes positive interaction with other group members. Peer support is important. Programs that are most successful encourage openness, spontaneous expression of feelings, allow patients to engage in independent decision making and use cognitive and behavioral approaches. Relapse prevention for adolescents is often more difficult than for adults, and the goal of total abstinence becomes more difficult to achieve. A patient should not be rejected because of a slip or relapse which is a symptom of the problem.

Discharge planning should include outpatient treatment for drug abuse and frequent attendance at self-help support groups. Prevention should concentrate on teaching life skills that provide support for self-esteem, social skills, and assertiveness training.

Silver Hill Hospital is a nationally recognized psychiatric and substance abuse treatment center providing a full range of services for adults and adolescents, from inpatient to partial hospital, halfway houses and outpatient programs. For further information, call (203) 966-3561, Extension 2509.

Addiction Psychiatry and Pain Management Focus of Silver Hill Spring Seminar

Staff Writer
Mental Health News

The latest developments in Addiction Psychiatry, the use of pain killers and the management of chronic pain is the focus of the Spring Seminar at Silver Hill Hospital in New Canaan on April 10th. Featuring presentations by five prominent experts in their fields, the seminar is co-sponsored by the New York University Department of Psychiatry, the American Academy of Addiction Psychiatry and Silver Hill.

Marc Galanter, M.D., a Professor of Psychiatry at New York University Medical Center will present: "Research on Healing Through Social and Spiritual Affiliation." Roger Weiss, M.D., Associate Professor of Psychiatry at Harvard Medical School will discuss Substance Abuse and Mood Disorders. Recent Developments in Pharmacotherapy and Alcoholism will be addressed by Henry R. Kranzler, M.D., Professor of Psychiatry at the University of Connecticut Health Center, and Dual Diagnosis (the combination of a psychiatric and an addictive disorder) is the topic of Richard Rosenthal, M.D., Chairman, Department of Psychiatry at St. Luke's Roosevelt Hospital Center. David Haddox, M.D., Vice President of Purdue Pharma, L.P. will describe the latest pharmaceutical developments in the treatment of pain.

According to Dr. Richard Frances, President and Medical Director of Silver Hill, "No group of patients suffers more than those with both addiction and psychiatric problems, including pain management. The Spring Seminar brings together five national experts in the dual diagnosis field to discuss these pressing issues. The event is a complement to last year's extremely well received symposium in which a different panel of speakers addressed the same topic. The 2001 presentations at Silver Hill will be published in a special supplement of the American Journal on Addiction in July, 2003, with an introduction by Dr. Frances.

Located at 208 Valley Road in New Canaan, Silver Hill Hospital is a nationally recognized behavioral health and substance abuse treatment center, providing a full range of treatment for adults and adolescents. Included are inpatient, partial hospital, halfway houses and outpatient programs.

The April 10th seminar, which includes luncheon, begins with coffee and registration at 8:30 a.m. and ends at 3:30 p.m. For a brochure, reservations or further information, contact Bridgette Guida, Community Outreach at (203) 966-3561, extension 2509.

Are You or A Loved One Among the Millions of Americans Suffering From Both Addiction and Mental Illness ?

Silver Hill Hospital's Psychiatrists from left to right:
Barry Kerner, M.D., Chief of Adult Psychiatry; Anri Kissilenko, M.D., Chief of Geriatric Services & Acute Care Unit; Natalia Manevich, M.D., Chief of Barrett House (Transitional Living) & Outpatient Services; Richard J. Frances, M.D., President & Medical Director; Sheila Cooperman, M.D., Chief of Adolescent & Eating Disorder Services; Scott Marder, M.D., Chief of River House & Wilton House (Transitional Living); and Joseph F. Scavetta, M.D., Chief of Substance Abuse Services.

Silver Hill Hospital has the leading doctors in treating addiction and mental illness.

We are a team of caring and dedicated professionals whose mission is to support you on your journey toward a healthier and more productive life

For more information please call 1 (800) 899-4455
Or visit our web-site at www.silverhillhospital.com

Silver Hill Hospital

Center of Excellence in Psychiatric and Addiction Treatment

SERVING THE COMMUNITY FOR 70 YEARS

Hall-Brooke's Comprehensive Services Include Unique Programs

Staff Writer
Mental Health News

A new leadership team was on board when Hall-Brooke Behavioral Health Services opened its new 58,000 square foot treatment facility in 2001. The combination of these new assets has produced an outstanding center of innovation.

Headed by Stephen P. Fahey, President and Chief Executive Officer, the leadership team quickly recognized that the new Hall-Brooke could, and should, play an expanded role in the provision of regional health services. It saw the potential for developing new programs to answer unfulfilled area needs.

Dr. Thomas E. Smith was named Hall-Brooke Medical Director prior to the opening. A nationally-recognized authority and researcher on schizophrenia, Dr. Smith had previously been Director of the Continuum Division of New York-Presbyterian Hospital, Weill Cornell Campus.

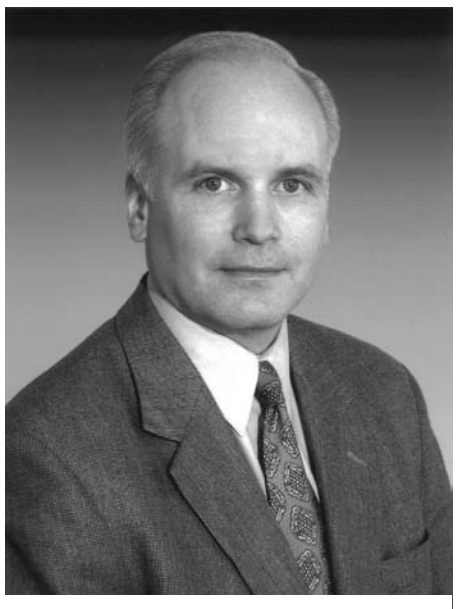
Fahey and Smith shared the vision of taking Hall-Brooke to the forefront of psychiatric and substance abuse treatment in Fairfield County. They brought in talented, highly trained and experienced department leaders. The positive chemistry at the new Hall-Brooke is palpable. Its bright hallways and executive offices brim with energy.

Within the last 12 months, Hall-Brooke has introduced programs which are unique in the region. These include a specially designed Intensive Outpatient Program for Adolescents and a new Psychological Assessment Service. In July, the Hall-Brooke School launches a summer program for children, ages 7 to 12, who have behavioral issues which prevent them from having successful experiences in traditional camp settings.

The intensive therapeutic program for teenagers is held three days a week after school. It involves parents in family therapy. When needed, case workers intervene, on behalf of youngsters, with school authorities and others involved in their lives. The operative theory is that an adolescent's behavioral problems are frequently reactions to toxic environments. Participants are taught to deal with difficult situations in ways which are not self-destructive. Post-program support is strong.

The psychiatric assessment program utilizes medical, scholastic and psychological testing and histories to provide treatment professionals with a complete mental profile of a patient. Tests, interviews and compilation of past data result in a comprehensive dossier which is extremely valuable in determining treatment protocols. The assessment can be used by a private psychiatrists, educators, parents, patients themselves. When complete, the assessment is released to the subject or guardian. Use of its assessment service does not require that Hall-Brooke have role in future treatment.

Stephen P. Fahey



Thomas E. Smith, M.D.

Safari Summer, a day program of fun and social growth, provides six weekly sessions for children who, because of behavioral issues, cannot flourish in traditional camps. Safari Summer is held from 8:30 a.m. to 3 p.m., Monday through Friday, July 7 to August 15. Activities are run by licensed professionals and include sports, swimming, arts and crafts and educational field trips. The program maintains a three to one ratio of children to staff. A full time nurse, licensed clinical social worker, certified teachers and certified rehabilitation therapist are on staff. The therapeutic program includes social skills groups, group therapy and creative therapies.

An affiliation in 2001 with the Psychiatric Department of Columbia University's College of Physicians and Surgeons enables Hall-Brooke to participate in important research. This also gives Hall-Brooke access to the newest treatment protocols.

Hall-Brooke is the only regional treatment center with beds for children who need acute care. It provides both inpatient and outpatient services for children, adolescents and adults who have behavioral health needs and/or suffer from substance abuse.

Hall-Brooke also operates Homestead Residential Services for 16 homes, accommodating 90 residents, who have behavioral health needs and/or are recovering from substance abuse. (See accompanying story)

Fahey is proud of Hall-Brooke's community service goals: to destigmatize mental illness and to serve as a resource for information about diagnosis, treatment and prevention of behavioral health problems. He is being aided in this goal by a new group of citizens, called the Friends of Hall-Brooke.

Fahey's commitment to mental health issues on a local and national level have been recognized by his appointment by Governor Rowland to Connecticut's Mental Health Strategy Board and his election to the Board of Directors of the National Association of Psychiatric Health Systems (NAPHS) of Washington, D.C.

Hall-Brooke is located on a 25-acre campus at 47 Long Lots Road, Westport, Connecticut It operates a Bridgeport Center at 4083 Main Street. Hall-Brooke is a wholly owned subsidiary of St. Vincent's Health Services of Bridgeport, Connecticut.

A brand new building…
New leadership team...New programs…

Hall-Brooke Wins Homeless Assistance Competition

The Homestead Residential Services program of Hall-Brooke Behavioral Health Services has been awarded $354,858 from the 2002 McKinney-Vento Act homeless assistance competition.

Currently, under the Homestead program, Hall-Brooke operates 16 multi-family homes, accommodating 90 residents, in Bridgeport, Fairfield, Southport, Westport and Norwalk.

At its main campus, 47 Long Lots Road, Westport, Hall-Brooke provides inpatient and outpatient psychiatric treatment for children, adolescents and adults.

Hall-Brooke's award application competed with hundreds of individual projects, designed by organizations throughout the nation, to help the homeless.

"Stewart B. McKinney, my predecessor and co-sponsor of the bill which created the awards, would be very pleased with the Homestead program," said 4th Dist. Cong. Christopher Shays. "It has made it possible for hundreds of persons with emotional and behavioral challenges to escape homelessness, to live responsibly in group and community settings, and to have a role in society."

Rep. McKinney, a Republican known for his interests in humanitarian causes and protection of the environment, died in 1987. He was a resident of Fairfield and served in the U.S. Congress from 1971 until his death during his 8th term.

The Homestead program has been administered by Hall-Brooke since 1988. It is supported by grants from the Connecticut State Department of Mental Health and Addictions Services and the U.S. Department of Housing and Urban Development (HUD).

The type of support and the populations served vary among six Homestead program versions. Some apartments serve persons who are dual-diagnosed, disabled by mental illness and chemical dependency. One program serves homeless single males over age 50. Another program version is for homeless single parents and their dependent children, some additionally disabled by HIV/AIDS and related illnesses. A residential case manager is assigned to each program participant to help coordinate outreach and referrals to community resources. Assistance is provided with budgeting and money management according to the resident's needs. Life Skill Training includes instruction in shopping, housekeeping duties, personal grooming as well as stress and anger management

The Hall-Brooke staff is available on a 24/7 basis when a resident is experiencing a crisis or emergency. Program participants are responsible for complying with treatment recommendations, including taking their medications as prescribed. When clinically indicated, the staff assists in monitoring medications.

Public transportation is accessible to all the residences, and travel training is provided when needed. Residents pay rent and a fee for residential support services.

"This program is highly successful," notes Stephen P. Fahey, president and chief executive officer of Hall-Brooke. "It has provided us with many wonderful stories of personal triumphs and achievements among past and present residents. We feel Homestead should be a model for the nation."

Hall-Brooke is a wholly owned subsidiary of St. Vincent's Health Services of Bridgeport and is an affiliate of the Department of Psychiatry of Columbia University's College of Physicians and Surgeons.

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

HALL-BROOKE
BEHAVIORAL HEALTH SERVICES

Exceptional Care for Mind, Body, and Sprit.

Main Campus

47 Long Lots Road
Westport, Connecticut 06880
(203) 227-1251 or Toll Free 1-800-543-3669

The Center at Bridgeport

4083 Main Street
Bridgeport, Connecticut 06606
(203) 365-8400

Hall-Brooke has provided comprehensive behavioral health and chemical dependency programs for 104 years.
It offers a full range of inpatient and outpatient treatment programs for children, adolescents and adults.
It has the only inpatient facility for children in the region. The Hall-Brooke School for day students is also located on the campus.

Member: St.Vincent's Health Services · ASCENSION HEALTH

Affiliate: Columbia University College of Physicians and Surgeons, Department of Psychiatry

Finding My Brother A Home

By Susan Frederick
Family Advocate
Fairfield County Committee

My brother Myron Trapani is 62 and has managed with paranoid schizophrenia for almost 40 years. He was living in Chappaqua when his illness was diagnosed and is presently residing in a group home in Rhinecliff, New York.

Due to changes in his behavior at the group home, the sponsoring agency and the local mental health clinic decided that he would have to move to a nursing home. As noted in Clifford Levy's articles in the New York Times, this seems to be a pattern due to the lack of decent housing for people with mental illness.

On Myron's behalf, I quickly stepped in and had him re-evaluated by a private psychiatrist at St. Francis Hospital in Poughkeepsie. As his sister, advocate and guardian, I felt a medication change was needed not a move to a nursing home.

Myron remained in inpatient care at the hospital for two months before we were able to find him a home. It was a challenging experience to find adequate and appropriate housing to meet his needs. With the help of NAMI in Poughkeepsie and the Commissioner of Mental Health, Dr. Kenneth M. Glatt, I found the information, guidelines and actions needed to negotiate the difficult and often daunting mental health housing system.

Myron is now living in a 21-room home with 24-hour assistance which allows him a more independent lifestyle than he would have experienced in a nursing home—where he never belonged in the first place.

Without a family member helping, I don't believe this story would have a happy ending.

It's often difficult to comprehend how people with mental illness survive the challenges of a system of care that can be so difficult to negotiate.

The critical housing shortage, the effort needed to get placed in an appropriate setting, and the painful reality of stigma against persons with mental illness, must be addressed at the highest levels of our county, state and national offices.

We all need to speak out in a clear and powerful voice so that these needs and rights for adequate care are finally addressed.

Susan Frederick

The New Learning Center

Staff Writer
Mental Health News

The New Learning Center, situated in the heart of Westport, is recognized as a pivotal resource to the community in the areas of facilitating healthy psychological functioning, family life, and personal growth. Situated in a campus-like setting, it provides services to populations in most of the surrounding towns in the Fairfield County area.

Unique in its concept, President Laura Lustig and her multi-disciplined, fully-licensed clinical staff have developed a Center that is a source of guidance, expertise and the highest quality service to the community at large and to other mental health agencies with whom it works. Under its auspices, the Center provides marriage and family therapy, individual therapy for adults and children age 3 - 18, group therapy and psychoeducational groups for children experiencing peer-related and learning disability issues. It provides a forum for workshops and discussions on mental health issues of concern. It also offers training for mental health professionals, and is affiliated with Sacred Heart University in providing adjunct professors to teach mental health courses. Our staff, many of whom have had guest appearances on local television programs, is frequently called upon to speak and consult with schools, agencies and community organizations.

Laura Lustig

Known in the community as "one-stop shopping", it is the mission of our dedicated staff to work with whole family needs at every stage of life, not only in providing services ourselves, but also in connecting people to other services needed to implement growth and stability.

Our name implies our philosophy: we believe that we are facilitators for individuals who contain the seeds of the strengths and resources within themselves for attaining self-fulfillment - because healthy living is something we learn.

For further details and information contact The New Learning Center at (203) 226-0100.

Southwest from page 48

education. In the substance abuse continuum inpatient and outpatient detox, methadone maintenance, early intervention and prevention, addictions counseling, residential treatment, crisis response and intensive outpatient programs are offered.

A large number of consumers are served annually by SWCMHS and its affiliates. State-operated mental health and substance abuse programs serve more then 4,700 people annually providing many of the services noted above. The majority of these are provided in greater Bridgeport, where about 3,750 people are seen from three different sites: Greater Bridgeport Community Mental Health Center, Downtown Service Site and Homeless Outreach Team. Of this number, over 1,300 patients are seen in the hospital units at the Greater Bridgeport Community Mental Health Center where inpatient psychiatric and detoxification services are provided. About 950 people per year are served from the F.S. DuBois Center in Stamford at its Summer Street location. The total cost of these state-operated services is $54 million per annum for the current fiscal year.

Our PNP affiliate agencies serve a distinct consumer group. Mental health contractors in the Southwest region served 3,590 different people in the fiscal year that ended June 30, 2002. The value of these contracts totaled approximately $18 million for that year. Substance abuse contractors provided services to 5,817 individuals during Fiscal Year 2002 at a cost of $9.4 million.

The total number of consumers seen annually by this combination of state-operated and contracted service providers in Region 1 is 14,107. Allowing for some small degree of duplication, since certain individuals will choose to receive services from different agencies at varying stages of their recovery, this total represents a significant percentage of the adult population in southwestern Connecticut.

DMHAS in general, through all of its facilities and PNP affiliates statewide, and SWCMHS in particular, are bringing more emphasis to promoting a recovery-oriented service system. To paraphrase a Commissioner's policy issued in September 2002, the concept of "recovery" is established as the overarching goal of the service system operated and funded by DMHAS. This action is consistent with the fact that the Department is a healthcare service agency. The policy states, in part, "services within this system shall identify and build upon each recovering individual's strength and areas of health in addressing his or her needs. The environment for this system shall encourage hope and emphasize individual dignity and respect. Recovery is a process rather than an event," (It) "is a process of restoring or developing a positive and meaningful sense of identify apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by that condition. Recovery principles shall also be applied to health promotion and prevention services for those at risk of mental illness and substance use disorders, especially those for whom selected or indicated prevention strategies are appropriate."

The current economic climate, which has spawned a budget crisis nationally, has not spared Connecticut or DMHAS. Budget reduction actions have included layoffs of state employees as well as other operational cutbacks. The cumulative effect has been much turmoil within recent months within the state system. The PNP contract agencies have not been affected substantively to date. Despite these setbacks we have been able to maintain essential services to consumers, and we are committed to continuing clinical services to all current consumers as well as those who need our assistance in the future.

In the months ahead we can look forward to reviewing the methods of service delivery, streamlining our management structures and organization and searching out every conceivable efficiency. While this is being done we shall maintain our connection and commitment to the consumers and families who have and must continue to rely on us for recovery-oriented services. For this is the reason we all chose this field of service initially, and why we choose to ride out the difficult days and look forward to better ones ahead.

***ECT* from page 24**

WHEN SHOULD ECT BE CONSIDERED?

ECT is not a treatment that is 'rushed' into; numerous practice surveys indicate that its use is selective. Use as a first line treatment is rare and limited to uncommon but highly desperate situations where it often has a lifesaving effect. Examples include individuals who are acutely agitated, suicidal or who are so depressed or catatonic that they have stopped moving and stopped eating. For most patients, ECT is relegated to second or third line or even later use, following failure or intolerance of a wide variety of other treatments including combinations thereof.

The alternatives to ECT are largely pharmacological. As already discussed, the efficacy of ECT in mood disorders, schizoaffective disorder and schizophrenia compares favorably with psychotropic medication alone. Although the numbers of available medications has burgeoned, a small number of individuals either do not respond to any of these or experience rare but serious medication reactions such as neuroleptic malignant syndrome, a rare, but sometimes life-threatening, adverse reaction to certain anti-psychotic medications. For these individuals, who have exhausted all other treatment options, there are no effective therapeutic alternatives. For individuals who are acutely agitated or suicidal or who are so depressed or catatonic that they have stopped moving and stopped eating, ECT can literally be life-saving. In some depressed patients, psychotherapy might be a viable treatment alternative; however, episodes leading to ECT referrals are typically so incapacitating that psychotherapy cannot be used.

WHAT KIND OF CONSENT IS NECESSARY?

All capable persons have the right to refuse all medical care and treatment - whether ECT, an appendectomy or a tooth extraction. The mere diagnosis of mental illness itself does not mean that individuals with mental illness have lost their capacity to refuse medical care and treatment unless the evidence to the contrary is compelling. The presence of psychosis, irrational thinking, or involuntary hospitalization do not, in themselves, constitute proof that capacity is lacking.

Competent persons who are capable of giving consent cannot be compelled to undergo any medical procedure against their will. However, in some instances, the patient may not respond to questions or may not show insight into the presence of any illness or the benefits or risks of treatment. In other instances, the patient may overtly accept or refuse treatment, but may be unable to give a rationale for that decision. Under such circumstances, the patient's underlying psychiatric disorder may alter their decision-making capacity, impairing their ability to consent to ECT or other treatments.

When ECT is the treatment of choice for individuals who lack the capacity to give a fully informed consent, treatment may only be provided by petitioning the court for authorization. Court-ordered ECT treatment is generally pursued for individuals who have been severely ill and often institutionalized for many years. There are probably fewer than a dozen instances of court-ordered ECT in New York each year.

WHAT ARE THE PROCEDURES FOR COURT ORDERED TREATMENT?

Under New York State law, courts must follow a two-step process in order to provide psychiatric treatment for a non-consenting incapable patient. First, the physician or facility proposing the treatment must establish by clear and convincing evidence that the patient lacks capacity to make treatment decisions. Once the court determines that the patient lacks capacity to make treatment decisions, the court must then determine that there is clear and convincing evidence establishing that "the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interests, taking into consideration all relevant circumstances, including the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatment."

CONCLUSION

Like all medical procedures and psychiatric treatments, ECT has beneficial effects as well as side effects. In making any decision about a medical treatment, the patient and physician must work together to weigh the pluses and minuses of a plan of treatment. In this regard, psychiatric treatments including ECT are no different from other medical treatments. Even though serious side effects may occur in some individuals after heart surgery or cancer chemotherapy, no one would suggest that these treatments should be rejected outright because of their possible risks. Psychiatric disorders can be just as devastating and fatal as other serious medical illnesses ,and ECT can be a life-saving medical treatment.

Dr. Fochtmann attended medical school at Washington University, St. Louis, Mo., did her psychiatric residency at Johns Hopkins Hospital, Baltimore, Md., and was a fellow in clinical pharmacology at the National Institute of Health, Bethesda, Md. She is currently Associate Professor of Psychiatry & Behavioral Science at SUNY Stony Brook where she is Director, Electroconvulsive Therapy Service. Her publications in scientific publications include work on ECT. She was a co-editor of, "The Practice of Electoconvulsive Therapy: Recommendations for Practice, Treatment & Privileging," a book published by the American Psychiatric Association.

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

Housing Options from page 1

U.S. Department of Housing and Urban Development: the Section 8 tenant-based rental assistance program and the Chapter 9 project-based rental assistance program.

Although the kinds of housing vary from state to state, the programs basically operate as follows:

Section 8 - The tenant-based rental assistance program provides vouchers or certificates to subsidize rent. Under this program, a person pays either 30 percent of his or her adjusted income, 10 percent of gross income, or the welfare assistance amount designated for housing. The certificate or voucher pays the remainder of the rent to the landlord. This program offers the most flexibility in terms of where a person can live and what kind of housing arrangement he or she can select. However, the number of available vouchers is limited, and the waiting list for this program is extremely long.

Chapter 9 - The project-based rental assistance program offers landlords an incentive to provide housing for people with disabilities by tying the subsidy to the rental building. The demand for this housing also outstrips the number of available units.

Contact your local housing authority to find out about program availability and to apply for public housing or Section 8 certificates or vouchers. Each housing authority has its own application system. You may need to ask your caseworker or a family member to help you navigate the system.

Other Housing

States and localities also fund housing programs. In addition, some non-profit organizations offer housing for people with disabilities. Contact your local or State mental health authority to find out about licensing and required services. In general, many localities offer several of the following options:

- Private Residential Housing
- Commercial Boarding Homes
- Supported Independent Living
- Personal Care Group Homes
- Community Residential Rehabilitation Centers
- Structured Residential Programs
- 24-Hour Home Care and Nursing Facilities.

These housing options are described below. Keep in mind that different localities may refer to and define these housing options differently.

Private Residential Housing:

Most private residential housing offers little or no supervision. The lease or rental agreement will be between you and the owner. In addition to your local community mental health center (CMHC) or case worker, classified ads in local newspapers, community bulletin boards, and friends are excellent sources to find private residential housing. If you are renting a room, be sure to find out if you are permitted to use the kitchen, have visitors, use the telephone, or have your own telephone installed in your room.

Commercial Boarding Homes:

If you want to live independently and are willing to share space with other people, a boarding home may be a good option for you to consider, especially if your income is meager. Boarding homes are not required to provide general or supportive services, but usually serve meals. Some commercial boarding homes have contracts with local mental health authorities to provide rooms and minimal supportive services for people with mental illness.

Supported Independent Living:

If you want to live alone in an apartment but need occasional help with daily living skills, supported independent living can offer the right balance between independence and assistance. However, this housing option is limited and extremely difficult to get.

Personal Care Group Homes:

If you need assistance carrying out daily living tasks, a personal care group home can provide you with the support you need. Personal care homes have staff that generally assist with personal hygiene; aid in everyday activities such as shopping, laundry, securing necessary medical care, and administering medications; and help with personal finances. Personal care homes generally are privately owned and operated, but licensed through your state.

Community Residential Rehabilitation Centers:

This housing option is the public sector equivalent of personal care homes. These group homes vary in the level of support and services they provide-from intensive therapeutic arrangements that tend to be transitional living situations to moderate-care arrangements for people who can live semi-independently. Your best bet to explore these options is to contact your case worker or your local CMHC.

Structured Residential Programs:

If you or your loved one is currently experiencing mental health problems but does not require inpatient hospital care or 24-hour supervision, a structured residential program can provide long-term therapeutic treatment and rehabilitation in a secure, home-like setting.

24-Hour Care Homes and Nursing Facilities:

If you or your loved one needs around-the-clock supervision and assistance with all daily living activities, a 24-hour care home or a nursing facility is an appropriate option. A client assessment, which includes a psychological evaluation, health assessment, and medical examination, usually is required for placement in a 24-hour care home. A pre-admission assessment is required for admission to a nursing facility.

Resources

To find the best housing option for you, work closely with your caseworker or the housing coordinator at your CMHC. He or she should know which options are available in your community. He or she will also help you identify, and apply, for the living arrangement that most closely matches your wants and needs.

In addition, your local affiliates of the National Alliance for the Mentally Ill (NAMI) and the National Mental Health Association (NMHA) should have information on housing options in your area. Check your telephone directory, or call the national offices for a referral to your local affiliate.

National Alliance for the Mentally Ill, Telephone: 800-950-6264 www.nami.org

National Mental Health Association, Telephone: 800-969-6642
www.nmha.org

U.S. Department of Housing and Urban Development, Telephone: (202) 708-1112,
www.hud.gov

Note: These are suggested resources. It is not meant to be a complete list. For further information visit the CMHS website at www.mentalhealth.org/cmhs/

Ten Secrets from page 25

computer skills--I'd consult a temporary employment agency and conduct informational interviews with several prospective employers. Ask your friends for references and hire the right expert for the job.

7) THE LONGER YOUR RECOVERY TAKES, THE MORE YOU'RE WORTH TO THE SYSTEM. You're worth $1,500/day to the hospital. That's $45,000/mo. And almost half a million a year! You're worth $150 for a 45 min. visit to the doctor or certified social worker in a clinic. You're worth $500-$1,000/week to a CDT or IPRT. You're worth about $15,000 a year to a supported housing agency, but only $35/day to a Drop-in Center of Psychosocial Club.

There is no financial incentive to cure a patient, no professional performance bonus, no deadline. If you get well, it's just the reverse; they lose money. It's in the system's financial interest for you not to recover. In our experience, money usually effects how much and what kind of treatment we get. For example, if your HMO pays for 30 days of inpatient care-then that's what is usually prescribed.

I received a call from a psychiatrist a few months ago at one of the psychiatric teaching hospitals. She called to tell me she couldn't put in writing that one of our members had a diagnosis of a psychiatric disability (for a County housing application), because the member didn't really have a disability - - "We only said that to get her into our program and collect the Medicaid." The member found another doctor in the same hospital who she's pleased with and now has her own apartment.

About a year ago I was invited to speak to a group of consumers at an IPRT at a local psychiatric hospital I suggested, "Accessing Shelter-Plus Care" as a topic. I was told this was not a good choice because "most of our patients are referred by supported housing agencies who might be upset to lose their clients to Shelter-Plus Care."

8) YOUR VOTE COUNTS. It can reallocate state funds to keep us out of the hospital. Forty years ago there were over 90,000 persons in in-patient care in the state at a cost of around 250 million dollars. Today there are 4,500 persons at a cost of about one billion dollars. You may ask, "How could the population drop by 85,000 and the cost quadruple?" One theory is it's due to the lobbying efforts of the State's facility employee union and the psychiatric hospital associations. Together, they spent over five million dollars last year in lobbying efforts.

As a community agency our contract specifically bars us from lobbying. We are allowed to write letters, peaceably gather and vote. Currently, some four billion dollars are spent annually for mental health care in New York between OMH & Medicaid with two-thirds going for in-patient care. That's almost three billion dollars for about 15 percent of the population. This imbalance results in short-changing all out-patient/community programs such as Psychosocial Clubs, Drop-in Centers, Peer Bridger programs, NAMI, housing and more. Your vote can change this. Vote carefully in every election. Do it for yourself and for the memory of Ken Steele who pioneered voter registration drives for consumers.

9) YOU DON'T HAVE TO SUFFER FROM PAST DEBT. Constant worry over past debt can overshadow your recovery. Many of our folks have run up tens of thousands of dollars of debt in hospital bills, credit cards and student loans. They and their families are distraught over mounting bills, harassing collection agencies and lawyers. They see no way out. Some seek loans from relatives, others are desperate and take any job just to pay the interest.

In the past year, we've eliminated over fifty thousand dollars of debt through a simple letter to the hospital, credit-card company, etc. from our member's doctor stating the diagnosis, treatment and requesting consideration. Occasionally, we have to call upon our in-house pro bono attorney.

10) AFFORDABLE HOUSING IS STILL AVAILABLE IN WESTCHESTER if you're able and willing to travel, barter, share and be proactive in your search.

The joy of our student-members who are persistent and patient enough to secure Section 8 or Shelter-Plus Care housing soon vanishes when they realize safe, convenient affordable one bedroom apartments are rare and if you're a smoker, have a pet or require an elevator, even more rare.

We encourage our members to go beyond the traditional newspaper ads and create and distribute flyers to churches, synagogues, supermarkets, homeowners, superintendents, senior citizen centers, club houses and more. Be proactive; you can't afford to wait around for your housing counselor to find your dream place in this housing market. We've found reasonable rentals in the northern and rural parts of the county which, of course; require longer travel times and usually a car. If you have questions about the safety of the neighborhood, call the local police.

A little known option is that White Plains and New Rochelle Sec. 8 will pay up to $800 for a room in a private house. This choice also offers the opportunity to barter services with the owner for reduced rent or cash. Several of our members provide shopping, pet/house sitting, companion, light housekeeping, gardening, cooking, simple home repairs, etc. services on a part-time basis. If you have access to two-three month's rent and can afford the rental agents' fee (another months' rent) you can just pick up the phone and start touring.

With some street smarts and persistence you can get your basic needs met. You don't have to wait years for an apartment of your own, free career training or pay hundreds of dollars for your meds, or settle for a high stress job, or be denied disability payments or wear old clothes. Most of these basic needs can be fulfilled within months, not years, if you know where to go and which application to fill out.

If, just one of these "secrets" is helpful to you or a loved one in relieving the suffering and pain that comes with a psychiatric disability, then the Center has fulfilled its mission.

NYS Faces from page 13

Psychiatric and clinical services are separately funded through Medicaid. About one third of the clients see a psychiatrist on site, which may be as little as 10 minutes a month . The rest go outside the facility for therapy. Recently, additional part-time on–site support services were provided by the MHA.

Despite Mr. Murphy's assurances, finding suitable placements for the 66 residents currently living at Joseph's Home is a formidable task, given the current housing situation in our County.

MIA & CONWAY HOUSE REMAIN OPEN

Two other smaller residences operated by Joseph's Home Inc. will remain open. Missing In Action in Valley Cottage, with 24 beds, serves as a residence for homeless veterans. The Maggie Conway House in Orangeburg is operated as a rooming house. However, attempts are being made to convert these to OMH Community Residences or Assisted Living Facilities, which are funded at a higher level, in order to provide "more personal safety, money, more services, more staff, and a better quality of life to the residents," Mr. Murphy states.

OTHER HOUSING PROGRAMS FACE SERIOUS PROBLEMS

The dilemma faced by Joseph's Home is not unique to this type of facility. In the late 1980's NYS Office of Mental Health created the Supported Housing program model. Exclusively operated by not-for-profit providers, they provided case management services coupled with a rent stipend and were designed for those consumers who were ready to live independently with minimal individualized supports of their own choosing. According to data collected by the Association for Community Living (ACL) the Mental Health system is failing to adequately fund Supported Housing programs, as well. (From the ACL Report on Mental Health Supported Housing in NYS 2002 – A Broken Contract).

Although supported housing has been pushed by the OMH in recent years because it is much less costly than traditional models such as congregate care facilities (community residences) or treatment apartments, However, " the stability of existing beds and the development of future beds are at risk, " according to the ACL report. "Supported housing rent stipends are not keeping pace with fair market rental rates, personnel costs, other than personal service costs, and administrative costs … putting the very viability of the program in question."

The report further states "If the stipends for permanent supported housing, as well as the reimbursement rates in the transitional continuum of care, do not reflect the actual costs of operating them, the safety net that has been created for people with severe psychiatric disabilities is in serious jeopardy."

Many of the serious concerns about the on-going erosion in all housing programs in NYS were addressed in a special presentation to NAMI-NYS Board members in August. The quality of staff in Community Residences and apartment programs throughout NYS is declining, declared William (Bill) DeVita, Executive Director of Rehabilitation Support Services, Inc. (RSS). RSS oversees a wide array of high quality residential and employment programs in 12 NYS counties north of NYC. The minimum requirement for mental health workers in licensed OMH residences is a high school diploma or GED. Meanwhile, consumer characteristics are growing more complex. Mental Health workers have to supervise various medications for residents, who often have multiple medical problems and take many other meds in addition to numerous psychiatric drugs. There is tremendous staff turnover and difficulty in replacing staff due to low salaries. (Last year the legislature finally passed a 3% cost of living adjustment (COLA) for direct care mental health workers after failing to do so for many years). And, as if they can be all things to all people, OMH is pressing to admit the highest risk consumers without increased supports. Then, they are forcing these residences, which are considered transitional, to move people along.

NYS DISCRIMINATES AGAINST MENTALLY ILL

Antonia Lasicki, Executive Director of the Association for Community Living (ACL), invited NAMI to join in a coalition to battle discrimination in housing for people with mental illness. Data collected by ACL compares the consumer price index, the OMRDD (Office of Mental Retardation) Residential Trend, and OMH (Office of Mental Health) CR funding changes from 1991 to 2000. The differential between funding for people with developmental disability and those with mental illness is dramatic. OMH funding changes are substantially below both the price index and OMRDD trends. Additionally, in 1999 Governor Pataki initiated a program called "New York Cares" designed to provide housing for all people with a developmental disability over a five year period. NAMI-NYS has called for an extension of this commitment to persons with serious mental illness.

Mental health advocates must make their voices heard. We need a public outcry to end this blatant discrimination in public policy! We can all help by writing to Governor George Pataki, Executive Chamber, State Capitol, Albany, NY 12224.

<u>Post Script</u>: As we go to press, we learned of the Governor's proposal for $65 million in capital funds for development of 2000 new mental health beds. Certainly, this seems a step in the right direction. This positive reaction to the expose of adult home scandals requires further study as specific plans are developed. It is essential, however, that the coming year bring some comprehensive long-range plans for expansion and overhaul of the overall housing program.

Westchester Arts Council Providing A Healing Resource

Staff Writer
Mental Health News

The Westchester Arts Council's Community Arts program, is a unique and outstanding friend to the mental health community in Westchester County. Through its partnership with the Westchester County Department of Community Mental Health and the Westchester County Department of Social Services, the Arts Council is making a difference in the lives of consumers by bringing the flavor of the artistic community to mental health programs.

"A significant body of research now underscores the importance of employing the arts as a tool in healing," says Jonathan Mann, the Director of the Arts Council's Community Arts program. "The Arts Council is an excellent resource for using the arts in these settings, and we hope more human service professionals will investigate how we can help them better serve their clients."

The Community Arts Program offers teaching artists performances and scholarships to clients of human service facilities throughout Westchester. Increasingly, staff and administrators at many different types of human service agencies recognize that the arts can help improve the effectiveness of the service they provide. In 2002, the Arts Council conducted residencies (special 7-week arts workshops) in 90 community sites, reaching a diverse group of more than 3,000 residents.

Throughout Westchester, the Arts Council forges partnerships with day care after school, anti-violence, substance abuse and teen pregnancy prevention, and job readiness programs, engaging people in productive, creative activities designed to build academic skills. The Arts Council is also a welcome presence in many shelters for homeless and the abused, mental health drop-in centers, senior centers and hospitals, helping adults develop creative decision making, collaborative, concentration and other social skills which help them overcome obstacles. With a particularly successful track record in the mental health arena, the Arts Council in 2002 completed artist residencies at 18 community sites, coordinated 19 performances, provided over 700 tickets to concerts at the Performing Arts Center at SUNY, Purchase, and continued its scholarship program to offer free arts classes to individuals moving from transitional to permanent housing.

For the residencies, the Council draws from its extensive 'Roster" of 100 prescreened professional artists representing a wide range of disciplines, from photography to sculpture, and even eclectic specialties like opera-singing and Polynesian dancing.

To find out more about the Arts Council's Community Arts program, call Jonathan Mann, the Arts Council's Director of Community Arts, at (914) 428-4220 x234.

Our Son from page 12

on credit. They did not give them receipts, and even if they did, our son would not have totaled them before he paid.

Our son was medication resistant when he first became ill. Finding that the medication did not eliminate the voices he heard, he often stopped taking it. If this happens, psychiatrists and parents must be notified immediately. Even when he was off meds for three months, we were not told. The director said he could do nothing. Since our son was neither dangerous nor violent, his behavior did not justify calling the police. The staff seemed willing to wait until he became dangerous and violent. His father and I went to the Mental Hygiene Court in Brooklyn three times to take out a "warrant for mental hygiene" to have him hospitalized. Obliged to accompany the police to the residence to identify him and then watch them handcuff him was the most painful experience we have had since we knew he had a mental illness. Fears that our son would consider this a betrayal and sever all ties to the family tormented us long afterwards.

Finally, we think the staff must be flexible to interpret rules according to each patient's needs. Once we were delayed returning from a family outing due to an accident. I called and asked a staff member to leave out our son's medication, and she replied in a huffy tone of voice that medication was locked up at a certain time. When a similar situation happened at the present residence, the staff was very accommodating and even surprised I thought it was necessary to ask.

Although we miss the boy who was our son before he became ill with schizophrenia, we know that he is getting proper care where he is today. He lives in the kind of residence that every parent would choose for children with similar needs.

Roxanne Lanquetot

Previously published in ACCESS, Summer, 1997, published by NYS-OMH.

Residential from page 12

things for myself.

I learned how to cook and maintain a clean apartment. I also learned how to live with others and be more social.

Throughout this time I attended NYH's day programs which helped improve my mental health and learn the skills necessary to function appropriately in society.

After approximately a year and a half, I was moved from the Level 2 residential program, to a Level 3 program where I lived with only two other individuals without the 24-hour supervision that was previously needed.

This new residential setting allowed me much more freedom and independence. I still met twice weekly with counselors and went to the hospital every day.

During these visits my therapists and counselors helped me to deal with many of the struggles and frustrations that I faced as well as the negative attitude that I often maintained.

Regardless of what was happening, they always remained positive and helped me in any way they could. After spending a year at a Level 3 setting I then qualified for Section 8, an apartment rental assistance program for disabled people.

After nearly four years of supervised residential treatment, Human Development Services of Westchester considered me ready for the next step in learning to live independently.

No longer responsible for me, their staff still kept in touch with me in order to ensure that I was doing well.

During the period spent with HDSW, I was able to progress from requiring daily visits to the hospital to only weekly sessions with the therapist.

I have learned much and matured a great deal since I was first hospitalized.

Much of this credit lies with HDSW, and I sincerely appreciate the dedication and hard work of their many mental health professionals who helped bring me to the good place where I am today.

A White Plains Resident

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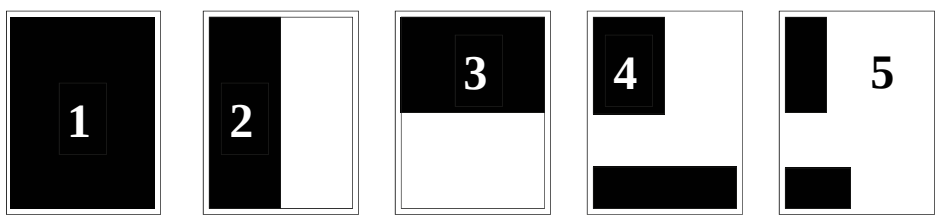

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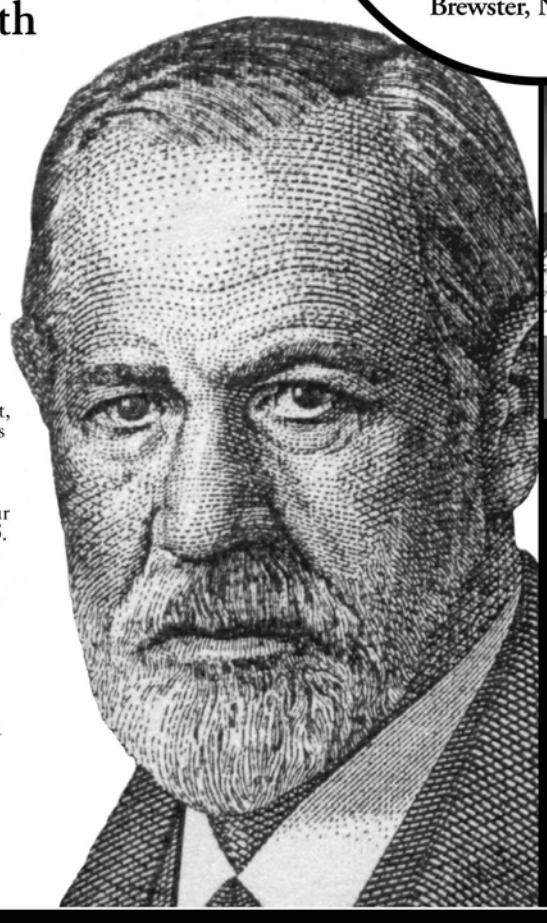

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