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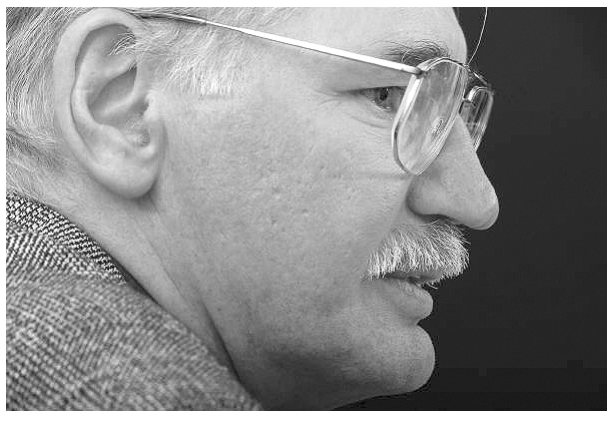
Understanding And Treating Co-Occurring Disorders

Staff Writer
Mental Health News

One in every five adults, or about 44 million Americans, experiences some type of mental disorder every year. Moreover, five percent of Americans have a severe and persistent mental illness, such as schizophrenia and schizo-affective disorders, major depression, and bipolar disorder. According to the U.S. Surgeon General, the United States spent more than $99 billion for mental, addictive, and dementia disorders in 1996. Indirect costs of all mental illness in 1990, the most recent year for which estimates are available, totaled $79 billion dollars. These costs include those associated with lost productivity and premature death.

Many individuals with serious mental illnesses have a co-occurring substance-abuse disorder. Estimates suggest that up to seven million adults in this country have a combination of at least one co-occurring mental health and substance-related disorder in any given year. In comparison to individuals with a primary mental or substance abuse disorder, individuals with co-occurring disorders tend to be more symptomatic, have multiple health and social problems, and require more costly



care, including inpatient hospitalization. Many are at increased risk of homelessness and incarceration.

Of an estimated 600,000 people who are homeless on any given day, approximately 25 to 30 percent have a mental illness. As many as one half of all people who are homeless and have a serious mental illness also have a substance-abuse disorder. The number of persons with co-occurring mental health and substance-abuse disorders who are also involved with the criminal justice system is reaching epidemic proportions. About 10 million adults each year enter U.S. jails, about 700,000 of these individuals have co-occurring disorders. More then two million youth under the age of 18 are arrested each year, half of whom will have contact with the juvenile justice system. A high percentage of these youth experience both serious mental health and substance-abuse problems.

The presence of co-occurring mental and substance-abuse disorders is complex, as the illnesses interact with, and exacerbate, one another. Emerging research suggests that mental disorders often precede substance abuse. It is also the case that alcohol abuse, drug abuse, and withdrawal can cause or worsen symptoms of mental illnesses. Substance use can also mask symptoms of mental illness, particularly when alcohol and drugs that are abused are used to "medicate" the mental illness. One disorder may interfere with an individual's ability to benefit from — and participate in — treatment for another disorder. Dysfunctional and maladaptive behaviors can be attributed to either disorder. Individuals with untreated mental disorders are at increased risk for substance abuse. Similarly, individuals who abuse alcohol are at increased risk for experiencing mental disorders.

While there is a good deal of variability from person to person and no single set of co-occurring disorders,

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A Consumer's Heroic Path To Recovery

By Lucee Martyn and
Patricia Maher-Brisen, APRN, BC
NAMI-NYC Metro

Like many consumers, Lucee Martyn has had a life marked by the challenges of addiction. As a NAMI-New York City Metro peer mentor, she is comfortable speaking about her dual struggles with mental illness and substance abuse. "I started drinking heavily at the age of 13," she says. "I started drinking to forget about my life, which included two years of repeated sexual assault by someone close to my family. I thought drinking was harmless, but eventually it became an addiction. Eventually, I drank everyday, because I would shake without the alcohol. At the age of 16, I was hospitalized for six months due to 'major depression with psychotic features.' I continued to drink in the hospital by having visitors smuggle it in for me. The hospital staff told me that the alcohol was intensifying the voices I

Lucee Martyn

would hear, and that the voices wouldn't stop unless the drinking did. But once I was back home, I knew I would have to face my rapist, and because drinking was my known escape, I used it to help me cope."

Lucee's story is, unfortunately, an all too familiar refrain amongst consumers. In at least half of all individuals with a biochemical disorder, there exists addiction and subsequent substance abuse. The line between the two is very often blurred.

Without realizing her addiction, Lucee's best friend told her that she was an alcoholic and that she should go to Alcoholics Anonymous (A.A.). Then, at the age of 19, she went to Smithers Institute (now The Addictions Institute of New York), where she was their youngest patient. "I was told that I would never make it in a New York City rehab. So with the clothes on my back, I was sent to Rhode Island, where I stayed at a rehab center for two years."

It was there she realized that she didn't want to drink anymore, but knew that the road to recovery would be long and painful. "I was determined to fight, because I knew that if I didn't I would die. I wanted to live because I wanted to help other teenagers that had experienced sexual assault, and to let them know that it's *not* their fault, and that turning to drugs and/or alcohol wasn't the best way to go."

After her inpatient rehabilitation, Lucee was sent to a halfway house for women with addictions. "The supervisor there helped me realize my humanity, and that I could have a good life. I stayed at the halfway house for three years. We had to go to church every Sunday. Although I was not a religious person, and began going reluctantly, I learned how to develop a relationship with God, as I understood him to be." Eventually, this relationship brought her great comfort, "because it was on my terms." Grateful for the strength her newfound spirituality gave her, Lucee sought to become a minister. She soon enrolled in a ministry school where she was able to counsel people about substance abuse. "Two months before my ordination, however, I was asked to leave, because I became sick again with major depression and the voices were

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From The Publisher: Two Commentaries
One About Trains and One About Teddy Bears

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

Ira H. Minot, CSW

Train Tragedy:

Taking The Nations Pulse On Suicide and Mental Illness

The scene of a recent deadly train derailment in Glendale, California lit up the newspapers and television news channels. The tragic loss of 11 commuters and injury to over 200 occurred when Juan Alvarez, intent on suicide, parked his car on the tracks. With the train approaching, Alvarez changed his mind and left the vehicle — saving his own life — but now facing the consequences of taking the lives of others.

We never heard of Juan Alvarez before this incident and, had he tried (or succeeded) in taking his life in a less public manner, I suspect we never would. However, Juan Alvarez represents a stunning national statistic, which warrants the attention given to the derailment, but never gets it.

The statistics for suicide are staggering, yet for some reason they are not newsworthy. Consider that suicide is the 11th leading cause of death in the United States, and among the young, it is the 3rd leading cause of death. In 2001, 30,622 Americans completed suicide — one every seventeen minutes; eighty per day. Seventy-five percent more Americans die by suicide each year than by homicide. Moreover, for every completed suicide in the U.S., there are five people hospitalized each year for a non-fatal attempt, and an estimated 22 emergency department visits for less lethal self-harming behaviors — totaling almost 700,000 hospital admissions annually for non-fatal suicidal behaviors.

According to a 2003 National Institute of Mental Health report, risk factors for attempted suicide in adults include depression, alcohol abuse, cocaine use, and separation or divorce. Risk factors for attempted suicide in youth include depression, alcohol or other drug use disorder, physical or sexual abuse, and disruptive behavior. As with people who die by suicide, many people who make serious suicide attempts also have co-occurring mental or substance abuse disorders — the theme in this issue of *Mental Health News*.

If we lived in a society that placed a higher premium on mental health care and mental health education, then perhaps Alvarez, and thousands of others with symptoms of suicidal behavior, would be in treatment and out of harms way. But we do not live in a society that places a high premium on understanding mental illness or that provides comprehensive mental health care.

Mental Health Parity legislation, which would oblige health insurance companies to cover mental health treatment at the same level as other medical illnesses, *still* hasn't become a national priority. Tragically, funding cuts to mental health systems across the nation are a regular occurrence. In fact, every year we see programs for medication coverage, supportive housing, child, adult and eldercare face the budgetary chopping block. This leaves thousands of people, every day, in every major city and small town in the United States, suffering from untreated mental illness. It's no wonder that eventually someone with an untreated mental illness, like Juan Alvarez, will attempt suicide.

We are making some strides in the direction of becoming a more sensitive nation, as evidenced by initiatives like the National Suicide Prevention Lifeline at 1-800-273-TALK, which is being spearheaded by the Mental Health Association of NYC (see page 9). But much more needs to be done because, as a whole, our nation continues to stigmatize people with mental illness, as revealed in my second commentary below.

Vermont Teddy Bear:

Spreading Stigma - Not Love This Valentine's Day

Would you be happy to send or receive a teddy bear that was dressed in a straightjacket? Would you—knowing that the straightjacket represents a perpetuated stereotype of a false image linking mental illness with violent behavior? Of course not. And if a national company hawked such an item and you, or a friend, or a member of your family suffered from a mental illness, wouldn't you be shocked and outraged?

Well that's just what happened this Valentine's Day, thanks to the Vermont Teddy Bear (VTB) Company's "Crazy for You Bear." The 15-inch bear is dressed in a straitjacket and comes complete with commitment papers that includes the symptoms "can't eat, can't sleep, my heart's racing."

Crazy About You Bear

Protest over the bear came quickly from The National Alliance for Mentally Ill (NAMI), whose "Stigma-buster's" campaign regularly monitors insensitivities toward people with mental illness in the media and corporate world. Calling the bear "A Real Heartbreaker," NAMI Vermont raised a protest, which received national media coverage, rightly claiming that from a company associated with caring and comfort, the bear came as a distressing surprise.

VTB did issue an apology, stating they did not intent to offend anyone and that they recognized the serious nature of mental illness. However, even after a January 22 article in *The New York Times*, which called for the company's CEO to resign from the board of trustees of the largest hospital in the state of Vermont, VTB continued to sell the bear on its Web site.

According to the *Associated Press*, (January 29), Vermont Teddy Bear Co. President Elisabeth Robert said, "The bear is meant as a funny Valentine's Day greeting and has been popular among customers. We made a very difficult decision not to withdraw it from the market," she said. "I listened to customers, from a lot of feedback from our employees. These people are Vermonters who really don't like to be told what to do." Mental health advocates have called for the company to stop selling the bear, calling it "tasteless," and saying it stigmatized people with mental illness. Governor Jim Douglas called the bear insensitive and inappropriate. Robert said the company had planned the bear as a one-time offering for Valentine's Day and that it will continue selling the bear until it is sold out. She said the company is "truly sorry if we hurt anybody with this bear" but added that freedom of expression was at stake. She said the bear got "the highest favorability rating" from customers, and that she consulted with the Vermont Teddy Bear board of directors and the radio stations that advertise the bear before deciding to keep it. "We're not in a position to be told what we can and cannot sell," she said.

So, Robert consulted with her board (who want her to sell bears), and she consulted with radio stations that advertise the bear (for money). So why should we still be upset? We all know that radio stations are never insensitive about disabilities or emotional topics. Only a few weeks ago, a local New York City radio show kept airing a parody song about Tsunami victims, and another area station made fun of the Deputy Governor of New Jersey's wife who suffered from depression.

Thanks to weeks of advocacy and outcries, VTB finally agreed to stop selling their straitjacketed bear on Thursday, February 3rd. But being the marketing gurus that they are, upon visiting the VTB website (February 5th) I found that the bear is still there in full regalia only saying that it is now "Sold Out." What a clever spin by VTB.

Thankfully, this campaign has been a big win for the power of advocacy by many in the mental health community.

But in the final analysis this entire flap is greater than a soul-less company trying to make a buck at the expense of people with mental illness. It's about a nation that fails to recognize people suffering from mental illness with the same respect and compassion as people with other serious medical illnesses and physical disabilities.

It comes down to the fact that we as a community must continue fighting to call the nation's attention to our illness' importance and seriousness. Just because mental illnesses do not show up on X-rays or cat scans, and just because having depression or bipolar disease doesn't require us to use crutches, is no reason why people who suffer from this debilitating disease should be discriminated against.

We must speak out against continual yearly funding cuts to already strained mental health community services. We must elect government officials and decision makers who support our mental health agenda at the local, state and national level — not those who simply buy their way into office.

We wish to thank you for your continued support and readership, which makes *Mental Health News* an important tool in the fight against stigma and discrimination towards people with mental illness.

Please continue to send us your comments and suggestions by e-mail to mhnmail@aol.com.

Have a great spring! □

Editorial To The Publisher

The State of Psychiatric Diagnoses Regarding Co-Morbidity:

The Lesson of Yogi's Pizza

By Joseph A. Deltito, MD

There exists a logic used in making psychiatric diagnoses that is not always obvious to patients or their families. In the United States and many other countries, the foremost recognized system for making psychiatric diagnoses is through the use of the "Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition" (The DSM-IV). The goals of this system of classification are to provide (1) clear and unambiguous definitions of psychiatric disorders such that there would be agreement between clinicians and researchers as to how to classify disorders, and (2) there would be an enhanced knowledge of the nature of these disorders.

Technically, the ability of a system to be agreed upon by all of those using it is called "reliability," and the fact that a system captures the truth about how these disorders are manifested is called "validity." An ideal system of classification has a high degree of both reliability and validity. A common error that is often made is to assume that, because there is high "reliability," then there must be high "validity." Over the course of Western Civilization, there was strong agreement among the scholars of the time that the world was flat, not round: they had good "reliability" but terrible "validity." Similarly, there have been ways of conceptualizing psychiatric disorders in the distant or recent past where there was great agreement among clinicians, which have proven simply not to be true, and which currently has little or no validity. For example, 40 years ago, many professionals agreed that the cause of several major psychiatric disorders, such as schizophrenia, was the result of "poor mothering." Obviously, this concept has not stood the test of time. All of the evidence gathered by researchers regarding the course of schizophrenia has certainly failed to support this position. Therefore, a core concept regarding the DSM-IV system is that it changes as we gather information through valid research, which over time should increase the reliability and validity of this system.

There is a story told about Yogi Berra, the famous baseball player, that he once went into a pizzeria and ordered a "large pie." He was asked if he wanted it sliced into six pieces or eight. He replied, "I am not that hungry. Cut it into six." So, much like Yogi's pizza, the amount of pieces that we cut all of the psychiatric diagnoses into is an arbitrary decision, which is based on the practical issues that we need to serve. We could divide all of the psychiatric conditions into 4 disorders or 40,000 disorders; however, there is a balance struck in the DSM-IV system where there is an attempt to make meaningful categories with the shared features, and done in such a way that clinicians and researchers can make reasonable predictions regarding the course of these disorders, treated or untreated. In psychiatry, for the most part, we lack the diagnostic tests used in other fields of medicine that are required to both present and confirm specific diagnoses. A diagnosis of anemia, diabetes or leukemia can be quickly established by blood tests performed in the laboratory. It *is* leukemia because we can *see* the leukemia in the blood cells retrieved from the afflicted individual. Since we do not have this type of hard evidence in psychiatry, we must rely on symptoms and descriptions, which, after time, begin to present as recognized syndromes for the purpose of correct psychiatric diagnoses.

A common misconception regarding the use of the DSM-IV system is that it classifies individuals (e.g., patients, subjects, people). It does not attempt to classify *people*, but the *disorders* that people have. For example, it does not attempt to describe the difference between Suzie and Jane, but the difference between schizophrenia and bipolar disorder. In the DSM-IV system, there is no assumption that each diagnostic entity is absolutely distinct from other disorders with no overlap. There is also no assumption that all people diagnosed with a given condition share all the same features as each other. It should be recognized that two people given the same diagnosis may not share many similar features, just that they share *some* key features. We may classify both a Chihuahua and a Great Dane as canines (dogs), but we also recognize how much they differ physically. Classifying canines by different breeds can be important for a variety of reasons, such as choosing the family pet, or choosing a dog to do certain jobs, like being a guard dog or a hunting companion. At other times, any type of dog is all that's needed for the purpose of studying parasitic diseases that affect dogs. Like Yogi's Pizza, subclassification into many or few categories is arbitrarily determined based on the given need we wish to serve.

In recent years, there has been much attention focused on individuals with psychiatric diseases who may suffer from multiple psychiatric disorders contemporaneously. When psychiatric disorders occur in individuals who are also afflicted with addictions to alcohol or illegal substances, the term "dual diagnoses" is used. When one psychiatric disorder co-exists in a person having other psychiatric or medical disorders, the term "co-morbidity" is used. The concept of co-morbidity in medicine is an important one, as the existence of multiple disorders in one individual may alter the course of that disorder or change the way we might treat it. Therefore, if someone has diabetes plus pneumonia, or thyroid disease plus osteoporosis, the course of the disease and the treatments chosen may be altered. Similarly, co-morbidity of psychiatric disease with other medical conditions may pose the same considerations, such as in someone with bipolar disorder who also has cancer, or someone with schizophrenia who also has coronary artery disease.

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When we talk about co-occurring or co-morbid psychiatric conditions, we enter into a realm that is much more complex and not necessarily so obvious as to its significance. For example, we might entertain that a given individual might suffer from bipolar disorder plus attention deficit disorder. What is not clear is that it truly makes sense to postulate that two different disorders co-exist, or are we dealing with a variant of bipolar disorder with features of sustained and significant problems with attention. In this case, a conceptualization whether we are dealing with true co-morbidity or merely another variant of bipolar disorder is crucial, for it may influence the way a clinician decides to treat the patient. I believe most of what is called co-morbidity or co-occurring disorders when involving two or more psychiatric conditions reveals primarily an artifact in the way in which we classify disorders, as opposed to truly representing the pathophysiologic existence of two or more separate and distinct disorders. We come back to Yogi's Pizza! If we have a limited number of psychiatric categories, we will describe the psychopathology in an individual by using more than one diagnostic category. If we have an expansive number of categories, we can describe this individual by using subsets of the larger categories. In this theoretical condition, we might have a category of "bipolar disorder with features of sustained problems with focus and attention." Yogi's Pizza can be divided into one, two or thousands of slices. Its division is arbitrary and serves the purposes of the one doing the division. It makes sense to limit the number of categories used, but to remember the heterogeneity of the presentations encountered within a given category — like all the different breeds of dogs within the category of canine. In co-morbid medical conditions, it is usually indicated to treat each condition optimally and vigorously. When the apparent co-morbidity is between two psychiatric conditions it often is more useful to conceptualize the condition as a variant of a parent disorder that should be treated vigorously, which will then lead the "associated" phenomena to also improve. We know that people with schizophrenia will also, at times, have mood symptoms of depression. We usually do not make a separate diagnosis of depression and then treat with antidepressant medications, but we treat the underlying schizophrenia more vigorously with pharmacologic treatments aimed at that condition. In patients with depression we often encounter features of anxiety. Once again, we usually do not conceptualize these individuals as having both an anxiety disorder and depression, but realize some individuals with depression may have prominent symptoms of anxiety as well. The treatment of such individuals is usually the more vigorous treatment of depression, not the current treatment for depression with a treatment for anxiety added. Certainly there may be times to conceptualize a patient as suffering from two distinctly different psychiatric disorders afflicting them simultaneously. Having anorexia nervosa does not "protect" someone from having co-existing obsessive-compulsive disorder (OCD), yet in most cases it makes sense to recognize that individuals with anorexia nervosa regularly have features of OCD. The point here is that the way we think about psychiatric diagnoses is "utilitarian," and very often depends on what practical purpose it serves. In psychiatry, as opposed to internal medicine, apparent co-morbidity or co-occurrence does not have the same significance and meaning.

Yogi was not very hungry that evening, so he chose to eat *six*, not *eight*, slices of pizza. The number of separate diagnostic categories we use in psychiatry is simply dependent on which purpose it serves; the categories are arbitrary, and serve for the purpose of enhanced understanding of psychiatric illness and its treatment. The concept of co-morbidity in psychiatry is different than it is in other disciplines of medicine.

Joseph A. Deltito, M.D. is a Clinical Professor of Psychiatry at New York Medical College and has an office practice for psychopharmacological consultations and forensic psychiatry in Greenwich, Connecticut. He is a frequent contributor to Court TV. Dr. Deltito serves on the Clinical Advisory Board of Mental Health News. □

Tragic Tsunamis Create A Mental Health Disaster

By Cynthia R. Pfeffer, MD
Professor of Psychiatry
Director, Childhood Bereavement Program, Weill Medical College of Cornell University

Natural disasters have occurred since antiquity. Earthquakes and their consequences are among the most feared natural events. On December 26, 2004, a major earthquake deep in the Indian Ocean—and its consequential tsunamis— reached the shores of India, Indonesia, Kenya, Malaysia, The Maldives, Mauritius, Somalia, Sri Lanka, Sumatra, and Thailand without any warning. In some communities, legend says that "when the ocean is disruptive, one should run for their lives." Those who understood this legendary statement knew about the history of the prior destructive brutality of the ocean. The recent tsunamis in December 2004 killed an estimated 150,000 people. Most were residents of these countries, and others were tourists. Besides the destruction to the physical environment, the likelihood of illness and additional loss of life among survivors reached unthinkable proportions. It was a social, economic, health and environmental cataclysm that stimulated massive global efforts of aide.

The ravages of the tsunamis were publicized worldwide through extensive, round-the-clock media coverage. Approximately one-third of those killed were children — and thousands of other children became orphans. International offers of aid and assistance were enormous. Initially, the most critical goals were the prevention of widespread diseases, such as cholera, most often caused by contaminated drinking water, airborne illnesses from thousands of decomposing bodies, and preventing lethal infections among the thousands of injured survivors; therefore, relief efforts concentrated on providing sanitary food and water, distributing clothing and providing shelter. However, as more and more shocking footage of these deadly waves was shown around the world, it became apparent that the enormous mental health needs of these survivors was equal to their physical survival. Depictions of the intense shock and grief etched on the faces of children and adults reached us 24/7 on our televisions and daily papers. Among the many survival stories was that of a family living in Banda Aceh. The father, seeing the "ocean wall" approaching, yelled to his three teenaged children to escape on the family motorcycle — and that was the last time those children saw their parents alive. A family member, who lives in a distant town, offered to care for the teenaged sister, but she refused to leave her brothers behind, and their fate has not been determined. In yet another amazing story, a child miraculously lived through the tsunami horror. The train on which he, his family, and hundreds of others were riding was destroyed by the waves.

Cynthia R. Pfeffer, MD

He managed to save his life by hanging onto the luggage rack of the train compartment he was in. His father also managed to survive, but the boy's mother and siblings did not. After burying their family, he and his father must now forge their future together, living with the pain of their loss. There is tremendous adversity that surviving families must face. As a result of the vast destruction, many survivors have no possessions, and, until these countries can rebuild, there are very few opportunities available to earn a living. Their futures remain grim and filled with worry.

Mental health needs are clear. With families losing multiple relatives, bereavement is extensive and complex. Loss of personal possessions and lack of financial plans for the future has increased the levels of grief and anxiety. The trauma is obvious and the suffering is severe. Avoidance of hopelessness is a great challenge. One father said, "I lost my wife and my children. Why should I want to live?" The intense guilt of surviving this disaster after so many relatives died is a pervasive phenomenon. One mother cried, "I was holding my two children but the water was pushing us along and I could not hold onto both children. I lost my daughter." The pain, disfigurement, and loss of physical functioning due to severe injuries have complicated the experience of many survivors. They are at an extremely high risk for depression, hopelessness, and thoughts of death.

Mental health intervention is further challenged by many factors, including the lack of trained mental health professionals who are knowledgeable about the cultural ways, in this region of the world, of enduring the loss of loved ones. Interventions to assist survivors in coping with death and destruction are badly needed, but there are insufficient numbers of experienced professionals with the knowledge that is needed to organize and administer such interventions. The fact that so many families lost multiple relatives further reduces the resources of families to support those relatives in need. Such families must depend on strangers for support. This is a major issue for the orphaned child survivors. Child welfare laws that were enacted in these countries in order to help protect children from various types of abuse, especially foreign pedophiles, are not clear. How will it be possible to ensure the safety of such orphaned children? It is imperative that clear and understandable solutions be constructed within the cultural framework of this region.

The United States was confronted with a major disaster caused by the terrorist attacks on September 11, 2001. From a mental health perspective, there are many similarities — but great differences — between the aftermath of the 2004 tsunamis and the September 11th terrorist attacks. Much has been learned in the United States about the families who were directly affected by 9/11, and this knowledge can, and should, be applied in assisting the tsunami survivors with their recovery.

Both events occurred suddenly and without warning. The devastation was immense and traumatizing for those who survived. Intense stresses were experienced by those attempting to avoid injury and death. Various degrees of physical injuries occurred among those who survived. For a sizable number of the bereaved, their loved ones have not been found or identified, and the hope to find missing loved ones persisted. The efforts to find them were overwhelming and exhaustive. The most common method used to identify the deceased was DNA sampling. There were many 9/11 stories of survival tinged with traumatic moments and outcomes, and shock pervaded all of those who survived.

The world again recognized the signs of **bereavement**: intense emotional expressions of sadness and anger; survivor guilt; fears; feelings of helplessness; feeling hopeless about the future; wishing to die; sleeplessness; inability to focus attention on current tasks for survival; the need for support from others; the importance of talking about loved ones and the circumstances of their loss. One guiding factor for many bereaved parents was to resume life in order to comfort and support their surviving grief-stricken children.

Once again, the world recognized the signs of **traumatic reactions**, involving: re-experiencing through recurrent thoughts and images; nightmares; feelings of reliving the events as if they were occurring again; avoidance that manifested as withdrawal and shock; and hyper-arousal, which manifests as itself as both poor sleep and startling to sudden sounds or events.

The world also recognized reactions of people suffering from catastrophe, involving **depression**, **anxiety**, and **impairments** in conducting common, everyday activities. The risk of developing psychiatric disorders is acutely increased, and often for lengthy periods of time.

However, there are significant differences between the aftermath of the tsunamis and the terrorist attacks on September 11, 2001. A most striking difference was that children were directly involved in the terror of attempting to save themselves, and thousands succumbed to the ferocious destruction of the tsunamis' forces. Additionally, personal possessions, homes, and entire families were wiped out, leaving very little with which to rebuild, or few relatives from whom to gain family support. The extent of resources, including trained, skilled professionals to assist with treating the physical and psychological wounds of the survivors, is limited. Also, sociocultural and religious factors about coping with loss have distinct regional characteristics. This region of the world is very far from the countries that offered aide. There are even more factors that have made the relief effort complicated; the safety of people in some of the affected regions has been compromised because of ongoing civil war – notably the Sudan – and there are severe restrictions on who can administer relief aide – American marines are not allowed in certain countries.

The outpouring of international support was immediate and aided by extensive, consistent media coverage. World leaders and national and private organizations mobilized to provide financial aide and organized shipments of needed supplies to treat injuries, dispose of the dead, and organize living situations for displaced and orphaned children. Quite early in this amazing and extensive aide process was the recognition of the major emotional toll suffered by the survivors. Appraisal of specific needs for those who have suffered from this disaster is required to in order to ensure the development of effective strategies for intervention.

A number of principles learned from the events of other natural and manmade disasters may guide current efforts for assistance to the tsunami survivors. Key to this is the utilization of public health principles that involve:

- Identification of the degree of emotional suffering among the population;

- Development of prevention strategies for those who are at risk for emotional problems, and treatment strategies for those who do suffer emotional problems.

A key issue is assessment of population needs, including the extent of psychological problems and the degree of manpower available to intervene. Because affected countries may have different contextual and sociocultural factors, it is expected that intervention needs will vary. Because it will be necessary to utilize tsunami survivors in assisting with the assessment needs of the

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MENTAL HEALTH NEWSDESK

Government Study Highlights Need for Integrated Counseling For Women with Substance Abuse and Mental Disorders and Trauma

By SAMHSA
United States Department of Health and Human Services (USDHHS)

The Substance Abuse and Mental Health Services Administration (SAMHSA) just released study findings showing that women with mental disorders, substance abuse disorders, and histories of violence (trauma) can improve when treated with counseling that addresses all three of their service needs. Women who have a voice in their own treatment report better outcomes than women who do not.

The findings come from the Women, Co-occurring Disorders and Violence Study (WCDVS), a five-year study conducted by SAMHSA of over 2,000 women with co-occurring mental and substance abuse disorders and trauma histories. The study was not randomized, but rather, women who fit the study eligibility criteria were recruited into a group receiving integrated services, or a group receiving usual care, which treated mental health, substance abuse, and trauma issues in isolation from each other.

Women in the study who received counseling that addressed all three aspects of their lives together improved more than women in usual care. Women's symptoms also improved when they participated in the planning, implementation and delivery of their own integrated services. Integrated services that involved the women themselves in treatment decisions cost the same as usual care and produced better outcomes, making the services cost-effective.

"The nature and impact of trauma remains too often misunderstood or neglected," explained SAMHSA Administrator Charles Curie. "Many women suffer tremendously as a result of misdiagnosis, mistreatment, absence of integrated care and a lack of a voice in their own treatment. The WCDVS results provide a roadmap for recovery for women with co-occurring disorders and trauma histories."

According to SAMHSA's National Survey on Drug Use and Health in 2003, an estimated 4.2 million persons 18 and older met diagnostic criteria for both serious mental illness and a substance use disorder (dependence or abuse) in the past year. Of these, 2.0 million were male and 2.2 million were female.

The study builds on recommendations from SAMHSA's Treatment Improvement Protocol (TIP) #25, "Substance Abuse Treatment and Domestic Violence." TIP #25 noted that to treat victims of domestic violence with substance abuse disorders, "holistic…collaborative, (and) coordinated" services are needed, as well as studies on collaborative, linked social service programs. The study results confirm clinical recommendations in TIP #25 that treating substance abuse issues without addressing a woman's history of violence is ineffective, and that all clients in substance abuse treatment programs should be assessed for domestic violence and childhood physical and sexual abuse.

The WCDVS went further by addressing the interplay of not only substance abuse disorders and trauma in the lives of women, but mental illness as well. The WCDVS also demonstrated the empowerment and healing that comes when a woman is directly involved in her own care and recovery. At the systems level, women with co-occurring disorders and trauma histories often receive services that are fragmented, less comprehensive, and more institutionally based than what they need. The WCDVS also addressed these issues in the study's guiding principles:

see Study on page 20

Morahan Appointed Chair of Mental Health and Developmental Disabilities Committee

Staff Writer
Mental Health News

Senator Thomas P. Morahan (R-C), New City has been appointed to chair the prestigious New York State Senate Mental Health and Developmental Disabilities Committee.

"I'm honored that Senator Bruno has appointed me to help oversee a significant part of our State's mental health and developmental disabilities responsibilities. I look forward to working with the State Office of Mental Health, State Office of Mental Retardation and Developmental Disabilities, the Commission on the Quality of Care, and the Developmental Disabilities Planning Council to ensure that all patients get the best possible care," Senator Morahan said.

"Mental health issues are critically important to the people of New York State, and Tom Morahan's understanding and commitment to this issue make him highly qualified to serve as chair and leader of the committee," Senate Majority Leader Joseph L. Bruno said. "Senator Morahan has always demonstrated his dedication and leadership, both to his local constituents and the entire state, and I'm confident that he will also do an outstanding job leading the Mental Health Committee."

Thomas P. Morahan

The Senator has been widely recognized as an advocate for mental health and those with special needs. In recognition of his work, Senator Morahan was awarded the Joseph R. Bernstein Memorial Award by the Rockland County Mental Health Association. □

Lepore New Vice President Of Behavioral Health Center At Medical Center

Staff Writer
Mental Health News

Dominick F. Lepore, MS, CTRS, has been appointed Vice President of the Behavioral Health Center (BHC) at the Westchester Medical Center in Valhalla, New York.

"After a ten year hiatus from Psychiatry, my main efforts are to enhance the core mission that drives the Westchester Medical Center. That mission is to provide quality care in a compassionate manner and simultaneously be the lead educators for our internal and external customers. BHC's contribution to the financial viability of the Medical Center has also become a priority in assessing all aspects of our services (Inpatient, Outpatient, Assertive Community Treatment (ACT) and the Comprehensive Psychiatric Emergency Program (CPEP)," Lepore said.

No stranger to the Westchester Medical Center, Lepore served as a Certified Therapeutic Recreation Specialist (CTRS) and Supervisor, and then as Director of Recreational and Expressive Therapies at the Medical Center's Psychiatric Institute. Prior to his new position as head of the Behavioral Health Center, Mr. Lepore served for four years as an Assistant Vice President in the office of Quality Clinical Resource Management and Regulatory Affairs at the Medical Center.

Dominick F. Lepore

According to Mr. Lepore, "I am pleased to be back to my roots in psychiatry and wish to express my highest confidence that we will continue to place the consumer first and foremost when providing the care for their complex needs." □

MENTAL HEALTH NEWSDESK

MHA of NYC Launches National Suicide Prevention Lifeline 1-800-273-TALK

Staff Writer
Mental Health News

The Mental Health Association of New York City (MHA of NYC) and its partners, the National Association of State Mental Health Program Directors (NASMHPD), Columbia University and Rutgers University, recently announced the launch of the federally- funded National Suicide Prevention Lifeline, 1-800-273-TALK.

The National Suicide Prevention Lifeline is a network of local crisis centers located in communities across the country that are committed to suicide prevention. Callers to the hotline will receive counseling, support and referrals from staff at the closest available crisis center in the network.

"The purpose and promise of this national suicide hotline is to be there for people in their time of greatest need," said Giselle Stolper, Executive Director of the MHA of NYC. "Working with our federal, State and local partners, we will be able to capitalize on our strengths and expand this national hotline to reach suffering individuals in ways that each of us could not do alone."

Suicide Prevention Lifeline Unifies Local Services for New Yorkers

Dr. John Draper, Director of the Lifeline, emphasizes the importance of combining nationwide access with local expertise. "It is critical that callers to the National Suicide Prevention Lifeline get help as soon as possible. A single phone number, available nationally, makes it easy for anyone to call from anywhere in the country and get connected to certified local crisis centers that are best equipped to help nearby callers access geographically convenient services and support."

Dr. Draper continues, "We are pleased that eight New York crisis and support hotlines are participating in the network to serve persons in distress across the State. Callers can reach them by using the local hotline numbers they already know, or by dialing the National Suicide Prevention Lifeline at 1-800-273-TALK."

Regional participating hotlines include: Crisis Services of Buffalo, Long Island Crisis Center of Bellmore, Suicide Prevention and Crisis Service of Tompkins County, Ithaca, Covenant House Nineline of New York City, HELPLINE of the Jewish Board of Family and Children's Services of New York City, LifeNet of New York City, Dutchess County Department of Mental Hygiene-HELPLINE of Poughkeepsie and Life Line: A Program of DePaul, Rochester.

To ensure seamless support for the National Suicide Prevention Lifeline and to link mental health resources nationally, the MHA of NYC will work closely with NASMHPD to create a centralized database of treatment and support services. "For many people, crisis hotlines serve as an entry point into the mental health system," said NASMHPD Executive Director Robert Glover. "By expanding the National Suicide Prevention Lifeline into underserved regions and by linking crisis centers to a national database of mental health resources, we can get people the help they need and reduce suicide in this country."

Lifeline Deemed National Priority by President's New Freedom Commission

The national hotline network is part of the National Suicide Prevention Initiative (NSPI), a collaborative, multi-project effort led by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) that incorporates the best practices and research in suicide prevention and intervention with the goal of reducing the incidence of suicide nationwide.

In the United States, suicide accounts for approximately 30,000 deaths annually. As the lead agency tasked with advancing the goals of the President's New Freedom Commission on Mental Health and the National Strategy for Suicide Prevention, SAMHSA is committed to working with state and local organizations, such as MHA of NYC, NASMHPD, and community crisis centers, to expand the availability of suicide prevention and intervention services. The National Suicide Prevention Lifeline is funded by a 3-year $6.6 million grant from SAMHSA's Center for Mental Health Services, awarded to the MHA of NYC.

The MHA of NYC was selected to manage the development of the National Suicide Prevention Lifeline due in part to the organization's extensive experience in operating 1-800-LIFENET, New York City's premier multilingual mental health crisis, information and referral hotline. LifeNet is one of 113 crisis centers in 43 states currently participating in the National Suicide Prevention Lifeline network.

The daily operations of the network will be coordinated by Link2Health Solutions, an entity created by the MHA of NYC for the primary purpose of overseeing this nationwide project. □

Mutant Gene Linked to Treatment Resistant Depression

By The National Institute of Mental Health, (NIMH)

A mutant gene that starves the brain of serotonin, a mood-regulating chemical messenger, has been discovered and found to be 10 times more prevalent in depressed patients than in control subjects, report researchers funded by the National Institutes of Health's National Institute of Mental Health (NIMH) and National Heart Lung and Blood Institute (NHLBI). Patients with the mutation failed to respond well to the most commonly prescribed class of antidepressant medications, which work via serotonin, suggesting that the mutation may underlie a treatment-resistant subtype of the illness.

The mutant gene codes for the brain enzyme, tryptophan hydroxylase-2, that makes serotonin, and results in 80 percent less of the neurotransmitter. It was carried by nine of 87 depressed patients, three of 219 healthy controls and none of 60 bipolar disorder patients. Drs. Marc Caron, Xiaodong Zhang and colleagues at Duke University announced their findings in the January 2005 "Neuron," published online in mid-December.

"If confirmed, this discovery could lead to a genetic test for vulnerability to depression and a way to predict which patients might respond best to serotonin-selective antidepressants," noted NIMH Director Thomas Insel, M.D.

The Duke researchers had previously reported in the July 9, 2004 "Science" that some mice have a tiny, one-letter variation in the sequence of their tryptophan hydroxylase gene (Tph2) that results in 50-70 percent less serotonin. This suggested that such a variant gene might also exist in humans and might be involved in mood and anxiety disorders, which often respond to serotonin selective reuptake inhibitors (SSRIs) — antidepressants that block the re- absorption of serotonin, enhancing its availability to neurons.

In the current study, a similar variant culled from human subjects produced 80 percent less serotonin in cell cultures than the common version of the enzyme. More than 10 percent of the 87 patients with unipolar major depression carried the mutation, compared to only one percent of the 219 controls. Among the nine SSRI-resistant patient carriers, seven had a family history of mental illness or substance abuse, six had been suicidal and four had generalized anxiety.

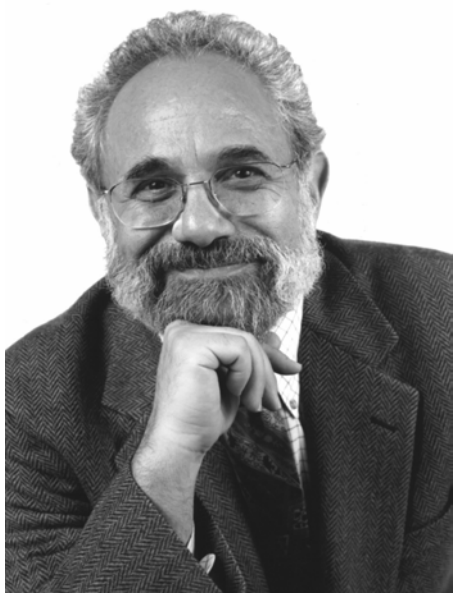
Although they fell short of meeting criteria for major depression, the three control group carriers also had family histories of psychiatric problems and experienced mild depression and anxiety symptoms. This points up the complexity of these disorders, say the researchers. For example, major depression is thought to be 40-70 percent heritable, but likely involves an interaction of several genes with environmental events. Previous studies have linked depression with the same region of chromosome 12, where the tryptophan hydroxylase-2gene is located. Whether the absence of the mutation among 60 patients with bipolar disorder proves to be evidence of a different underlying biology remains to be investigated in future studies.

The researchers say their finding "provides a potential molecular mechanism for aberrant serotonin function in neuropsychiatric disorders." □

POINT OF VIEW

Mental Health Is Key To Restructuring Long-Term Care

By Michael B. Friedman, LMSW



Michael B. Friedman

A consensus seems to be emerging in Albany that New York State should restructure its long-term care system and reduce the use of nursing homes by helping people to live in community settings. This is a reasonable goal, but the effort to achieve it cannot be fully effective if the mental health needs of older adults are ignored. And sadly, none of the proposals now on the table addresses mental health issues.

For example, the governor has proposed increasing home health and case management services to help people avoid placement in nursing homes, or to help them return from nursing homes to the community. Good concepts — but, unfortunately, mental illness is quite common among people who receive home health or case management services, and very few service providers are prepared to deal with it.

It is not immediately apparent that mental health services should be a key part of the effort to provide alternatives to nursing homes because the popular images of nursing home residents are of people who've become too decrepit or demented to care for themselves any longer. We think of old people who have broken their hips and never return to their previous level of functioning. We think of people who have Parkinson's Disease who can no longer stand, feed themselves, or control urinary or bowel functions. We think of people with Alzheimer's Disease who can no longer recognize their own children and seem shells of their former selves.

These images reflect only part of the reality of nursing homes residents. They neglect the fact that mental and behavioral disorders are among the major reasons that people go to, and remain in, nursing homes.

Yes, many people in nursing homes have chronic physical illness or have failed to recover from injuries. But upwards of 50% of this population have co-occurring mental illnesses — especially depression and anxiety disorders.

Yes, many people are in nursing homes because of dementia. But sometimes what is diagnosed as dementia is actually unrecognized – and untreated – depression. And many people correctly diagnosed with dementia also have depression and anxiety disorders that, if treated, could result in improved functioning.

In addition, 10% to15% of people are in nursing homes *primarily* because they have mental illnesses with behavioral symptoms that make it difficult for them to be served in community settings or cared for by their families. For the most part, they are people who cannot care for themselves, at least at the time of admission, and who do not have family or friends who are able to take care of them at home. And let's not forget that one of the ways New York State reduced the census of state psychiatric centers was to discharge older adults to nursing homes.

Finally, it is critical to be clear that a great many people who are in nursing homes putatively because of dementia or physical illnesses or injuries are actually there because of their behavior. Home health workers, case managers and, most importantly, their families could manage their physical problems in the community if it weren't for such behavioral problems as wandering, non-adherence to medical regimens, belligerence, and actions that are dangerous to themselves and to others —such as leaving stoves on or smoking in bed.

The fact that these mental and behavioral disorders are among the major reasons that people are put in nursing homes has important implications for the effort to restructure New York State's long-term care system.

- Every taskforce, planning group, and advisory body convened to work out the details of restructuring should include experts on geriatric mental health.

- Home health and case management services need to be reconceptualized as services to address mental health and behavioral problems as well as health problems and the difficulties of meeting life's basic needs.

- The health, mental health, and aging service systems need to be integrated because health and mental health conditions, social isolation, and difficulties meeting basic needs co-occur and interact. They need be addressed in a coordinated manner.

- Mental health services need to be far more accessible than they are. There need to be more services. They need to be affordable. They need to be mobile so as to reach people in their homes and other community settings where older people go for help—such as senior centers, social service programs in naturally occurring retirement communities, and houses of worship. And they need to be designed to engage cultural minorities and others who tend not to seek mental health services.

- The quality of mental health services needs to be improved. Currently, primary care physicians provide most mental health services in the community, and frequently they are unable to make accurate diagnoses or provide the best treatment. In addition, many mental health professionals are not prepared to serve older adults, whose mental health needs are often qualitatively different from those of younger adults.

- Because families are the primary caregivers for people with mental and physical disabilities, significant attention needs to be devoted to providing support to help them to continue their extraordinary efforts without burning out.

- Of course, it is not realistic to believe that all older adults can continue to live independently or solely with the support of their families or friends. But nursing homes should not be the only next step. Housing alternatives including assisted living, community residences, and other forms of congregate care should be available for older adults with co-occurring mental and physical problems.

- Widespread public education is needed to help older adults, their families, their physicians, and others who care for them to understand what mental illness is, that it is treatable, and where to go for good treatment. Public education also needs to address stigma – the sense that mental illness is shameful, and ageism–the belief that mental illnesses (especially depression and cognitive dysfunction) are the inevitable consequences of old age. They aren't.

- Substantial efforts are needed to develop a workforce large enough and competent enough to meet the mental health needs of older adults. This includes not just developing the workforce of geriatric mental health providers, but educating and training primary care physicians, nurses, home health workers, providers of services to the aging, and others.

- Finally, the delivery of mental health services that can help reduce the need for people to go to nursing homes will require a significant redesign of financing models, ranging from the very simple—such as higher fees for home visits-- to the very complex—such as integrated funding for health and mental health services.

None of this will be easy, but these are the challenges that must be confronted in order to restructure long-term care in ways that help people live where most prefer to live —in their homes and in their communities. It just can't be done without addressing mental health needs, as well as health and concrete service needs.

Michael B. Friedman is the Director of the Center for Policy and Advocacy of The Mental Health Associations of New York City and Westchester. He can be reached at center@mhaofnyc.org. *The opinions in this article are his own and do not necessarily reflect the positions of The Mental Health Associations.* □

A Voice of Sanity
A Consumer Advocacy Column

Surviving A Deadly Game Of Ping Pong

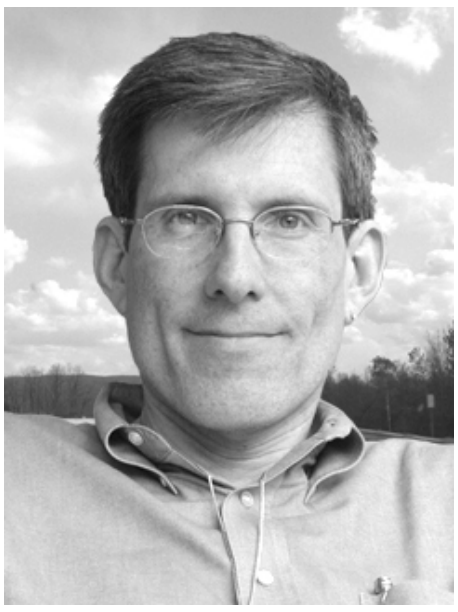
By Joshua Koerner
Executive Director, CHOICE

What's wrong with this picture: A blazingly hot August day on the campus of a big teaching hospital. I am strolling past the tennis courts and the golf course, walking from the site of the day hospital, where I am enrolled, to the main building, where the cafeteria is located. My life is a shambles: in April I had a spectacular meltdown, evidence of which can be seen on my left hand, which is still healing from the 3-inch gash that required both micro-surgery and a skin graft to close. I'm profoundly depressed, living at home with my mother for the first time in six years, unable to work, unable, really, to even think straight — and I'm smoking a joint.

I see this all the time, or variations of it: clients who are on disability, who cannot work, and yet they drink, or smoke pot, or spend their entire precious benefit checks the first week of the month on gambling, lottery tickets, or hookers. Back when I was in the same situation, I wasn't concerned with putting my life back together — that seemed impossible. I was horrifically depressed, and marijuana made me feel better. It would continue to make me feel better — and continue to destroy my life — for the better part the next ten years.

That's addiction. Addiction is one of those words, like depression, that has entered common usage, but which most people really don't understand completely. People call themselves workaholics, chocoholics and shopaholics; but addiction is more that just what, or how much of, something you use. Addiction is a process: it's the management of feelings, using a substance (drugs) or activities (gambling), in an obsessive fashion, in spite of profoundly negative consequences (loss of job, loss of spouse, arrest). So it isn't the amount used: you can have a drink after work every day and not be an alcoholic. On the other hand, you can confine your drinking to the weekends, but if it leads to fights and arrests for driving under the influence, chances are you have a problem. For me, it wasn't an occasional joint: I had a morning bong hit the way other people have a morning cigarette.

And then there were the consequences, one of which was insanity. Drugs pushed me over the edge, from the neurotic to the psychotic. Make no mistake: it wasn't just marijuana. I drank. I huffed nitrous oxide, mostly out of balloons filled from Whip-it cartridges, but several times right off a tank.



Joshua Koerner

I had a serious dalliance with Quaaludes, but they were difficult to get and my source, a script doctor in Watts, was busted. And there was cocaine.

Which brings me to another consequence — poverty. Nothing was as important as getting the drugs; certainly not saving money. I went through thousands of dollars, fifty or a hundred dollars at a time, sometimes little bags of coke, and mostly bigger bags of pot. I sold an entire Honda Accord (granted it was used, but still, I got five grand for it) and basically smoked up the proceeds. I smoked and snorted the proceeds of a movie sale as well.

Pot smoking influenced my education, my social life, and my career choices. It never occurred to me that my troubles — the lack of a degree, the lack of a job, and a lengthening psychiatric history — might be traceable to the drugs I'd used, and was continuing to use. I went from Mensa member to dropout to mental patient to cab driver. I earned money, drove down to the Bronx, copped, and smoked pot, all without leaving the cab. Sometimes I was even tipped — not with cash, but with a joint.

Any connection between my deteriorating socio-economic condition and my near-constant use of drugs escaped me. There's nothing unusual about that; it's called denial. What's more notable is that a direct intervention to put a stop to the drug use didn't occur to the people who were treating me, either.

It's not like I ever made a secret of it. The very first time I was admitted to a locked, inpatient psychiatric unit, I smuggled in a chunk of hash that I smoked using an empty soda can as a pipe. When I left the unit on a pass, I came back with four joints stashed in my pack of cigarettes, which the staff found immediately (another patient having ratted on me for the hash) and then tossed my room looking for more. That was in 1979. In 1986, on what was by then maybe my fifth hospitalization, I went home on a pass and found a roach and smoked it, came back manic, and admitted what had happened, and for the rest of that stay I was given a drug test every time I came back from a pass.

You would think that somewhere along the line someone would have stamped my records POTHEAD and referred me for drug treatment. That's not the way it works. We have two distinct systems: one treats mental illness, the other treats substance abuse. Even though having a mental illness raises the chances that someone has a substance abuse disorder to roughly one in two, substance abuse treatment within the mental health system is grotesquely under-funded. Even though addiction is really just another mental illness, and many addicts have a number of co-occurring mental illnesses, mental health services within the substance abuse is just as inadequate.

It was Abraham Maslow (the same Maslow who postulated the "hierarchy of needs") who said, "If the only tool you have is a hammer, you tend to see every problem as a nail." Everyone in the mental health system saw my drug use as self-medicating, thinking that if my mental illness was under control I wouldn't need drugs. No one wanted to admit that the addiction was a distinct disease that needed to be treated. I have a friend who was in an IPRT (a type of vocational program) for two years and yet never got a job. He was smoking pot every day, they all knew it, they would say things like, "Gee, maybe you should cut back on that," but they never did anything about it. What is the point of spending two years giving someone vocational therapy if they're smoking pot?

I got lucky. Finally, someone did that for me. I was showing up to therapy stoned. After having spent over a decade in the mental health system, someone finally figured out that I had a drug problem and sent me for drug treatment. They told me if I didn't accept treatment for my addiction, I'd have to end my therapy, and by that point I was starting to figure out that I needed therapy if I was going to get a better job than driving a cab.

Drug treatment was a revelation. I was accustomed to the culture of mental health professionals: this is about you, not us, you are not us and we're not telling you anything about us. I used to go out to the parking lot of the outpatient clinic and try to find my therapist's car, just to see if I could learn anything: a bumper sticker, or maybe some CDs that might give me a clue as to who was treating me. Substance abuse treatment was a true peer service: most of the people working at the clinic I attended were addicts themselves and didn't care who knew it. They also made no secret of how tight-assed they thought some of those mental health people could be. Sometimes a staff member would hug a patient. There is no hugging on inpatient units; that can get you thrown into seclusion. These people weren't about seclusion. They were about fellowship.

Wow. After years spent feeling like a bug, like something to be studied, this was astonishing. Still, it took me a long time to "get it." Recovery is a complex, multi-dimensional process that involves other people; I wasn't much of a joiner, and I didn't trust other people. But being part of what was to me a radically new treatment milieu helped me to achieve a level of self-acceptance that had always eluded me in the mental health system.

What if I had fallen into substance abuse treatment first? Then my symptoms of depression and mania might easily have been labeled a consequence of the drug use and I could have suffered for years trying to white knuckle my way through mood swings.

Neither system really wants the responsibility of dealing with the whole person. I have a friend who is diagnosed with schizophrenia and is a big-time crack addict. Obtaining good treatment for the schizophrenia was hard enough; then he had a relapse and started using crack again. He couldn't find any substance abuse program that wasn't scared to death of schizophrenia. When he finally did, and successfully completed nine months of drug treatment, the mental health provider he had been seeing made it clear they didn't want him back: they were afraid to deal with someone who was addicted to cocaine.

It's a disgrace that people in need are bouncing between two systems, perhaps making progress in one while losing ground in the other. It's outrageous that the mental health field isn't paying more attention to addiction, and that the addiction field can't also find a way to tolerate the symptoms of mental illness. It's been said for twenty years: we need better integration of our mental health and substance abuse services. When will this message be heard?

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

The NYSPA Report

Warning Labels and Psychiatric Medications: Clarifying the Debate

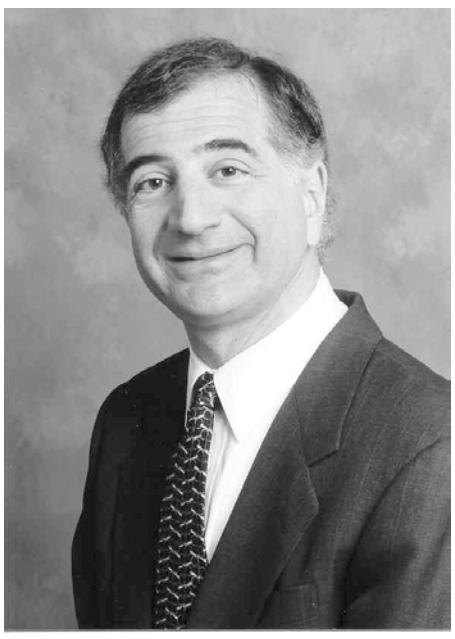
By Jack M. Gorman, MD
Esther and Joseph Klingenstein Professor and Chair
Department of Psychiatry and Professor of Neuroscience
Mount Sinai School of Medicine

Recently, the United States Food and Drug Administration (FDA) issued a "black box warning" for all antidepressants marketed in this country. The warning cautions that children and adolescents treated with these medications may experience an increase in self-destructive thinking. The new warning has left parents and clinicians wondering whether it is safe to prescribe antidepressants to children with mood or anxiety disorders.

Ever since fluoxetine (marketed as Prozac in the U.S. until it became a generic drug) was first approved in 1987, there have been intermittent alarms that Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants increase the risk for suicide. None of these claims has ever been substantiated by scientific evidence when adult patients are concerned. Moreover, there is some evidence that since the introduction of SSRIs, the suicide rate in Western countries has begun to decline, although cause and effect is difficult to conclude.

In pediatric patients, however, the scientific evidence does appear to suggest that antidepressants may increase the risk for suicidal thoughts. Analyses conducted by several manufacturers (of their own products), by the FDA, and by a group of investigators at Columbia University, found that about one in fifty (2%) of children and adolescents treated with antidepressants had increased thoughts of suicide or self-destructive behavior, a rate significantly higher than seen with placebo. Importantly, there have not been any actual suicides in any of these studies, and the rate of suicide attempts in this age group among depressed children who are not given treatment is higher than 2%. Still, there does appear to be some risk of developing aberrant behavior in the pediatric age group when treated with antidepressant drugs.

After two emotional public hearings in which parents grieving the loss of their children who committed suicide testified, the FDA ordered that labels for all antidepressants begin with a "black box" warning about the potential for suicide. Recently, I was asked at a conference about depression and anxiety disorders for primary care physicians if pediatricians should continue to prescribe antidepressants. My answer was as follows: every year we place children with diabetes mellitus on insulin. In a small number of cases, this results in severe and potentially life-threatening adverse reactions, including profound hypoglycemia and insulin shock. That never dissuades pediatricians from prescribing insulin; rather, it calls upon their expertise to monitor their patients carefully and intervene quickly in the case of impending complications. Every year, far more children die from suicide than diabetes mellitus; hence, the treatment of depression in children and adolescents is important, and antidepressant drugs are one of the tools we can use for that purpose. If a pediatrician feels comfortable monitoring a depressed child on antidepressant medication for potential adverse reactions, he or she should proceed, as would be the case in treating any medical condition. If not, then referral to a child psychiatrist might be indicated.



Jack M. Gorman, MD

Physicians and the public often do not realize that the FDA has jurisdiction only over drug companies; it has no authority to regulate medical practice. In New York State, that responsibility rests with the Department of Health, and, in some instances, the Department of Education — the latter because it issues medical licenses. Hence, the FDA only determines which drugs may be marketed in the United States, and what the companies may say about those drugs in advertisements and to physicians.

Hence, if the FDA has approved a drug for, say, the treatment of depression in adults, the company may not advertise the drug for any other purpose. The FDA has said publicly that it fully supports physicians who prescribe medications "off label" when that practice is supported by the evidence. Parents of children with depression and anxiety disorders need to trust the judgment of physicians about whether a drug is effective for a particular problem or age group — even if the official FDA label does not mention them specifically. The physician should weigh the scientific evidence about the drug and its safety based on reports in the scientific literature — they should not rely only by what is stated on the drug label.

As all physicians know, the "label" for each medication is published in the Physicians' Desk Reference (PDR), and includes a variety of information. Occasionally, the first section written about a drug is a boxed "warning," the so-called "black box" warning. This is intended to alert the physician to the particular drug that has been found to have a particular serious and adverse effect, usually one that is uncommon but potentially life-threatening (presumably, drugs with common life-threatening adverse effects are never approved by the FDA, and are withdrawn from the market once the problem is discovered). Pharmaceutical companies hate these warnings, because it affects some of the marketing strategies they are able to undertake (for example, direct-to-consumer advertising is not permitted). Furthermore, physicians become anxious when drugs get black box warnings, and this can have a profound influence on whether or not they prescribe a particular medication.

However, it is important to remember that a number of medications prescribed by psychiatrists have black box warnings. These include the antipsychotic medication thioridizine (marketed in the U.S.before it became generic as Mellaril), sodium valproate (marketed as Depakote) for acute mania, and lamotrigine (marketed in the U.S. as Lamictal) for bipolar disorder.

In the examples mentioned above, black box warnings have mainly served to alert physicians to potential serious adverse reactions of drugs that are generally felt to be important in the treatment of mental illness. Like all physicians, psychiatrists recognize that medications can pose risks; that is one of the most important things we are trained to be alert for, and to know how to evaluate and intervene. For doctors, they are part of the risk to benefit assessment we make every time we consider prescribing medication to a patient. Our work is enhanced by having the risk part clearly and emphatically spelled out so that we cannot miss it. A black box warning should never mean that a medication is dismissed from consideration. Rather, it means that physicians and their patients, including the parents of children who may need to take antidepressants, are placed on alert to watch for complications. □

THE MENTAL HEALTH LAWYER

What Are The Rights Of Parents To Make Healthcare Decisions For Their Children?

By Carolyn Reinach Wolf, Esq.

Carolyn Reinach Wolf, Esq.

The answer to this question may, at first glance, appear to be a simple one. Parents know their children best, and children are often too young and lack the maturity or intellectual capacity to make treatment decisions on their own. But with recent FDA warnings on antidepressants, new confidentiality regulations, and a host of other concerns, parents often have more questions than answers relating to what authority they have to consent to — or refuse treatment — for their minor children. The laws in New York, which outline the rights of parents to make medical and mental health care decisions for their children, are quite complicated. The following article is intended to provide an outline of the laws that govern parental health care decision making for their children. As always, one should consult a professional before taking any action.

Medical Treatment Generally

It is a well-established principle in our common law that a competent adult has a right to decline medical treatment, despite the fact that the treatment may be beneficial — or even necessary — to preserve the patient's life. The patient's right to determine the course of his or her own medical treatment is paramount to what might otherwise be the doctor's obligation to provide needed medical care. Accordingly, a violation of this right may result in civil liability for those who administer medical treatment without consent. In 1972, the New York State Legislature codified this common law principle as part of the Public Health Law. Public Health Law Section 2504 states that, "any person who is eighteen years of age or older, or is the parent of a child, or has married, may give effective consent for medical, dental, health and hospital services for himself or herself, and the consent of no other person shall be necessary."

Essentially, most minors are considered legally "incompetent" to make most health care decisions due to their age, and such decision-making authority vests in the parents. However, as provided in Section 2504 above, minors who are married, or who have children themselves, may make health care decisions for themselves. In some states, children — based upon their age, intellect and level of maturity — can be declared "mature minors" and thereby "competent" to make decisions. This mature minor doctrine in New York law does not have a very clear (or useful) definition.

The New York State legislature gave wide berth to parents to make health care decisions on behalf of their children, but did not intend for Public Health Law Section 2504 to be an absolute right, or all encompassing. For example, in 1981, the New York Court of Appeals held that a parent may not deprive their child of lifesaving treatment, even when the parent's decision is based on constitutional grounds, such as religious beliefs. The parent's right must yield to the state's interest in protecting those who are deemed incompetent. In ratifying certain provisions of the Family Court Act and correlative laws, the state legislature set out guidelines as to when the state, through the Family Court or Supreme Court, may intervene against the wishes of a parent on behalf of a child, so that the child's needs are properly met. This provision for substituted judgment is codified in the Family Court Act, Section 233, which provides "that whenever a child within the jurisdiction of the court appears to the court to be in need of medical, surgical, therapeutic, or hospital care or treatment, a suitable order may be made therefore."

Such state intervention on behalf of a minor is often referred to by the Latin phrase *parens patriae*. It is this *parens patriae* analysis that defines when parental decision making must yield to the judgment of the state. A classic example is the case of a child who may bleed to death because of the parents' refusal to authorize a blood transfusion because of the religious beliefs of the parents. Courts have held that the State's interest in protecting the minor's health and welfare outweigh the parents legitimate religious beliefs. By contrast, a New York court has allowed, under very limited circumstances, a parent to terminate artificial life support for a child living in a persistent vegetative state.

The courts have repeatedly highlighted the importance of parental involvement in making treatment choices and, it should be noted, that parents are not deprived of the right to choose amongst competing serious or life-saving treatments. Accordingly, parents are legally empowered to make treatment determinations, in light of their families' morals, social values and financial ability, to provide reasonable, safe and — if necessary — life-sustaining treatment for their children.

Apart from general medical decision making, parents are often faced with situations relating to emergency medical treatment, psychiatric treatment, and disclosure of medical information.

Emergency Medical Treatment

The provision of emergency medical services by a hospital does not require parental consent, or the consent of the child, where obtaining that consent would imperil the child. Stated differently, when a hospital provides emergency medical treatment to a minor, consent to that treatment from the child's parent is unnecessary.

Psychiatric Treatment: Voluntary Hospitalization

A child under the age of sixteen may not voluntarily consent to inpatient psychiatric hospitalization. The child can only be admitted upon application by a parent or guardian.

If the child is between the ages of sixteen and eighteen, the director of the facility may accept the minor's voluntary application, or that of a parent or guardian.

Involuntary Hospitalization

There are no age restrictions on the use of involuntary hospitalizations. The minor will be hospitalized if he or she meets the statutory criteria for involuntary hospitalization set forth by the Mental Hygiene Law. More pointedly, a minor will be involuntarily hospitalized if those statutory requirements are met, regardless of whether or not the parent or guardian consents.

Outpatient and Inpatient Treatment Within a Psychiatric Facility Where the Child is Consenting

The Mental Hygiene Law states that, in providing outpatient mental health services or anti-psychotic medications to a minor residing in a hospital, the important role of the parents or guardians shall be recognized. As clinically appropriate, steps must be taken to actively involve the parents or guardians, and the consent of such persons shall be required for such treatment in non-emergency situations, except as otherwise provided.

However, a mental health practitioner may provide outpatient mental health services or perform an initial interview with a minor voluntarily seeking such services without parental consent if the mental health practitioner determines that:

(1) the minor is knowingly and voluntarily seeking such services; and,

(2) provision of such services is clinically indicated and necessary to the minor's well-being; and,

see The Rights on page 20

The NARSAD Report

The National Alliance for Research on Schizophrenia and Depression

Multiple Diagnoses in Children: Understanding and Tackling Co-morbidity

By Constance E. Lieber, President NARSAD

Constance E. Lieber

Increasingly, it is recognized that many adults and children who suffer from a mental disorder also meet the criteria for an additional psychiatric diagnosis. "Comorbidity" — having two or more diagnosable conditions at the same time — compounds the torment of those with mental illness, and presents treatment challenges for the health care providers who serve them. The National Alliance for Research on Schizophrenia and Depression (NARSAD) researchers have been conducting investigations into various aspects of mental illness co-morbidity in children and adolescents. This work is expanding the knowledge base on the subject within the scientific community, and helping to pave the way for new clinical treatment approaches.

With national studies showing a shift to a younger age of onset for both depression and substance abuse among adolescents, D. Ping Wu, PhD, Columbia University (1998 Young Investigator), decided to try to better understand these changes by examining the relationship between depression and substance use and abuse in this population. His study had three aims: First, he wished to examine the relationship between various types of depression and different substances (cigarettes, alcohol, marijuana and other drugs). Second, he also wanted to conduct a "longitudinal" study (research which follows a group of subjects over an extended period of time — often several years) to examine the depression/substance abuse relationship over time. Third, Dr. Wu aimed to analyze gender differences as it relates to depression and substance abuse. The results of Dr. Wu's study reinforced that rates of alcohol use and abuse are significantly higher in depressed youth as compared with their non-depressed peers. His data further indicates that the co-morbidity between alcohol use and depression can be partly explained by shared risk factors. Finally, Dr. Wu uncovered substantial gender differences in this area. His findings suggest a significant link between alcohol use and depression among boys, while in girls there is a marked relationship between smoking and depression. Another researcher who studied co-morbidity in young people is D. Tova M. Ferro, PhD, Columbia University (1998 Young Investigator), in her work on understanding the co-occurrence of major depression and conduct disorder in children. Conduct disorder is characterized by a pattern of behaviors that violate the rights of others — including behaviors such as physical aggression, verbal abuse, and destruction of property. According to the National Institute of Mental Health (NIMH), this disorder is common among youths in juvenile detention and those who end up in the criminal justice system.

Bipolar disorder is a mental illness that causes unusual shifts in a person's mood, energy, and ability to function. Different from the normal ups and downs that everyone goes through, the symptoms of bipolar disorder are severe, and can result in damaged relationships, difficulty with day-to-day functioning, and poor job or school performance. Bipolar disorder occurs in about one percent of the population over 18. The condition typically develops in late adolescence or early adulthood; however, some people have their first symptoms during childhood, and some develop them late in life. Researcher Filoteia Simona Noaghuil, MD, Columbia University (2002 Young Investigator), is attempting to determine signs in pre-pubescent children that indicate a future susceptibility to developing bipolar disorder. She is doing this by conducting a follow-up study of adults who were diagnosed before puberty with either depression alone, or with a co-morbid combination of depression and another disorder (either attention hyperactivity disorder, conduct disorder, or psychotic depression), or who have a family history of bipolar disorder. It is Dr. Noaghuil's hypothesis that the rates of bipolar disorder will be highest in the children who suffered from one of these co-occurring conditions, or who had a family history of the illness.

Attention deficit hyperactivity disorder (ADHD) is a condition principally characterized by inattention, hyperactivity, and impulsivity. The disorder becomes apparent in some children in the early years of schooling, and it is one that makes it hard for these children to control their behavior and pay attention. It is estimated that between 3 and 5 percent of children have ADHD — or approximately 2 million children in the United States. Additionally, by adolescence, those with ADHD are 5.5 times likelier than the general population to suffer from depression as well. W. Burleson Daviss, MD, University of Pittsburgh (2002 Young Investigator), is involved in an ongoing study of potential risk factors for these conditions to co-occur. Dr. Daviss will also compare the symptoms and general impairment of a depressed group of ADHD patients with ADHD patients without depression. He theorizes that those adolescents suffering from both depression and ADHD will be significantly more impaired than those with only ADHD. He further suggests that the symptoms and severity of the two conditions will vary over time, independently of each other. Dr. Daviss' work should shed additional light on the course of illness for children with both conditions, and inform future treatment approaches.

Also studying co-morbid depression and ADHD in children is Aileen Oandasan, MD, University of Texas Medical Branch at Galveston (2003 Young Investigator), who is investigating the problem from a clinical perspective. Young people with both ADHD and depression may have more complicated and protracted courses of illness than those with only one condition, with impairment often persisting into adulthood. Furthermore, the course of each disorder is more severe — and response to treatment reduced — when this is the case. Dr. Oandasan is examining two ways of treating children suffering from both of these conditions. Typically, psychiatrists use either a combination of drugs that include a stimulant and an antidepressant (a two-drug approach), or buproprion monotherapy (a single-drug approach). In her ongoing study, Dr. Oandasan seeks to compare the two approaches and then determine which one is more effective in treating these children.

Mental illness in children and adolescents reduces young people's ability to maintain healthy relationships with family and friends, and to perform up to potential in school. When a psychiatric disorder is compounded by a secondary condition — very often depression — it makes the formative and teenage years that much more difficult. NARSAD is committed to supporting scientists who are studying co-occurring disorders in order to meaningfully aid the progress towards alleviating — and with hope, eventually curing — the suffering of these children.

NARSAD is the largest donor-supported organization in the world devoted exclusively to supporting scientific research on brain and behavior disorders. Since 1987, NARSAD has awarded $162.1 million in research grants to 1,902 scientists at 323 leading universities, institutions, and teaching hospitals in the United States, as well as in 22 other countries. By raising and distributing funds for research on psychiatric brain disorders, the pace has accelerated — resulting in greater knowledge of brain functioning, neurochemistry, new and improved treatments, and genetic origins.

Constance E. Lieber has served as President of NARSAD since 1989. □

NARSAD

Research Newsletter Winter 2004/05

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EDITORIAL:

The aim of the NARSAD Research Newsletter is to provide insight into the progress of NARSAD's research mission — better treatments and cures — to those of us who are not part of the professional neuroscience and psychiatric communities. This issue of the Research Newsletter covers an extraordinary range of developments in modern psychiatry and brain science.

Starting with our memorial tribute to the late Dr. Julius Axelrod and reaching to the extraordinary insights of our Young Investigators reporting at the 2004 symposium, this issue illustrates the remarkable history of mental health research over more than half a century and unveils its new potentials. The superbly clarifying talk on genetics by Dr. Wade Berrettini brings up-to-date information on the progress of genetics in brain science. The profile of Dr. Jeffrey Lieberman discusses major clinical trials aimed to provide definitive information on the effectiveness of antipsychotic medications and on treatments for cognitive impairment.

The report of the Gala Award Dinner highlights outstanding lifetime research achievements of scientific leaders in schizophrenia, affective disorders and child and adolescent psychiatry.

Our listing of Research Partners emphasizes the vital interest of NARSAD supporters in providing funding for those who are literally the best and the brightest in research related to psychiatric disorders.

Call 1-800-829-8289 to receive your free copy of the NARSAD Research Newsletter

NARSAD RESEARCH

60 Cutter Mill Road, Suite 404, Great Neck, NY 11021 • 800-829-8289 • (fax) 516-487-6930 • www.narsad.org

The NAMI-NYS Corner

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

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

J. David Seay, JD

Dual-diagnosis, or "co-occurring" disorders — mental illness co-diagnosed or co-occurring with some other diagnosis, such as addiction, mental retardation, or developmental disability — are of special concern to NAMI New York State. The national NAMI organization's Web site (www.nami.org) has a wealth of information on co-occurring disorders, and I will summarize some of it in this column.

Research shows that in order to really recover, a person with co-occurring disorders must be treated for both problems at the same time. It does not work to just focus on one at a time. "We'll fix the alcoholism, and then move on to the clinical depression." It just does not work that way, and yet our system of care often forces that approach. Dual diagnosis services are designed to integrate help for each condition, allowing people to recover from both in the same setting and at the same time.

Although better research is needed, the American Medical Association (AMA) believes that about half of individuals with serious mental illness are also affected by substance abuse or other addiction. Thirty-seven percent of alcohol abusers and 53% of drug abusers also have at least one serious mental illness. Of all people who are diagnosed as mentally ill, 29% abuse either alcohol or drugs.

The consequences are harsh for consumers. Persons with a co-occurring disorder have a greater propensity for violence, medication noncompliance, and failure to respond to treatment than do individuals with just one diagnosis. It also leads to overall poorer functioning and a greater risk of relapse. There is also the social "downward drift," whereby they find themselves living in bad neighborhoods, where substance abuse is common, and where they are less able to establish good interpersonal relationships with others. Persons with co-occurring disorders are also more likely to be arrested and sent to prison, or even to wind up homeless. Without the establishment of more integrated treatment programs, these cycles will surely continue.

In New York State, mental health and substance abuse services are handled by two separate state agencies. This was not always so. Some advocates have called for the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) to be re-merged back together in order to better address the problems of separate services. Others feel that creating larger bureaucracies is not the answer, and that there is no guarantee that a merger of these agencies would actually result in more integrated services "on the ground," where people get services. What *is* agreed upon is the need to take whatever actions are prudent to better integrate the mental health and addiction services where they are provided, whether or not the respective state offices are merged or remain separate. In either case, it presents a formidable challenge for state policy makers to do the right thing — and do the right thing they must; New Yorkers with co-occurring disorders deserve no less.

NAMI-New York State's 2005 Agenda for Action is out, and our Government Affairs Committee, ably co-chaired by Muriel Shepherd and Judith Beyer, is off and running to advocate for its key points The Agenda for Action for 2005 is: **"REACH FOR RESULTS."**

LEGISLATIVE PRIORITIES

KENDRA'S LAW

Kendra's Law (named after Kendra Webdale, a young woman who died in January, 1999 after being pushed in front of a New York City subway train by a person who failed to take the medication prescribed for his mental illness) for assisted outpatient treatment for seriously mentally ill New Yorkers must not be allowed to "sunset" on June 30th. Kendra's Law saves lives, avoids unnecessary hospitalizations, and promotes recovery from mental illness in the community. NAMI-NYS calls for Kendra's Law to be renewed and made permanent. Ask your legislators to preserve Kendra's Law. REACH FOR RESULTS: RENEW KENDRA'S LAW!

TIMOTHY'S LAW

Demand that comprehensive mental health parity legislation be enacted in New York. Pass "Timothy's Law," the bill named for 12-year-old Timothy O'Clair from Schenectady, who tragically completed suicide after his family's mental health benefits ran out. His courageous parents have come forward to tell their devastating story, convinced that Timothy would be alive today had New York's laws prohibited insurance discrimination against persons with mental illness. Urge the senate and assembly to settle their differences and reach an agreement on Timothy's Law now. REACH FOR RESULTS: PASS TIMOTHY'S LAW!

"BOOT THE SHU" LAW

NAMI-NYS calls for the passage of Assemblyman Aubrey's bill to ban the use of prison "special housing units" (SHUs) — the punitive 23-hour lockdowns also known as "the box" — for persons with mental illness. It is time to end this barbaric practice. Ask your assemblyman to vote again to "boot the SHU" and ask your senator to sponsor the bill in the senate. REACH FOR RESULTS: BOOT THE SHU!

HOUSING WAITING LIST LAW

No one will ever know the full extent of the need for community mental health housing (with services) without a waiting list. Ask your elected officials to pass a bill that requires a waiting list for community mental health housing. REACH FOR RESULTS: PASS A HOUSING WAITING LIST LAW!

BUDGET PRIORITIES

HOUSING

Increase the budget for housing — with services — for New Yorkers living with mental illness. Thousands are inappropriately placed in adult homes, jails, prisons, homeless shelters and nursing homes, while countless others live at home with aging parents who are terrified of what will happen to their mentally ill children when they can no longer care for them. Estimates show that 40,000 to 70,000 more housing units are needed. NAMI-NYS calls for a commitment for 4,000 new units a year, and a long-term plan for housing and services. REACH FOR RESULTS: FUND MORE HOUSING!

COMMUNITY SERVICES

Under the Personalized Recovery-Oriented Services (PROS) program, community "safety net" programs — such as small local clubhouses, drop-in centers, vocational programs and other "non-Medicaid" community mental health services — are in jeopardy. NAMI-NYS urges the state to fund these services. Intensive Case Management and Assertive Community Treatment teams must also be fully funded. REACH FOR RESULTS: FUND COMMUNITY SERVICES!

RESEARCH

Demand that New York State stop the efforts to slowly starve the research budget through staff cuts and attrition. Keep the world-class Nathan Kline Institute for Psychiatric Research and the New York State Psychiatric Institute intact and working toward cures for mental illness. Research is our hope for the future. REACH FOR RESULTS: FUND RESEARCH!

FAMILY HEALTH PLUS, MEDICAID SERVICES, AND ACCESS TO MEDICATIONS

Mental health benefits must NOT be removed from the Family Health Plus Program.

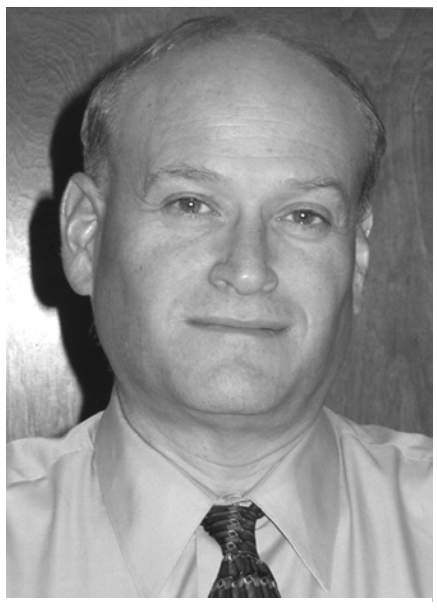
Efforts to restrict access to medications by a Preferred Drug List (PDL) and to eliminate "optional services" such as dental, nursing, podiatry, and psychological services must be stopped. For persons with serious mental illness, these are NOT optional. Restrictions to access for psychiatric medications under Medicaid must NOT be allowed. PDLs and other schemes to save money by blocking or slowing access are unacceptable. NAMI-NYS opposes any PDL. REACH FOR RESULTS: KEEP MENTAL HEALTH BENEFITS IN FAMILY HEALTH PLUS, PRESERVE MEDICAID SERVICES AND OPPOSE A PDL!

I invite everyone who reads this column to join with us in urging our state officials to "Reach for Results." It is within our grasp. □

A Mental Health News Personal Message: You May Sometimes Feel Like Giving Up Because You Are Feeling Hopeless Right Now. This Is Common During A Mental Illness. It Is Not Your Fault - It Is Your "Illness Talking." Call Your Treatment Professionals Today, And Tell Them You Need Extra Help. Don't Ever Give Up - This Crisis Will Pass. You Are Needed In This World !

The MHA-NYS Connection

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



Glenn Liebman

One of the rites of passage of mid-January in Albany is the submission of the Governor's Executive Budget Proposal to the legislature. After the governor introduces his budget proposal, everyone scrambles to interpret what the cuts or additions mean to their specific areas of interest, including those of us in mental health.

This year's budget was a mixed bag for many of the mental health advocates. Recognizing the state's multi-billion dollar budget deficit, our expectation was that there would be devastating cuts in mental health. Thankfully, this did not happen. There have been proposed cuts, but there have also been some additions as well. The most notable addition is the increase to the rate for supported housing in the downstate area — a very positive step for recipients that will hopefully translate into rental subsidies, which will make supported housing more affordable. One of the concerns we have about the budget, from our perspective, was the cut to local assistance — which will result in cuts to community mental health providers, including some mental health associations (MHA's). Last year, $7.7 million of local assistance funding was cut, leaving many community providers without the funding they needed to operate many critical programs. This year, there are additional proposed cuts of $3.9 million to local assistance. We have voiced our opposition and will work hard to restore these cuts

Another portion of the state budget that has a major impact to our community is the budget submitted by the Department of Health. The Medicaid dollars that many recipients rely on comes through the Department of Health budget. There have been major cuts proposed for Medicaid, including elimination of coverage for mental health services for individuals in Family Health Plus. In addition, there are proposed cuts to psychological services, dental services and podiatry services in institutional settings, such as hospitals and nursing homes.

One of the proposed remedies to the spiraling cost of Medicaid is the proposed establishment of a Preferred Drug Program (PDP). The PDP would implement a series of mechanisms designed to curtail the costs of prescription drugs by creating a list of preferred drugs that are only to be prescribed to Medicaid patients, unless the doctor obtains prior authorization to prescribe a medication not on the preferred list.

In this year's budget the governor, as he did over the past several years, has carved out atypical antipsychotics and anti-depressants from the restrictions of the PDP. This means that those medications would not be subject to the PDP, and would remain openly accessible to all Medicaid patients. This is a very positive step, which we support, but it does not go far enough to remove our serious concerns about the PDP.

Many individuals living with mental health needs also have co-occurring physical health needs. For years, recipients of mental health services, advocates, and clinicians have stressed that in order to achieve recovery, we must recognize the totality of the individual. It is not fair to create separate silos for mental health and for physical health. As former Surgeon General David Satcher stated, "there is no health without mental health." That is why a carve-out of these medications is only a partial solution. Side-effect medications for people with psychiatric disabilities must also be carved out to insure greater access and greater opportunity for recovery.

Another safeguard that many patient advocacy organizations have pushed for is a guarantee that physicians may override the PDP to get the medications they need for their patients. This would allow the doctor to have final say over what medication he or she is prescribing to their patient, based upon their best medical judgment. This judgment should not be made by committees formed to develop the PDP formulary — this decision should rest firmly in the hands of the individual's doctor, in consultation with the patient.

There are other ways to reduce Medicaid costs without the establishment of a PDP. There are individuals in Medicaid (just as in the private sector) that take a variety of medications, some of which may not be medically necessary for their overall health care needs. By reviewing Medicaid data and establishing a strong survey tool and assessment, the state can better review individual data and work with the advocates, clinicians, consumers and other stakeholders in the health care system to develop guidelines and protocols for medication management. With the inclusion of evidenced-based practices, strong consumer feedback and clinical judgment, this tool and assessment will help identify the mechanisms necessary to insure the individualized care needs of the patient without the arbitrary restriction imposed by a PDP.

To reach the Mental Health Association of New York State call (518) 434-0439 and you are invited to visit their website at www.mhanys.org. □

Finding Treatment For Co-Occurring Disorders

By Steven Bogen, MD
Phelps Memorial Hospital Center

It should come as no surprise that people can suffer from major psychiatric conditions — such as schizophrenia, bipolar disorder, depression, or panic disorder — and at the same time have addictions to drugs and alcohol. These conditions are relatively common, each affecting significant percentages of the population. Yet finding treatment for these patients has generally not been easy. For the purpose of this article, I will use the term "addiction" to refer to drug and/or alcohol addiction. I will use the term "psychiatric disorder" to refer to severe and long-lasting conditions, such as mood disorders, schizophrenia, severe personality disorders, anxiety disorders, etc., and will refer to addiction separately, although addiction is certainly a real and very significant psychiatric condition. I will use the term "co-occurring disorders" or "dual diagnosis" when referring to people who have both types of conditions, occurring either simultaneously or in an overlapping fashion.

Addiction and psychiatric disorders are each common conditions, but how commonly do they occur in the same person? One of the most comprehensive studies to address the question was the Epidemiological Catchment Area study in1984, which was designed to determine the lifetime prevalence of many prominent psychiatric and addictive disorders. The study found that the likelihood of an alcoholic having a major depression is 1.7 times greater than for non-alcoholics. For women there was an even greater co-occurrence: 19% of female alcoholics had also been diagnosed with depression versus 7% of women in the general population. Of course, these findings do not address the question of whether depression led to alcoholism, if alcoholism led to depression, or if independent factors led to both. It is certain that many people will be dealing with both problems at some point in their lives, if not simultaneously.

Obviously, these conditions cause a great deal of distress, dysfunction, and danger, and professional treatment for these disorders is extremely important. Historically, treatment of addiction and psychiatric disorders were provided separately. Treatments were developed in parallel to each other. Patients would be told to come back for psychiatric treatment after being abstinent from alcohol or drugs for six months. People attending Alcoholics Anonymous meetings would be told that taking antidepressants or any "psychotropic" medication was not "real" sobriety. Patients would enter psychoanalysis for years and their drinking or drugging would be ignored, treated as a "symptom" that would go away after their inner conflicts were resolved. We still have separate licensing of programs under the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and its Office of Mental Health (OMH).

Steven Bogen, MD

The separation of treatments probably stems from the wish that addiction and psychiatric disorders be separate. Making a psychiatric diagnosis of a patient with an addiction problem is, in fact, more difficult. Excessive and frequent alcohol and drug use cause symptoms that can mimic all major psychiatric syndromes. Unfortunately, for dual diagnosis patients, ignoring or postponing treatment one of the two disorders is a recipe for failure.

If addictive disorders can cause the same sort of psychiatric symptoms, how can co-occurring disorders be reliably diagnosed? Good diagnosis begins with a careful history. In addition to inquiring of the patient, external sources often can be crucial, albeit more time-consuming, to elicit both the psychiatric and addiction history. Of particular attention is whether the psychiatric symptoms preceded the substance use and whether psychiatric symptoms have occurred during periods of abstinence. If a person goes into depression only during or immediately after bouts of drinking, and feels okay when he sobers up, we might classify this mainly as an addiction problem. It would require addiction treatment, but not psychiatric treatment such as antidepressants. Careful diagnosis can spare the patient from unnecessary medication. Other important features in making a proper diagnosis include family psychiatric history, history of past psychiatric treatments, and direct observation of the patient. For diagnostic purposes, inpatient treatment provides the advantage of (hopefully) observing the patient while abstinent from substance use, while outpatient treatment offers the advantage of (hopefully) observing the patient over a longer period of time.

Many forces have put pressure on mental health providers to treat more patients more rapidly. Professionals may have more expertise in psychiatric disorders than addiction, or vice versa. With co-occurring disorders, a patient's health is only as strong as the weakest link. When the treatment focuses on only one of the two disorders, negative outcomes can occur:

A young professional woman was seen for psychiatric consultation. The psychiatrist evaluated her history of problems with her moods, irritability, and impulsive behavior. She was under the influence of drugs at the time of the evaluation. She was diagnosed as having a mood disorder. Her enduring history of cocaine, pills and alcohol was not addressed in the assessment or the plan. She was provided with prescriptions and samples of several medications. She promptly took the entire supply of medications with the hope of getting "high" on them.

A young man who had a history of binge use with cocaine and ecstasy, plus schizoaffective disorder, was referred by his psychiatrist for residential treatment. The patient overheard comments about the program. and perceived that the treatment would focus only on his substance abuse and not his psychiatric illness. He quickly became distraught and felt that his situation was hopeless. He began to save his pills with a plan to kill himself. He did not discuss this with the staff as he thought it would be of no use, assuming they did not understand his mental illness.

Clearly, each condition has a direct effect on the other and its treatment. Umbrellas are good when it's raining but not when it's also windy. If there's also lightning, an umbrella can lead to disastrous results. Good treatment involves a thorough view of the problems and a thorough plan.

Dr. Steven Bogen is the Program Director of the Phelps Memorial Hospital Center Behavioral Rehabilitation Unit, a 21-day rehabilitation program for dually-diagnosed patients. □

You are Not Alone...
The Mental Health Community
Has Programs and Services To Help You
Through Difficult Times

The Rights from page 13

(3) (i) a parent or guardian is not reasonably available; or, (ii) requiring parental or guardian consent or involvement would have a detrimental effect on the course of outpatient treatment; or, (iii) a parent or guardian has refused to give such consent and a physician determines that treatment is necessary and in the best interests of the minor.

Once the three criteria set forth above are met, a mental health physician can provide outpatient services to a minor, or can administer antipsychotic medications to a minor who is an inpatient in a hospital, without the parent's consent.

A minor child sixteen years of age or older, who consents, may be administered antipsychotic medications without the consent of a parent or guardian, or the authorization of a court, where:

(i) a parent or guardian is not reasonably available, provided the treating physician determines that: (a) the minor has capacity; and, (b) such medications are in the minor's best interests; or,

(ii) requiring consent of a parent or guardian would have a detrimental effect on the minor, provided the treating physician and a second physician, who specializes in psychiatry and who is not an employee of the hospital, determine that: (a) such detrimental effect would occur; (b) the minor has capacity; and, (c) such medications are in the minor's best interests; or,

(iii) the parent or guardian has refused to give such consent, provided the treating physician and a second physician, who specializes in psychiatry and who is not an employee of the hospital, determine that: (a) the minor has capacity; and, (b) such medications are in the minor's best interests. Notice of the decision to administer antipsychotic medication pursuant to this subparagraph shall be provided to the parent or guardian.

Thus, a consenting minor over 16 years of age does not need parental consent or a court's permission in order to receive antipsychotic medication when the above-mentioned requirements are met.

Treatment With Antipsychotic Medications Where the Child is Not Consenting

A minor patient who objects to any invasive medical treatment or procedure may not be treated over their objection except as defined below. It is worthwhile for a parent to review the following relevant portions of the New York Code, Rules and Regulations:

(1) Emergency treatment. Facilities may give treatment, except electroconvulsive therapy, to any inpatient (including minors), regardless of admission status or objection, where the patient is presently dangerous and the proposed treatment is the most appropriate reasonably available means of reducing that dangerousness. Such treatment may continue only as long as necessary to prevent dangerous behavior.

(2) Minors. (i) Except as provided in subparagraph (ii) of this paragraph, a patient who is a minor may be provided treatment over his or her objection if the patient's parent, legal guardian, or other legally authorized representative has consented to the treatment, and the treatment is not one for which the consent of a minor would be legally sufficient. (iii) If an individual, who is a minor and is a patient in a state-operated psychiatric center, (or a facility licensed by the Office of Mental Health) objects to psychotropic medication, to which his or her parent, legal guardian or other legally authorized representative has consented, such medication shall not be administered, pending the completion of a hospital review process, which shall be fully documented in the patient's medical record.

Medical Records - Consent for Release

Generally, a parent may consent to the disclosure of protected health information for a child if the child fits the definition of a minor as stated above. This disclosure may be made regardless of the consent of the minor.

Conclusion

Medical decisions are often difficult to make, and in most circumstances, a parent is best-suited to determine what is in their child's best interests. Hopefully, this review of the applicable laws will help to clarify parental consent issues as they apply to medical and/or psychiatric treatment of minors. □

Heroic Path from page 1

back, as well. I left school feeling like a failure, and the thought of drinking came back to me."

Experience, combined with her own innate strength, taught her that falling back on her addiction wasn't the answer. "So I fought it, and I didn't drink. I didn't want to go down that road again." She realized that she needed to address both issues simultaneously if she really wanted to get well. "I sought hospitalization, received outpatient care for my depression, and resumed AA meetings."

It was in a group setting where Lucee learned that she was not alone in her battle against what members of the community call co-occurring disorders — or MICA. "The groups that I attend give me a community of people to turn to when I am feeling isolated and want to drink. Even though my mental stability was off and on, I was able to continue with meetings and my therapy as well. Having resources for support in the community is vital to recovery."

NAMI-NYC Metro has long recognized the need for MICA groups. On Wednesday, January 26, 2005, NAMI launched a new support group to address the needs of dually diagnosed consumers. This Co-occurring Illness Support Group is an integrative model for individuals diagnosed with both psychiatric and addictive (drug and alcohol substance related) disorders. The two facilitators of the group, Shirlee Cohen, NP, and Patricia Maher-Brisen, APRN, BC, strongly believe from their experiences that *both* of these illnesses must be addressed equally if a person is to recover.

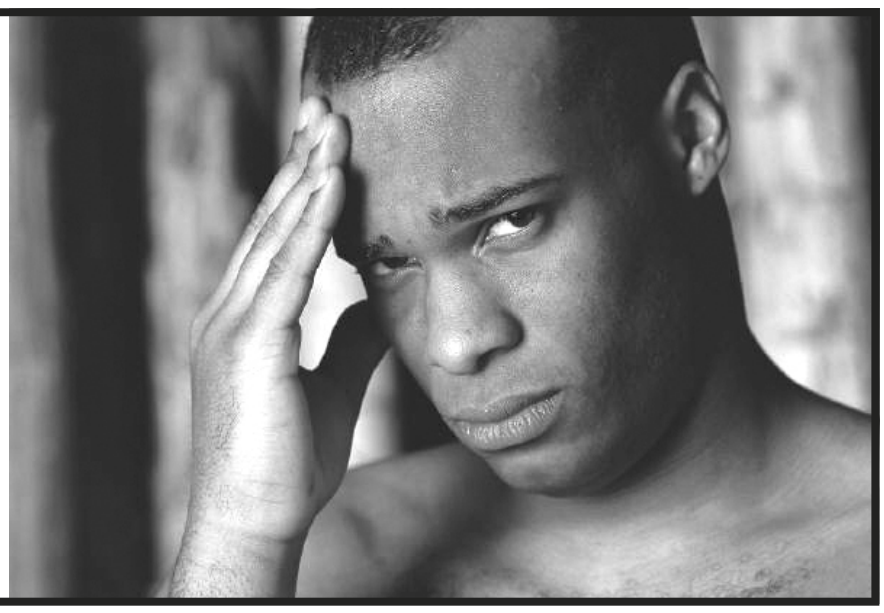
"On February 4th, 2005, I celebrated 25 years of sobriety and two years of stability with my mental illness," says Lucee. "Now I know I can continue my life and accomplish whatever I choose."

The NAMI-NYC Metro Co-occurring Illness Support Group will continue to be held on the fourth Wednesday of each month from 6 PM to 7:30 PM at the NAMI-NYC Metro Office. We are very excited about this new group, and we welcome all interested individuals. Please call the Helpline at 212-684-3264 to get on the participant list, and for any additional information. □

Study from page 8

- Service providers must better recognize the presence of trauma, past and present, as a central concern in a woman's life.
- Women should be encouraged to play an active role in their healing process, and provided with a better understanding of how to do so from the onset.
- There must be a more widespread and comprehensive recognition that violence and trauma significantly impact a person's belief system, self-perception and relationships with others.
- Providers need to meet women where they "are" mentally and emotionally, with careful readiness assessments, pacing and patience.

The WDCVS, as well as TIP #25, call on policymakers and service providers to collaborate and coordinate services in order to improve care for women with co-occurring disorders and trauma. □



Hardwired To Connect: Nurturing "Authoritative Communities" And Lessening Anger In Our Youth

By Robert Brooks, PhD

A thought-provoking report was released several months ago titled, "Hardwired to Connect: The New Scientific Case for Authoritative Communities." The report, which was prepared by the Commission on Children at Risk, a group comprised of 33 prominent children's doctors, researchers, and mental health and youth service providers, details the deteriorating mental and behavioral health of children in the United States.

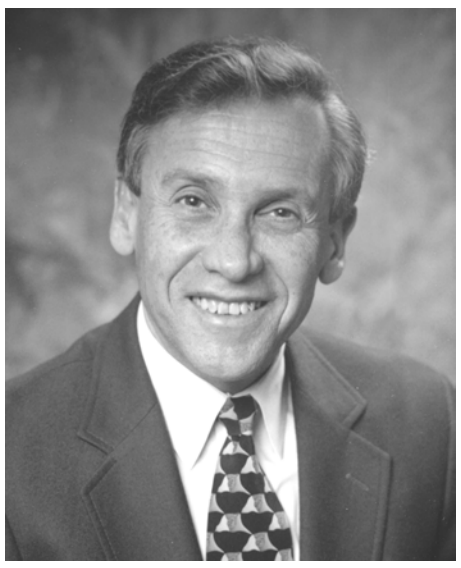
The commission contends, "In large measure, what's causing the crisis of American childhood is a lack of connectedness. We mean two kinds of connectedness — close connections to other people, and deep connections to moral and spiritual meaning." The commission observes that while research from the fields of neuroscience and basic biology indicate that children are "hardwired to connect" to other people and for moral meaning in their lives, "in recent decades, the U.S. social institutions that foster these two forms of connectedness for children have gotten significantly weaker."

As an antidote to this lack of connectedness, the commission advocates the creation of "authoritative communities." They explain their use of the word "authoritative" by noting, "First, the word refers to a strong body of scholarly evidence demonstrating the value of that particular combination of warmth and structure in which children in a democratic society appear most likely to thrive. Second, the word comes from the Latin auctor, which can mean 'one who creates.' We like that. Authoritative communities just don't happen. They are created and sustained by dedicated individuals with a shared vision of building a good life for the next generation."

The commission lists the following 10 main characteristics of an authoritative community:

1. It is a social institution that includes children and youth.
2. It treats children as ends in themselves.
3. It is warm and nurturing.
4. It establishes clear limits and expectations.
5. The core of its work is performed largely by non-specialists.
6. It is multi-generational.
7. It has a long-term focus.
8. It reflects and transmits a shared understanding of what it means to be a good person.
9. It encourages spiritual and religious development.
10. It is philosophically oriented to the equal dignity of all persons and to the principle of love of neighbor.

This list requires more than just a perfunctory reading. I believe we should carefully consider each point and ask, "In what way do I foster the qualities of an authoritative community within my family, my neighborhood, my place of work?" An awareness of the 10 characteristics can guide our individual behaviors as we assume responsibility for ensuring that our children thrive emotionally, physically, and spiritually — and that we lessen the alienation and violence that is prevalent in so many youth. All too often as a society, we have focused on dealing with children's problems once they appear, rather than



Robert Brooks, PhD

on preventing problems from emerging. It makes more sense to adopt a crisis prevention rather than a crisis intervention approach in the upbringing of our youth, guided by the goal of creating environments in which children feel secure and connected, and in which they learn to be compassionate, caring individuals.

Each of us can contribute to the realization of this goal. Each contribution, regardless of how large or small, builds upon the foundation and structure of an authoritative community. There are many ways in which parents and other adults can help to construct such a community. What follows are several suggestions, which I hope will prompt you to consider other possible avenues for realizing an authoritative community.

I should first like to consider the role of parents. Almost all parents recognize the value of developing warm, comfortable, and secure relationships with their children, but various external pressures and challenges can serve as obstacles in achieving this task. For example, there are a large number of children being raised in single-parent homes in which the parent receives little, if any, support, and is overwhelmed by a myriad of demands that lessen her or his effectiveness as a parent. Of course, such stress is not unique to the single parent. During the past couple of decades, dual-parent households have witnessed an increase in both parents working. Juggling work schedules with parenting demands has resulted in many stressed-out parents who feel they are on a nonstop treadmill going around in circles. As one father said, "I want to spend time with my children. I know I should spend time with them, but with all of my responsibilities at work, I seem to be spending less and less time with them." A mother lamented, "I have some flexibility in my work schedule, but even with that flexibility I feel like I am constantly driving my kids from one activity to the next. I think I spend more time with my kids in the car than anywhere else. That would be okay if I was relaxed in the car, but I'm not, since I'm always rushing and worried that I won't get my kids to where they should be on time."

As a parent and as a therapist, I certainly recognize and appreciate the stresses of parenting in today's world. I can understand the parent who says, "I know I should limit the number of hours my children watch television or play video games, but at least it keeps them occupied while I'm catching up with other things." However, while I can empathize with these sentiments, I believe we must strive to build into our daily routine opportunities to truly connect with our children without the presence of countless distractions. Not only will our children benefit from our undivided attention and love, but it has been my experience that our own emotional health will be enhanced as we engage in activities that bring meaning and purpose to our lives as parents.

see Our Youth on page 24

FOUR WINDS HOSPITAL

APRIL

GRAND ROUNDS

Friday, April 15th • 9:30 - 11:00 am

Suicide Prevention

Sharon E. Carpinello, R.N., Ph.D., Commissioner,
New York State Office of Mental Health

Suicide is consistently the leading cause of violent death in New York, the United States, and the world. Lives lost in New York to suicide (1,292 in 2002) exceed the number of homicides by 25%. This presentation will enable participants to:

- Learn about identification of suicide prevention action steps related to improving access to mental health care and services, including identifying persons at risk, restricting access to means of self-harm and saving lives through research.
- Understand the challenge of suicide prevention across multiple populations, as well as identification of early intervention and screening across multiple systems.

Fee: $15.^{00}$ payable to Four Winds Hospital

1.5 CME Credits Available

SPECIAL TRAINING

Thursday, April 21st • 9:30 am - 12:00 pm

Child Abuse Identification and Reporting

Valerie Saltz, L.C.S.W., Four Winds Hospital

New York State recognizes certain professionals to be specially equipped to hold the important role of mandated reporter of child abuse or maltreatment. These include any child care worker, school officials, doctors, nurses, dentists, podiatrists, EMT's, etc. A State Education Department certificate of completion will be given at the end of the class.

Fee: $45.^{00}$ payable to the Four Winds Foundation, a not-for-profit organization

Save the Date!

Nursing Career Day

Tuesday, April 26 • 4:00 - 7:00 pm

Experience Four Winds firsthand during this informal event.

Join a team that uses a multi-disciplinary approach to treatment.

Your Voice Will Make a Difference!

Refreshments, Tours, an Opportunity to Meet with Nursing Leadership

Competitive Salaries/Benefits

RSVP by April 19th at
1-800-546-1754 ext. 2413

APRIL

GRAND ROUNDS

Friday, April 29th • 9:30 - 11:00 am

Music and the Mind: Beethoven

Richard Kogan, M.D., Director of the Human Sexuality Program, Weill-Cornell Medical Center and New York Presbyterian Hospital

After Beethoven became deaf, catastrophic for anyone but particularly for a musician, he contemplated suicide. Dr. Kogan, a psychiatrist and virtuoso pianist, will offer a lecture/performance demonstration of this great composer, and will explain that Beethoven decided to devote himself to furthering his artistic expression and actually incorporated his suffering in to his music. The ninth symphony, which speaks to us all, was written while he was deaf. At the conclusion of this program, participants should:

- Recognize the psychological factors that influenced Beethoven's artistic development.
- Understand some of the fundamental concepts about creativity.
- Gain a better understanding of the impact of catastrophic illness on the psyche.

Fee: $35.^{00}$ payable to the Four Winds Foundation, a not-for-profit organization

1.5 CME Credits Available

MAY

May is Mental Health Month

A COMMUNITY SERVICE

Thursday, May 5, 2005 • 2:00 - 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.

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

Free of Charge • Open to the Public

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

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

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

Community and Professional Education Programs

MAY

GRAND ROUNDS

Friday, May 6th • 9:30 - 11:00 am

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

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

Frustrated by the challenges of helping defiant, oppositional, aggressive children? Dr. Crenshaw shares his successful techniques developed during more than 30 years as a clinical child psychologist. At the conclusion of this program, participants will:

- Learn at least two specific techniques relative to anger modulation.
- Learn at least two specific techniques to utilize when teaching the language of feelings.
- Learn at least two specific techniques that will enable participants to access the inner world of the child.

Fee: $15.^{00}$ payable to Four Winds Hospital

1.5 CME Credits Available

GRAND ROUNDS

Friday, May 13th • 9:30 - 11:00 am

The Time to Act is Now! Meeting the Mental Health Needs of Older Adults

The Werner and Elaine Dannheisser Memorial Lecture Series

Michael B. Friedman, LMSW, Chairman of the Geriatric Mental Health Alliance of New York, and Director, The Center for Policy and Advocacy of The Mental Health Associations of New York City and Westchester

The current mental health system does not serve older adults with mental health disorders adequately and there has been no preparation for the "elder boom" when the population of older adults with mental disorder doubles. Mr. Friedman will assist attendees to understand:

- Demographic trends.
- The prevalence and nature of mental illness among older adults currently, and what to expect over the next 25 years.
- Key policy changes needed to shape the current system to be responsive to the needs of older adults.

Fee: $20.^{00}$ payable to the Four Winds Foundation, a not-for-profit organization

1.5 CME Credits Available

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

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

Registration is Required for All Programs.

Please Call 1-800-546-1754 ext. 2413.

MAY

GRAND ROUNDS

Friday, May 20th • 9:30 - 11:00 am

Resiliency-Focused Therapy

David Drassner, Ph.D., Psychologist/Consultant-Independent Practice, Rockland County; President, Rockland Resiliency Institute; Adjunct Assistant Professor, Teachers College, Columbia University Department of Counseling and Clinical Psychology

This presentation will introduce a strengths-based model for therapy, prevention, and consultation. Narrative approaches that instill hope and precipitate positive change will be reviewed. Participants will enhance skills in such areas as resiliency-focused interviewing, developing therapeutic questions, and collaborating with ancillary family, agency, and collegial support systems. Participants will:

- Enhance their knowledge of resiliency research and implications for psychotherapy.
- Identify and utilize interpersonal and environmental contextual factors that amplify positive therapeutic growth and change.
- Expand their skills in applying therapy and counseling techniques and strategies that amplify client hope, initiative and resiliency.

Fee: $15.^{00}$ payable to Four Winds Hospital

1.5 CME Credits Available

Save The Dates!

8th Annual Chamber Music Series to Support The Counseling Center

February 20, 2005 • 2:30 pm

Performing pieces by Dvorak, Bruch, Piazzola, and Fauré

(This performance is dedicated in memory of John B. Segal)

- Abraham Appleman, violin - Metropolitan Opera Orchestra
- Ronald Arron, viola - Metropolitan Opera Orchestra
- Edward Arron, cello - Artistic Director Metropolitan Museum Artists Concert Series
- Jeewon Park, piano - Concert Pianist

March 13, 2005 • 2:30 pm

Performing pieces by Beethoven, Bruckner and Dvorak

- David Chan, violin, Concertmaster - Metropolitan Opera Orchestra
- Nancy Wu, violin - Assistant Concertmaster, Metropolitan Opera Orchestra
- Michael Ouzounian, viola - Metropolitan Opera Orchestra
- Ronald Arron, viola - Metropolitan Opera Orchestra
- Edward Arron, cello - Artistic Director Metropolitan Museum Artists Concert Series

April 14, 2005 • 2:30 pm

Performing pieces by Debussy, Beethoven, Schubert and Brahms

- Korliss Uecker, soprano - Metropolitan Opera
- Anthony McGill, clarinet - Metropolitan Opera Orchestra
- Jerry Grossman, cello - Metropolitan Opera Orchestra
- Bernard Rose, piano - Concert Pianist

All performances held at Christ Church, 17 Sagamore Rd., Bronxville, NY

Ticket Price: $20.^{00}$ per concert; $10.^{00}$ seniors and students

For complete details call:
The Counseling Center • Bronxville, NY
1-914-793-3388

Tsunami Relief Fund

The employees of Four Winds Hospitals, in Westchester and Saratoga are committed to serving children in need, both locally, and globally. Saddened by the plight of the children left behind without families, shelter and food, Four Winds held a fundraiser assisting the relief effort of the Save The Children Tsunami Relief Fund. Employees contributed $8,250 and the hospitals have matched the employee contributions. Together, the administration and staff of Four Winds were pleased to donate $16,500 to assist in the Tsunami Relief effort in Southeast Asia.

Our Youth from page 21

In "Raising Resilient Children," the book I co-authored with my colleague, Dr. Sam Goldstein, we recommend several steps for nurturing connections with our children and helping them to feel acceptance and unconditional love. For example, we advocate setting aside times each day, week, or month that are designated as "special." When we actually use the term "special," we express to our children that we value them and that we enjoy having uninterrupted time with them. Obviously, these prearranged times should not preclude having other spontaneous moments, in which they have our undivided attention. However, time set aside each week for all of our children together, as well as each child alone, emphasizes their significance to us, and that we love them.

When children are young, parents can say to the child, "When I read to you, when I play with you, it is such an important, special time that even if the phone rings, I won't answer it." One six-year old in my practice reported with excitement and joy, "I know my parents love me." When I asked how he knew, he answered, "When they read to me and the phone rings, they let the answering machine answer it." As I have often noted, sometimes the simplest gestures bring far-reaching results.

These special individual times should continue into the adolescent years of our children. We must remember that even as our teenagers appear to be pushing us away with one arm, the other arm is often holding us near. There are countless opportunities to spend time with our adolescent, whether going to a sporting event, going out for dinner, cooking a meal together, playing a video game (better to join certain activities than to fight them), or being involved with a cause that holds special interest for our teenager. I recall one father's relationship with his teenage daughter improving significantly when he collaborated with her in her efforts to have a traffic light placed at a dangerous intersection in their town.

Connections with our children are nurtured through family traditions we create. Hectic schedules should not deter parents from involving their children in activities, such as holding a family meeting each week to discuss "family matters" and to consider if any changes are necessary in family life, or volunteering as a family to work for a charity, or establishing a weekly meal during which family members voice positive comments about, and appreciation for, each other. I worked with several families who initially were skeptical about such an activity, believing it was very contrived; they were pleasantly surprised to discover that even if contrived at first, they soon enjoyed hearing more positive comments from each other.

There are many opportunities for adults, whether they are parents or not, to support the existence of an authoritative community beyond the boundaries of one's family. To do so, we must subscribe to the belief that each child is our "own" child, that each child is part of "our" community. There is ample research to demonstrate that the presence of even one caring adult in a child's life can foster hope and resilience in that child and diminish the likelihood of violent behavior, drug use, or dropping out of school. One must never underestimate the power of one adult to change the course of a child's life forever.

There is an urgent need for adults of all ages to serve as mentors for children, especially those youngsters who have limited experience with caring adults who can help them to develop compassion, responsibility, self-esteem, and self-discipline. Numerous organizations, such as Big Brothers and Big Sisters, as well as church-sponsored groups, are in existence to bring adults in contact with children in need. Youth sports is another avenue through which children can connect with adults, and in the process learn the importance of teamwork, fun, perseverance and, very importantly, how to lose and win with grace and dignity. However, without adults who are willing to donate their time as coaches, youth sports cannot exist. Adults can also tutor children and reinforce their strengths or "islands of competence" in areas such as music or art.

The specific activity with a child is less important than the development of a child's relationship with an adult who appreciates the features of a community in which children are nurtured and valued. In this regard, we should keep in mind a key recommendation offered in "Hardwired to Connect," namely, "that all adults examine the degree to which they are positively influencing the lives of children through participating in authoritative communities, and, where possible, to do a better job." Many other recommendations and suggestions may be found in this report.

As you consider the ways in which you can impact positively on the lives of youth in your community, and help to lessen anger and violence, you may wish to reflect upon the words of Hillel, the Hebrew scholar who lived in the first century:

"If I am not for myself, then who will be for me?

And if I am only for myself, then what am I?

And if not now, when?"

Robert Brooks, PhD, is one of today's leading speakers on the themes of resilience, self-esteem, motivation and family relationships. Visit his Web site at: www.drrobertbrooks.com for more information on his writings, published books, area speeches, and how to contact him. □

MHA Of Westchester's Steps Toward Integrated Substance Abuse And Mental Health Treatment

Staff Writer
Mental Health News

The Mental Health Association of Westchester County, Inc. (MHA), in conjunction with the Department of Community Mental Health, other mental health programs and the Office of Mental Health (OMH), is piloting the use of the Dartmouth Assessment of Lifestyle Instrument (DALI), developed by Rosenberg, et.al. (1998), a NYS validated instrument that helps clinicians identify substance use/abuse in individuals presenting for mental health services.

Research has demonstrated that integrated treatment approaches are essential to the success of services provided to individuals with Co-Occurring Disorders. MHA is committed to providing Evidence Based and Best Practice Treatment Interventions. The above initiative is in response to the growing number of Dually Diagnosed individuals requesting treatment and the high correlation between substance use and mental illness. Outcomes from this pilot project will be utilized to strengthen client service-planning agency wide.

As part of MHA's community education program and dedication to fostering professional development, we sponsored a community-based conference in 2004 on integrated treatment of the Dually Diagnosed. MHA's Co-Occurring Disorders Track will provide integrated services and continue to foster heightened awareness, community education, and increase the availability of quality services for individuals who are dually diagnosed.

Additional information about MHA and trainings/initiatives is available on our website (www.mhawestchester.org). □

Westchester County DCMH Helps Individuals With Co-Occurring Disorders

Staff Writer
Mental Health News

In 2002 Westchester County's Department of Community Mental Health received a grant from the New York State Office of Mental Health and the New York State Office of Alcoholism and Substance Abuse Services to develop a system of care that would address the needs of adults with co-occurring mental health and substance abuse disorders. The County hired Kathy Pokoik, who has a Masters degree in Public Health and is a CASAC to be Westchester's Dual Recovery Coordinator. Kathy came to the County with sixteen years of experience in both systems to take on this important role.

Prior to the creation of this position it was difficult for an individual with a mental health problem and a substance abuse disorder to obtain proper treatment According the latest research cited in *Integrated Treatment for Dual Disorders*, it is estimated that 40-60% of individuals suffering from a mental health problems also have a simultaneous addiction disorder, so the challenge is considerable.

In the past there had been attempts to pull together the two treatment systems to develop a more cohesive approach. Some believed that abstinence was the only way to be enrolled in programs which included abstinence to psychotropic medication which did not support persons in the mental health system. Mental Health practitioners supported the Harm Reduction Model, which Substance Abuse professionals felt was not the answer. The differing treatment philosophies created further barriers and ultimately delayed an individual from getting help. Often individuals were referred back and forth between the teo systems until they dropped out of treatment in frustration.

Providers knew that problems existed, but did not have adequate time to look at creating a different system of care, or possess adequate funding to train their staff. The grant money provided all of these opportunities with the creation of this new role.

Kathy's initial task was to create networks in each of the geographic regions, bringing together providers from both the mental health and OASAS systems to discuss ways to improve services. "No wrong door" was the new philosophy embraced by both systems. Kathy also assembled an Advisory Board comprised of leaders in the mental health and substance abuse fields to help inform the department as to what was needed to move the process along.

In 2003, she was a successful in helping the networks cut down many barriers to care, as well as bringing in experts in the field to provide excellent training opportunities. She also provided 63 individuals with case coordination services through our department, bringing together many different service systems to provide individuals at high risk with a much better outcome.

Kathy Pokoik

During 2004, the emphasis was to continue network development, to create a more competent workforce through trainings and consultations, and to promote the use of screening tools for mental illness and substance abuse.

As 2004 drew to an end, DCMH was already working with the Office of Mental Health to field-test the DALI, a screening tool to be used in mental health programs to identify substance abuse disorders. Four agencies are in the process of piloting the DALI,: MHA/Westchester, St. Vincent's Medical Center, the Yonkers and Peekskill Community Service Centers of DCMH and Rockland Psychiatric Center/White Plains The M.I.N.I., a screening tool a for substance abuse programs to identify individuals with mental illness, has already been piloted at St. John's Riverside.

DCMH received an award from the National Association of Counties (NACo) in 2004 for the Dual Recovery Initiative in recognition of innovative programming.

The Department under Commissioner Jennifer Schaffer's, Ph.D. leadership looks forward to improving this system further in 2005.

If you or any member of your family need Kathy Pokoik's help, or you would like to attend network or training meetings, please don't hesitate to call. She can be reached at (914) 995-2703 or e-mail at kdp1@westchestergov.com □

Association Of
Behavioral Healthcare Management
New York Chapter

One Day Conference

BEHAVIORAL HEALTH MANAGEMENT INSTITUTE

July 29, 2005

9:15 a.m. - 4:00 p.m.
St. Vincent Catholic Medical Center
New York, New York

Keynote Presenter:

Daniel Garza M.D.
Chair, Clinical Committee
Disaster Psychiatry Outreach

For Information and Brochure
Mark Gustin
Conference Chair

718-245-5674

You Recognize This Warning Sign,
And You Take Action.

Can You Recognize A Problem With
Your Child's Mental Health As Well?

To Help A Child
You Know,
Call
(914) 636-4440
ext. 200

THE GUIDANCE CENTER

HDSW

Human Development Services of Westchester

Creating Community

- *Human Development Services of Westchester* serves adults and families who are recovering from episodes of serious mental illness, and are preparing to live independently. Some have had long periods of homelessness and come directly from the shelter system
- *In the Residential Program*, our staff works with each resident to select the level of supportive housing and the specific rehabilitation services which will assist the person to improve his or her self-care and life skills, with the goal of returning to a more satisfying and independent lifestyle.
- *The Housing Services Program*, available to low and moderate income individuals and families in Port Chester through the Neighborhood Preservation Company, includes tenant assistance, eviction prevention, home ownership counseling, landlord-tenant mediation and housing court assistance.
- *Hope House* is a place where persons recovering from mental illness can find the support and resources they need to pursue their vocational and educational goals. Located in Port Chester, the Clubhouse is open 365 days a year and draws members from throughout the region.
- *In the Case Management Program*, HDSW staff provides rehabilitation and support services to persons recovering from psychiatric illness so that they may maintain their stability in the community.

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

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

Opportunities to Heal Grow and Recover

PUTNAM FAMILY & COMMUNITY SERVICES, INC.

Putnam Family & Community Services, INC.

is a
private, non-profit, multi-service agency providing comprehensive mental health and chemical dependency services to Putnam County and surrounding areas.

Mental Health Services

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In The News At The Office Of Mental Health News

Salud Mental Premier Inspires Latino Community

Staff Writer
Mental Health News

Two years in the making, the premier issue of *Salud Mental* has just been released. The new bilingual, bicultural mental health education quarterly comes to us from the publisher of our award-winning; Westchester, New York based *Mental Health News*.

Reactions to the 48 page premier issue of *Salud Mental* and the story behind the project's founder and publisher are inspiring many in the Latino community.

A survivor of a ten-year, life threatening battle with depression, which left him homeless and destitute, Ira Minot, of White Plains, New York wowed the northeast's mental health community six years ago with the creation of *Mental Health News*. Working without staff or funds on the kitchen table of his one-bedroom 'shelter-plus' apartment, Minot's *Mental Health News* quickly caught the attention of the mental health community. Today, a nonprofit organization, the publication reaches an estimated 70,000 readers made up of consumers and their families, clinicians, mental health providers and decision makers at the local, state and national level. The organization's Board and Advisory Council reads like a veritable 'who's who' of notables from the most prestigious mental health organizations, psychiatric hospitals, medical colleges and universities.

"My goal was to provide a roadmap to mental health education, information and resources and to give our mental health community the recognition it deserves for saving the lives of people with mental illness each and every day," states Minot. The unassuming publisher and founder who came from a background as a psychiatric social worker and a fundraising director for nonprofits, was struck down with severe depression in his late 30's. "Even with a graduate degree in mental health, I could not find my way out of an illness that strikes one-in-five people in the United States."

The new *Salud Mental* contains a wealth of articles in English and Spanish written by some of the northeast regions most influential leaders and provider organizations from the local and national Latino mental health community.

"I could not publish Mental Health News and Salud Mental without the help of our dedicated readers, supporters, Board and Advisory Council." "We act as a team and an extended family to create each exciting issue of *Mental Health News* and now the new *Salud Mental*" states Minot.

Working with a "Field of Dreams" principle of "build it and they will come," *Salud Mental* is gaining momentum in attracting the funding required to expand distribution beyond the metro-New York region. Initial funders for the pilot project include: The New York Community Trust, The United Way of New York City, Bristol-Myers Squibb, Forrest Pharmaceuticals and the New York State Office of Mental Health.

Salud Mental is available in a full readable format on its new website which is funded by the Verizon Foundation at www.mhnews-latino.org. For further information you may call Mr. Minot directly at Salud Mental at (914) 948-6699. □

Mental Health News Announces Upcoming Issue Themes

Summer 2005 Issue: "Mental Health and Senior Adults"
Fall 2005 Issue: "Understanding and Treating Schizophrenia"

See Page 43 For Deadline Dates: For Articles And Ads

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The Mental Health News

New York City Section

Long-Term Planning and Funding: Turning The Patchwork Quilt Of Services For Individuals With Co-Occurring Disorders Into A Cohesive Whole

By Meggan Christman,
Policy Advocate, Coalition of Voluntary Mental Health Agencies

We have come to accept that co-occurrence is the rule, not the exception, and to believe that integrated treatment for individuals with co-occurring psychiatric and addictive disorders is good public policy. There is significant consensus that integrating treatment increases the efficiency and success of the treatment and is cost-effective in the long-run. There is even consensus around evidence-based and promising practices — with room for creative innovation and regional adaptation. Training is becoming increasingly available; a limited number of grants currently exist to improve system integration and treatment.

What is lacking is a **comprehensive long-term, system-wide plan** to link appropriate existing services to individuals in need, to identify the gaps, and then to fill them and fund them. To achieve a comprehensive gap-needs assessment requires an accurate understanding of what currently exists — both in available services and needs. Neither is available right now with respect to co-occurring disorders. There are statistics that estimate the co-morbidity of substance abuse and mental health disorders filtered through census data that give us a general, aggregate picture. Most estimates suggest a 50% rate, or higher, of co-occurrence.

In order to effectively plan how to get from point A to point B, you have to understand exactly where point A and point B are. **Point B:** The ultimate goal should be a seamless system of care, where every door is the right door, and services are provided in an integrated, patient-centered way. To achieve this, improvements must be made in 1) screening and assessment 2) staff training, 3) program-level adaptations like evidence-based practices, 4) system-wide integration, and 5) fiscal support. Improvements at all levels must be addressed simultaneously. Tackling the improvements in a linear way, looking first and only at screening and assessment creates the moral dilemma for some providers of screening for problems that they are not fully prepared to treat. Those who *are* already treating dually diagnosed individuals are not being reimbursed at a rate that reflects the cost of providing services — resulting in an inadequate capacity to treat these individuals.

Planning for a challenge that exists pervasively in the here and now cannot be linear. It must be tackled in a more aggressive way, more closely resembling the branches of a tree with roots in every service sector: mental health, substance abuse, forensic, housing, children and families, etc., feeding information and

Meggan Christman

resources into a coordinating body that aids in the implementation of integrated service throughout the continuum of providers. There is no need to re-invent the wheel in order to accomplish this.

Point A: I would be so bold as to propose that almost every mental health program in New York City has some capability in co-occurring disorders, whether formal or informal. Many providers are highly proficient, providing high-quality, innovative services every day. Integrated Dual Diagnosis Treatment (IDDT) as an evidence-based practice may be relatively new, but many of the basic underlying principles have been around for a long time, growing in the laboratories of exceptional programs, nurtured by insightful mental health practitioners. There is also already an Inter-agency Work Group, convened jointly by the New York State Office of Mental Health (OMH) and the New York State Office of Alcoholism and Substance Abuse Services (OASAS), with the purpose of providing coordination and integration.

Initiatives on both sides of the aisle have sought to increase the frequency and quality of screening for individuals with substance abuse issues in mental health programs and mental health issues in substance abuse programs. One such program is the New York City Department of Health and Mental Hygiene's Quality IMPACT initiative, through which agencies implement the SAMHSA-developed Simple Screen. The NYS OASAS has recently developed supportive materials and guidelines around the Modified MINI, a screening instrument used to screen for mental health problems.

There is an assortment of trainings being offered. One concern is that training staff in a piecemeal way — without a

see The Patchwork on page 42

Treatment Services For Individuals With Co-Occurring Psychiatric And Substance Use Disorders: A Plan for Integrated Treatment

By Letitia Coburn, R-LCSW, DTR, CASAC-T, Program Director, Chemical Dependence
St. John's Riverside Hospital

As treatment providers move into 2005, we must recognize the increasing needs of individuals with co-occurring psychiatric and substance use disorders (ICOPSD): those with both substance abuse or dependence and mental health concerns. We need to respond to their complicated needs with vital, integrated treatment provision designed to manage both their psychiatric symptoms and substance relapse potential, while lauding the clients' strengths and experiences of self-determination. A timely response to this need is crucial for multiple reasons:

- To reduce the incidence of relapse for our consumers
- To reduce the need for lengthy and costly inpatient psychiatric treatment
- To return our consumers to their homes in the community
- To implement less restrictive levels of care for our consumers.

These improvements are constantly in need of re-evaluation due to changes in the sociological, psychosocial and pharmacological world that our consumers inhabit. Recent environmental changes include: the nature of entitlement provision; availability of new and increasingly dangerous opiates and other street drugs; declining family structures; innovative mandate programs via drug treatment courts; and evolving criteria for continued treatment by managed care providers. These changes necessitate an intelligent and flexible response from today's treatment providers.

Kenneth Minkoff, MD, a leading advocate for people living with both disorders, supports this expectation of treatment providers. He encourages programs "to provide an empathic, hopeful, continuous treatment relationship" (1998) through necessary treatment episodes.

Integrated Treatment

Treatment providers have frequently mislabeled, misdiagnosed and/or not recognized individuals with co-occurring disorders. Traditionally, behaviors related to these two disorders are ignored, attributed to "acting-out," or ascribed to psychiatric symptoms unmanageable within a traditional treatment setting. Treatment programs have historically treated such individuals via either a parallel service approach or a sequential approach. In the parallel treatment approach, an individual concurrently attends both a substance abuse treatment program and a separate outpatient psychiatric treatment facility. In a sequential approach, an individual will traditionally attend a treatment program for one disorder (usually a substance abuse treatment program to secure sobriety), and then be referred to a program to address the alternate disorder (Smyth, 1996).

Minkoff (2001) recommends that each of the two disorders be considered primary. Individuals with these disorders

see Integrated Treatment on page 42

Best Practice In A Dual Recovery Program

By Joyce Kevelson, Assistant Vice President, Queens Behavioral Health Services, and Donna Ray, LCSW, Program Manager, Project Cope F.E.G.S.

After decades of failed attempts at recovery from substance abuse and mental illness, Jean, a woman in her 50's, enrolled at F.E.G.S. Project Cope. Jean was the daughter of parents with serious drug problems. It was easy for her to follow their path — using alcohol, heroin, and crack cocaine. Trauma was evident in her earliest years. She had been an abused child who did not graduate from high school and was unable to hold down a job or sustain a healthy relationship. To pay for her drug addiction, Jean turned to prostitution.

Her substance abuse and associated lifestyle ultimately caused extensive medical problems, which she must still deal with to this day. She hit bottom with the loss of her soul mate, which was followed by severe depression, several suicide attempts, and psychiatric hospitalization. Finally Jean decided that, with the help of the counselors she met along this tragic journey, she would take another path — the path of recovery.

After nearly two years at Project Cope, Jean is finally free of drugs, managing her mental illness, reunited with her family, and getting ready to move into her own apartment. She feels that the many groups, especially the individual counseling and the encouragement from peers, have helped her to recover. After nearly two years in the Project Cope program, she finally feels ready to tackle her goal of becoming a home attendant and to "give back" to those still suffering.

"Dual Diagnosis is an expectation, not an exception," says Dr. Ken Minkoff, noted psychiatrist in the field of dual recovery. A number of studies clearly indicate that 55% of individuals in treatment for psychiatric disorders have co-occurring substance abuse disorders.

In some cases it is clear which came first, in others it is less evident. Yet for decades, providers ineffectively continued to treat individuals, either in a psychiatrically focused program or in a substance abuse licensed program, with little appreciation of the interaction between the two disorders. According to many articles by Drs. Drake and Minkoff, treatment success involves the formation of empathic, hopeful, integrated treatment relationships. The need for a dual recovery program prompted F.E.G.S., some four years ago, to develop Project Cope, a State Office of Mental Health-licensed rehabilitation program for individuals with psychiatric and substance abuse disorders.

Understanding that recovery does not follow a smooth path to success prompted F.E.G.S. to employ harm reduction vs. abstinence on admission. Since relapse is part of recovery, a committed community of staff and fellow "recoverers" was created who understand and support each member's wish to achieve abstinence and sobriety. Clients are often surprised when they are not discharged from the program when they slip and slide. They often say to us, "You really understand our struggle." Others say, "I was ready to make changes, but there weren't any programs like this when I was younger."

Psychiatric rehabilitation is an action-oriented approach using direct-skills teaching techniques to help people with disabilities achieve the goals needed to improve their quality of life. It's a strength-based approach with a strong belief that individuals can recover and live productive lives. Combining the principles of psychiatric rehabilitation, together with the therapeutic community's social learning philosophy, facilitates hope and assists individuals in regaining functions in living, learning, working, and socializing.

Individuals often take a circuitous path to recovery, ending up in prisons, hospitals, or on the streets. They are abandoned by family and friends and feel like a runaway train, with no direction and no control. F.E.G.S, in collaboration with the State Office of Mental Health and the University of Rochester, has initiated a family psycho-education program that reaches out to families and reunites them with clients. This effort was developed in order to help the client's family members understand the importance of their role in the recovery process.

Modalities such as Dialectic Behavior Therapy help clients develop impulse control, manage their anger, regulate their emotions, and employ alternatives to destructive behaviors. In addition, Dr. Alice Medalia, a well-known researcher in Cognitive Remediation, trained the staff to teach clients the skills that will help them regain a sense of competence. Clients learn to negotiate interpersonal relationships with each other through a variety of strategies: "push ups" (positive feedback) and "pull ups" (negative feedback). Key concepts — "You can't keep it unless you give it away," "Live and let live" or "Easy does it" — are essential to letting go and moving on.

Project Cope has had great success in working with people to achieve recovery. Coordinating treatment with other providers has been integral to ensuring that we address all aspects of a person's life. Testimonies from clients tell us that much of this is attributed to the structure; a smaller staff-to-client ratio and a clean, intimate, and warm environment that is safe and predictable. While we have achieved much, we continue to explore research and listen very closely to our clients, who are the best source of what works and what doesn't. Flexibility, and a willingness to learn, is the name of the game. □

Harm Reduction vs. Abstinence Approaches For Individuals With Co-Occurring Disorders: An Agency's Evolution

By Michael Blady, LCSW
Associate Senior Vice President,
Adult Mental Health Services and
Michael Skoraszewski, PsyD,
Senior Vice President,
Adult Mental Health Services
Institute for Community Living, Inc.

In 1991, when the Institute for Community Living (ICL) began providing residential services specifically designed to address the unique needs of individuals with co-occurring serious mental illness and substance abuse disorders (who were, in addition, homeless), the concepts 'best practices' and 'evidence-based treatment' were not yet part of the lexicon of mental health services. All we knew was that our residential programs for people with serious and persistent mental illness were ill-prepared, as were those of our colleagues, to address the growing sector of the population that was also presenting with substance abuse issues. We also learned that residential programs for substance abusers were not prepared or willing to admit individuals with psychiatric disorders.

Working with researchers who had experience with therapeutic communities, we developed an integrated approach that viewed mental illness, complicated by substance abuse, as a unique disorder that demanded a unified approach instead of sequential treatment. Essentially, what ICL did was to take the self-help, community-as-healing-agent components that had proven effective in residential substance abuse programs and replaced the confrontational aspects with an ego-supportive approach. We then added modalities from the field of psychiatric rehabilitation — e.g., psycho-education, and psychiatric symptom management (including medication) — to create an integrated treatment model that simultaneously addressed both disorders.

In the 13 years since Halsey House (our first program) opened, there has been considerable program development and study in the field of co-occurring disorders. It is now the rule rather than the exception that mental health and substance abuse agencies offer integrated services to serve this population, which is sometimes described as comprising up to 70% of the seriously mentally ill.

In recent years, there has been a good deal of debate among practitioners of the two main philosophies in substance-abuse treatment — abstinence and harm reduction. One school of thought maintains that any use of substances is problematic and it presents only one goal as an acceptable outcome — abstinence from all drugs and alcohol. While relapses and continued use early in treatment are to be expected, they are explicitly defined as problematic behaviors, even if there are no other consequences associated with use, e.g., domestic conflict, lost time at work. An important aspect of recovery in an abstinence model is that the individual has to admit that he or she is powerless against his or her addiction, and that the only way to recover is to not use.

The other school proposes a much more 'palliative' approach, emphasizing choice and control of behaviors. This 'harm reduction' model starts from a premise that not all conditions are curable, and that control of the negative behaviors and problems resulting from use is an acceptable outcome. Temporary cessation or reduction of use, along with reduction in symptoms of addiction and the severity of co-existing problems, are all improvements, short of cure, that are worthy of pursuit.

In reviewing the current literature, it is clear that there is no single approach or model that is universally regarded as 'the best practice.' Motivational interventions, cognitive-behavioral approaches and therapeutic communities have all produced positive outcomes with certain segments of the target population.

What researchers and practitioners *do* agree on is that treatment must be integrated. As defined by the federal Center for Substance Abuse Treatment (CSAT), "Integrated treatment is broadly defined as any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service system." For services to be fully effective, integrated treatment should be provided within the context of an integrated program that provides an organizational structure, and which supports the provision of comprehensive interventions. In turn, an integrated program should function within an integrated system, which will provide an organizational structure to support an array of treatments that can be matched to the individual needs, wants, and aspirations of individual consumers.

Over the past 14 years, ICL has continuously reviewed it's approach to providing integrated MICA services within the context of changing populations, changing needs, assessment of outcomes and published research. Our system of treatment for MICA consumers now encompasses both harm reduction and abstinence philosophies. The organizational structure that supports this system starts at the top with a CEO, who has been committed to integrated programming from the very beginning ('buy-in' from leadership is crucial). The programs that predominantly serve MICA consumers are clustered under the direction of a vice president who supervises all the program directors in this cluster, and convenes monthly strategic planning meetings. These strategic planning meetings have been occurring continuously since 1990, even before our first program opened. At these meetings, every aspect of the MICA service-delivery system is reviewed on a regular basis, and changes in programming are carefully planned from concept to implementation.

Our four congregate residential MICA treatment programs continue to offer abstinence-oriented modified therapeutic community programming for those who both want and need that level of support. While reduction of harm is continually celebrated through level changes that acknowledge the achievement of intermediate goals, the tacit acceptance of usage in these programs is perceived as undermining the fabric of a recovery community that relies on the establishment of a shared commitment to the goal of abstinence.

Many of the therapeutic-community graduates move into specialized and supported housing programs, in which they complete the final phase of their treatment. Many of these apartments are clustered in single sites, which permit the development of an ongoing sober support system. The apartments are regarded as permanent housing, though some of the residents opt to move to scatter-site supportive housing when they are ready.

Residential case managers and counselors are cross-trained in both mental health and substance abuse interventions, and are supported by substance abuse specialists, many of whom are in recovery themselves. In-service training on the concepts and practice of therapeutic community interventions are regularly provided by a senior coordinator of MICA service, who works to ensure that there is clinical consistency across the programs.

Treatment is further integrated through participation in a specialized MICA Continuing Day Treatment Program, which employs cross-trained Masters-level therapists and persons in recovery. The clinicians in this program, including the psychiatrist and the nurse, address the complex interaction of behavior, attitudes, values and brain chemistry that marks co-occurring disorders with a consistent, whole-person approach.

In the past 18 months, two new programs, both CR/SRO's operating on harm- reduction principles, have been added to ICL's MICA Cluster of programs. These programs primarily serve chronically homeless consumers (two years of homelessness out of the last four) and those who are being discharged from long-term state hospitalizations.

It has been a challenge helping the MICA Cluster community (both staff and consumers) to consider and accept an alternate philosophy and associated interventions into the system. One example of the flexibility that has been achieved is that we now have residential programs that accommodate the needs of consumers on methadone maintenance. In abstinence-oriented programs, it is very problematic introducing someone who is using a substance — which can be abused and has street value as a drug — into the community. By broadening the philosophical basis of our system to include other approaches, we have been able to serve a population that has, in the past, languished in shelters because of the mental health community's (including our own) reluctance to serve them.

Services to consumers with co-occurring disorders within ICL are not limited to the MICA Cluster. All of our residential services programs — congregate treatment, CR/SRO's treatment, and apartment and supported housing — work with people who are dually-disordered. The approach in all of these programs, as well as among our ACT, Blended-Case Management, and clinic programs is based more on harm reduction and cognitive-behavioral approaches.

While this range of programs and approaches enables ICL to provide a full array of interventions to meet the agency's goal of an integrated service system for MICA consumers, there remain formidable challenges. Primary among them is improving our ability to match intervention to individual needs, wants, and aspirations. Performing accurate clinical assessments; understanding how such factors as trauma, incarceration, culture, and gender can impact the effectiveness of treatment; and, training our staff to reliably provide services that incorporate practices grounded in the best outcome data available, are all parts of the challenge. As an organization and in collaboration with other service providers and research centers, we are actively working to identify 'evidence-based practices' and advocate for maintaining a statewide system of treatment alternatives that best serve the needs of all consumers with co-occurring disorders.

If you would like more information about ICL's range of MICA housing and treatment alternatives, contact our Central Access Department at 1-866-ICL-ACCESS (1-866-425-2223). □

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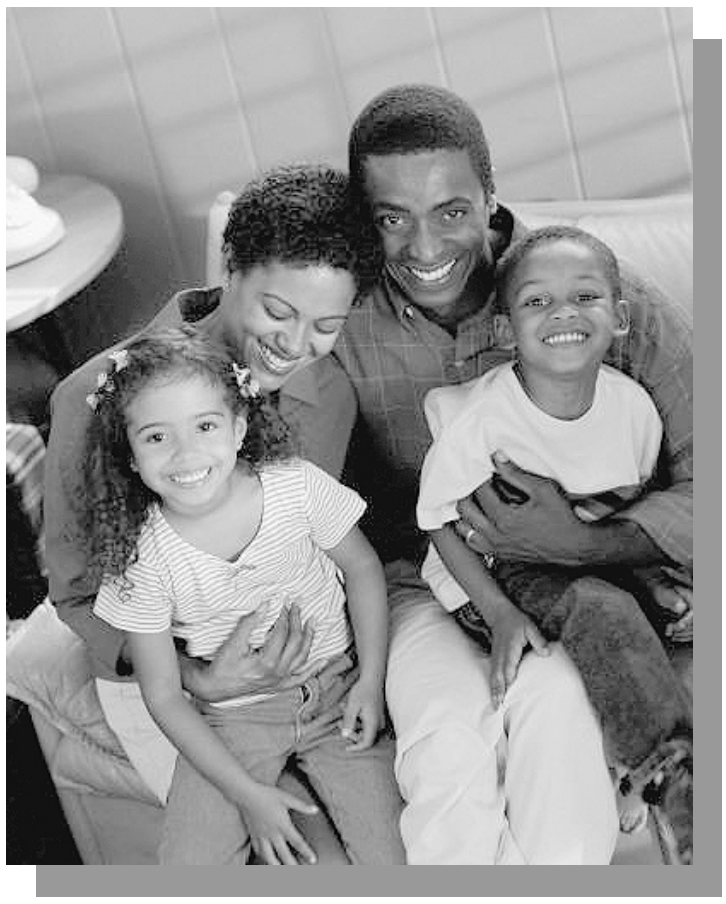

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Everyone Deserves Treatment For Co-occurring Disorders

By Harris B. Stratyner, PhD
Associate Professor of Psychiatry, Clinical Division
Director of Addiction Recovery Services Mount Sinai Medical Center

Harris B. Stratyner, PhD

Over my 25 year career, I have been known for what was originally referred to as MICA treatment (utilizing my model of "care-frontation"). In its original form, what has now come to be referred to as treatment for individuals with *co-occurring* disorders, was generally considered to be indicated for people with seriously persistent mental illness (SPMI) and addiction. This placed them in a "chronic" category and generally translated to a lower socioeconomic level because the illnesses were seen as eventually preventing these individuals from earning a living, continuing in school, or interrupting their professions. However, some 20 years later, we now know, at least some of us, that co-occurring or dual diagnosis treatment can help those individuals lead productive lives, and furthermore, is needed for all socioeconomic groups, even including those who are very financially successful.

What's different about treating the CEO of a corporation, a successful attorney, or perhaps a celebrity? As someone who has specialized in this type of patient for over 15 years, allow me to elaborate.

Basically, people are people, but the approach that a clinician takes with a certain individual, based upon his or her socioeconomic status in the community, has to be designed to engage that person in treatment, rather than deter them from seeking help. Many people who have achieved a lifestyle that is considered to be associated with success and wealth have certain psychosocial and environmental stressors (AXIS IV issues) that are, in some ways, unique to their lifestyle. For example, if someone is a famous writer, can we really expect a rehabilitation program to forbid that individual from bringing his or her laptop to the unit? Isn't it more logical that clinicians should consider our hypothetical writer's profession to be a potential relapse trigger, and therefore help that individual to learn how to be productive without the use of drugs and alcohol? This is not enabling — it's teaching coping skills. However, if the laptop does become a distraction, it can always be discussed in treatment.

When we talk about counseling people who have acquired a certain amount of success, and/or money, or celebrity (or however our society defines these things), we must realize that they are accustomed to a certain amount of being "catered to." I am not here to say this is right or wrong — it simply "is." This is a controversial topic, but I would be remiss if I did not bring it up here — it is what I believe Robert Millman, MD, meant by the term "acquired situational narcissism." There are many specific factors that treating this population raises, like exposure to the press, fear of financial ruin, or perhaps even additional stigma, if you will.

Let's face it, when you have a lot of money, power, or are a well-known public figure, people do cater to you, and if you are, for example, a bipolar individual with alcoholism, you still need someone to talk realistically to you about these two diseases that feed off of each other — just like the individual who is not in the limelight.

So we begin to see that amenities programs are simply a way of removing another rationalization for not engaging in treatment. A concierge, gourmet meals, a private bath, and other accoutrements that these individuals pay a premium for are simply a way to engage them in treatment. Don't these people deserve recovery as well?

I grew up around many famous and powerful individuals simply because of my late father's profession; however, both my father and my mother always made it quite clear to me that all people are created equal. Therefore, I believe even the "rich and famous" deserve treatment. I would hope someday that all programs had these amenities without extra fees that only a few can afford, but we are not there yet — I am grateful, though, that the programs I have been associated with at least keep the **attention to treatment** on an equal plane. □

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

Many Patients Have Co-occurring Mental Health and Substance Abuse Disorders: Both Must Be Addressed for Successful Treatment

By SAMHSA, Substance Abuse and Mental Health Services Administration

Co-occurring substance abuse and mental disorders are more common than most professional counselors, medical personnel or the general public realize. A new Treatment Improvement Protocol released today by the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 50-75 percent of patients in substance abuse treatment programs have co-occurring mental illness while 20-50 percent of those treated in mental health settings have co-occurring substance abuse. Most people with co-occurring disorders do not receive treatment for both mental disorders and substance abuse. Many receive no treatment of any kind.

The new Treatment Improvement Protocol is designed for substance abuse treatment counselors and mental health providers who usually treat one or the other of the two ailments, but it will also be useful for administrators, primary care providers, criminal justice staff and other health care and social service personnel who work with people with co-occurring disorders.

Substance Abuse Treatment for Persons with Co-Occurring Disorders, TIP 42, provides counselors with principles, assessment instruments, strategies, settings and models for treating patients wherever they show for treatment, whether it be in substance abuse treatment facilities, mental health facilities or medical offices or clinics. TIP 42, created by a panel of experts and reviewed in the field, also emphasizes that outcomes for patients are enhanced when both illnesses are addressed using an integrated approach.

"All too often individuals are treated only for one of the two disorders – if they receive treatment at all," SAMHSA Administrator Charles Curie said. "If one of the co-occurring disorders remains untreated, both usually get worse. Additional complications often arise, including the risk for other medical problems, suicide, unemployment, homelessness, incarceration, and separation from families and friends."

"Since people with co-occurring disorders cannot separate their addiction from their mental disorder, they should not have to negotiate separate service delivery systems," Curie said. "We know that with appropriate treatment and supportive services people with co-occurring disorders can and do recover. This is the premise of TIP 42. "

SAMHSA's 2003 National Survey on Drug Use and Health shows that 27.3 percent of persons 18 and older in the past year with serious mental illness used an illicit drug. In 2003, the survey also found that 5.7 million persons ages 18 and over with serious mental illness engaged in binge alcohol use and 1.9 million were heavy drinkers. Overall, the survey showed that about 4.2 million adults aged 18 and older met the medical criteria for both substance abuse and mental illness.

The consensus panel that created the document is encouraging development of a unified substance abuse and mental health approach. Emphasis is placed on assisting substance abuse treatment systems to develop the capacity to treat individuals with co-occurring disorders while mental health systems develop similar capacities.

This Treatment Improvement Protocol is part of SAMHSA's promise to Congress following the November 2002 *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders* to document state-of-the-art treatment for individuals with co-occurring mental and substance abuse disorders.

Along with the TIP, SAMHSA has created a State Incentive Grant for Co-Occurring Disorders to help states enhance their infrastructure and treatment systems; established a national co-occurring disorders prevention and treatment technical assistance and cross-training center, the Co-Occurring Center for Excellence, to provide a broad array of information on co-occurring disorders to states and community providers in the substance abuse, mental health and related public health fields; and increased federal agency collaboration within HHS to enhance research attention to co-occurring disorders.

SAMHSA has also broadened the agency's efforts to identify and disseminate known effective programs for prevention and treatment of co-occurring disorders, including the development of a new tool kit on treating co-occurring disorders; increased collaboration between SAMHSA and the Centers for Medicare and Medicaid to explore ways to use existing reimbursement mechanisms for services to people with co-occurring disorders; and convened two National Policy Academies on Co-Occurring Disorders to help states and communities enhance service capacity.

The TIP panel was chaired by Stanley Sacks, Ph.D., of the National Development and Research Institutes, Inc., New York and co-chaired by Richard Ries, M.D., Professor of Psychiatry, University of Washington.

TIP 42, inventory number BKD515, can be ordered through SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20847-2345, by calling 1-800-729-6686, or via the website http://ncadi.samhsa.gov. □

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experts now agree that co-occurring disorders should be seen as the expectation among persons with serious mental illness, not the exception. Therefore, our treatment systems must be designed with their needs in mind.

Unfortunately for people with co-occurring disorders, the decision to seek professional help can be frustrating and confusing — should they enter the mental health or the substance-abuse treatment system? Traditionally, the mental health system has had a tendency to exclude persons who also abuse substances, maintaining that the primary work of providers is with mental illness and not with substance abuse. Likewise, many substance-abuse treatment programs have often excluded people who were taking prescribed medications correctly, by requiring that all individuals entering treatment demonstrate their motivation by being "clean" of all drugs — including prescribed medications. Many substance-abuse treatment programs have relied heavily on confronting the individual's denial of a problem at all. To the contrary, mental health treatment often focuses on shoring the individual's fragile defenses, taking a supportive rather than confrontational approach. Historical differences in culture, philosophy, structure, and funding have contributed to a lack of coordination that has made it difficult for either consumers or providers to move easily across service settings.

These and other differences have contributed to inadequate and costly care, and therefore, the failure of either system to address the comprehensive needs of consumers. Many of these individuals have long histories of engaging in self-destructive behaviors to cope with the pain of their illnesses. These behaviors often worsen symptoms, causing the individual to lose hope of recovery. People with co-occurring disorders may then become stuck in a cycle of pain, alienation, and self-destructiveness that isolates them from their personal support systems and from treatment systems. Providers themselves may become frustrated, not understanding how to help individuals move away from self-destructive patterns of behavior. Inadequate and costly care has been the result. Individuals and providers both remain stuck in a cycle of hopelessness, with the person with co-occurring disorders feeling like a misfit — "unwelcomed, unwanted, and blamed for the complexity of their difficulties."

Fortunately, in recent years, a growing consensus has emerged asserting the need to do more for this population. Both mental health and substance-abuse service providers have a responsibility to understand the disease processes and to help clients recover. Research is available that points the way.

Integrated Treatment

Beginning in 1998, with the support of the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Department of Health and Human Services, the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) entered into a partnership that resulted in the development of a new conceptual framework that presents co-occurring disorders in terms of multiple symptoms and severity instead of diagnosis. The framework provides a visual way of thinking about both the systems of care and the level of service coordination needed to improve consumer outcomes — especially the integrated care necessary for individuals with the most severe mental illnesses and substance use. This conceptual framework combines observations about the current service delivery systems with a vision for the future delivery of integrated services.

Typically, if they are treated at all, individuals with less severe mental disorders and less severe substance abuse enter the service system through a primary-care setting (Quadrant I). These individuals may present to a primary-care doctor, a school-based health clinic or other primary-care setting. For persons with mild mental disorders or substance-abuse problems, it may be appropriate to manage their psychiatric medications and other treatments in less intensive or specialized settings, such as primary care. When necessary, individuals may be referred to specialized service agencies or providers.

Those individuals with increasingly severe mental disorders accompanied by a lower level of substance abuse are more likely to be seen in a community mental health setting, which provides treatment for the primary mental disorder and also may address the substance abuse problems (Quadrant II). Individuals with a high degree of substance abuse and lower level of mental disorder typically are seen primarily in substance abuse service settings (Quadrant III). While the mental disorders of these individuals may be addressed, the agency's primary expertise remains substance abuse. Referrals to other specialized service settings are common in both Quadrants II and III. These referrals place the burden of connecting the separate treatment systems squarely on the individual and family.

Both the mental health and substance-abuse fields generally agree that the most effective treatment for persons with substance abuse and severe mental illnesses – those found in Quadrants II and IV – is integrated treatment, in which services are offered through a single, unified, comprehensive service system. Integrated treatment matches the intensity of the disorders with a commensurate intensity of treatment interventions. With increasing evidence that any substance abuse by persons with serious mental illness is potentially destabilizing, some treatment professionals and researchers, therefore, are calling for integrated treatment to be available to persons in Quadrant III as well.

An integrated, community-based treatment setting is consumer-centered and provides services through a "no wrong door" philosophy; that is, no matter how the individual enters care, the services needed to respond effectively to

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The emotional, behavioral, and psychiatric health care needs of adolescents and their families are unique, and are best cared for in a specially designed treatment program. That is why Bridgeport Hospital, a 425-bed teaching hospital in Bridgeport, Connecticut, provides both Intensive Outpatient (IOP) and Inpatient services to meet those needs.

The REACH Adolescent Service, an afternoon, community based, IOP program for adolescents between 13 and 17 years old with emotional and behavioral difficulties, offers an intensive outpatient program that includes group therapy, multi-family group work, medication management, and case management.

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Left to Right:
Karen Parniawski, Psych Tech; Jyll Souto, LCSW;
Margaret McGovern, Art Therapist; Kathy Graziano, APRN;
Rafael Valentin, Psych Tech

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For referral to the outpatient program, please call (203) 384-3377 and ask for an evaluation appointment.
For referral to the inpatient program, please call (203) 384-3709 and speak to the charge nurse.

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population and to administer interventions, these individuals may be at a significantly higher risk for psychological problems. These issues highlight the very complicated events leading to mental health recovery.

Bereavement is a process that is a normal reaction to a significant loss. Children and adults experience grief, but in different ways. Young children do not have cognitive development sufficient to understand the permanence of death. Children are less able to tolerate the intense and painful emotions of sadness, guilt, anger, and anxiety, which are the fundamental aspects of grieving. Children display various coping characteristics, such as increased activity and withdrawal, in order to decrease experiencing these painful emotions. Children may appear not to be impacted by a significant loss. However, physical symptoms, such as sleeplessness, bedwetting, and strong emotional reactions (including clinging onto the surviving caretakers), worries about the safety of surviving relatives, and the inability to be away from surviving loved ones, are manifestations of children's responses to the death of a loved one. Adolescents respond to the death of a loved one in similar ways as adults because they have abstract cognitive abilities and greater tolerance for painful feelings. However, their concepts of themselves and attachment capacities are not as mature as those of adults. Adolescents experience hopelessness, and they worry about their futures. They often avoid speaking with surviving caretakers about the loss and prefer communicating with peers. Therefore, interventions should have a developmental specificity for children, adolescents, and adults.

Deaths caused by natural disasters, similar to those by suicide, terrorist attacks, homicides, and accidents, are usually associated with traumatic reactions. Such traumatic bereavement involves disturbing recurrent images and intrusive thoughts of how the loss occurred, hyperarousal to sudden sounds, problems sleeping, nightmares, intense longing for the deceased, and intense shock at the loss.

Interventions for those who suffer traumatic bereavement involve consistent external support from others, discussion of feelings and reactions, methods to decrease hyperarousal, and techniques to maintain a focus on other activities that enable the bereaved to have relief from recurrent and intrusive images and thoughts. Techniques to assist in relaxation are often helpful. Guided expressive psychotherapy enables the bereaved to talk about their painful feelings; longing for the deceased and anxiety about their life circumstances is an important aide to the bereavement process. The support of group discussions with other bereaved people enhances coping with the vicissitudes of new life roles, such as being the head of the house, the sole parent, and the financial provider. Expressive psychotherapy fosters discussion of the traumatic events to enable the bereaved to extinguish recurrent intrusive images of the event. For children, art therapy is an important intervention method to decrease frightening images associated with the traumatic event. Cognitive psychotherapeutic methods help the survivors' to restructure the way they think about the traumatic event, and it also helps to reduce the despair associated with loss. Cognitive therapy aims to decrease depression and anxiety. Medications, such as selective serotonin re-uptake inhibitors, can be helpful in reducing some of the symptoms of traumatic reactions already discussed (such as hyper-arousal), as well as intense anxieties about the event, and worries about coping with new life circumstances. Selection of other medications is based on an individual's symptom profile.

Genuine expressions of kindness offered to bereaved individuals are one of the most effective approaches to reduce feelings of loneliness, anxiety, and sadness. It empowers the bereaved to conceive of hope in order to confront life's course.

More research is needed to understand the long-term outcomes of traumatized bereaved children, adolescents, and adults. There is a paucity of information about the risk for developing psychiatric disorders after traumatic events associated with the death of loved ones. Currently, there exists an insufficient amount of research for understanding what effective psychotherapeutic and psychopharmacologic interventions are available for traumatized populations. This is particularly relevant for bereaved children. Research, further investigation, and clinical care of traumatized individuals should become an integrated effort in relieving bereaved people of their pain, suffering, and despair. Increased financial support and higher enthusiasm for these intertwined research and clinical endeavors will ensure that the most significant needs of bereaved individuals are addressed, and that the potential for healthy outcomes are strengthened.

Bereavement is a human condition that is gripping, intense, and painful. Grieving reorganizes ones' emotions and perceptions. For many, this condition is long-lasting and debilitating, but for most it leads to new personal strengths and goals. It is imperative for all of us to understand more about the physical and psychological manifestations of this universal process; we must develop more effective socio-culturally pertinent interventions to help reduce bereavement complications that are suffered by those whose loss occurs under traumatic circumstances. □

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context of expectations around competency, or standards for credentialing — can waste resources. In order for training to be truly effective, mental health professionals should be involved in all stages of planning and evaluation. On-site technical assistance with application of learned skills into daily treatment practices is one way to increase the effectiveness of training and impact agency culture. Creating a feedback mechanism that assesses the impact that the trainings have on improved outcomes for patients, and program performance measurement, will help to improve future trainings.

Measures are being taken at all levels of government — federal, state and local — to improve services for dually diagnosed individuals. Prevalence and quality of screening for co-occurring disorders is improving. Training is available. Interagency task forces convene to aid in coordination. However, there are still many blanks to fill in. A comprehensive plan for integrating these efforts is necessary, and we cannot fill gaps in need when we do not have a complete picture of where we are and where we're going. A comprehensive planning effort is necessary for assessing needs, assessing existing services, credentialing programs and individuals who achieve a standard of core competency, training those who do not, providing incentives for agencies to provide services, and adequately reimbursing those agencies who are providing integrated treatment already.

Funding is drastically lagging behind the motivation and inclination of both policymakers and service providers to implement them. The cost of providing services to individuals with dual diagnoses is higher than the cost of providing services to an individual with a singular mental health disorder. Child psychiatrists charge higher rates because of the required additional specialization and training. Dual recovery providers also need additional specialization, education, training, and experience with multiple disorders across many delivery systems in order to provide effective treatment. It is logical that these professionals be compensated for their additional specialization and expertise. With current reimbursement rates, agencies are unable to offer salaries that reflect these higher competencies, and therefore have difficulty hiring and maintaining staff that are able to effectively treat the individuals who walk through their doors. Unless funding is adapted to accurately reflect the true cost of providing effective evidence-based services, agencies will continue to be limited in their ability to do so.

Individuals who are dually diagnosed and do not receive integrated treatment will continue to have high rates of negative outcomes, including hospitalization, overdose, violence, legal problems, homelessness, victimization, HIV-infection, and other co-occurring health concerns. The Presidents' New Freedom Commission on Mental Health, Report of the Subcommittee on Co-occurring Substance Abuse and Mental Health Disorders states, "Individuals in integrated programs spent significantly less time in institutions, hospitals, emergency rooms, jails, or living on the streets homeless." The high cost in human potential, as well as the high cost to taxpayers for these expensive alternatives, can be minimized. A larger investment now will mean significant savings down the road. Looking at the big picture over the long term, both in funding and in planning, is necessary in order to improve the quality of life and to reduce costs to our society. □

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function best when their symptoms are managed within an integrated treatment setting. Challenges associated with an integrated approach include: ensuring that staff are trained comparably in treating both substance abuse disorders and psychiatric illness; providing adequate time to assess both illnesses separately and as co-factors of each other; individualizing treatment plans so as to address the diverse levels of individual functioning; and ensuring that individuals are often functioning at different stages of change (Prochaska & DiClemente, 1984) in regards to the two disorders. Stages of change assessments must be made for both of the disorders.

The last challenge necessitates an example to illuminate its complexity. An individual may recognize that he needs treatment for his cocaine addiction and therefore may be assessed to be in the preparation stage for substance abuse. However, he may concurrently be in the pre-contemplation stage of change in regards to his PTSD symptoms.

In order to optimize treatment outcomes, program planners must address each of the above concerns in a comprehensive way. The program could utilize Prochaska & DiClemente's model of change and Motivational Interviewing as joint methodologies for the program. These approaches would serve to provide the flexible and compassionate stance necessary for our consumers. They would also ground clinical assessment and interventions in a dialectical framework that would support varying stages of change within each individual. Finally, they are compatible with a treatment philosophy that relapse within each of the disorders is expected. Staff members must be prepared to work with collateral treatment providers, e.g., Dual Diagnosis Intensive Outpatient Programs, that maintain a "Harm Reduction" model of treatment. The treatment task is to join with the client's goals for growth and to help the client integrate how "small" changes improve his or her chances of reaching those goals.

Training and Supervision for Staff

Program planners must incorporate appropriate staffing and training plans to meet the needs of our consumers. All staff should be trained in the theoretical underpinnings of the program, treatment models, chemical dependency and the psychiatric disorders. Ongoing in-services should introduce new areas of expertise to staff on a monthly basis, so as to increase staff effectiveness and familiarity with the evolving health care system.

The population of individuals with co-occurring disorders can be a demanding group with which to work. Clinicians and nursing staff need to have ongoing, regular supervision to ensure excellent treatment provision, to minimize ineffective counter-transference, and to maintain staff member wellness.

Guidelines for Treatment
Expectations for Consumers

Staff members must definitively work as a team that collaborates on all initial assessments and treatment planning. Program planners and staff members should anticipate a wide range of behaviors and symptoms that affect our consumers during their stays in co-occurring disorders treatment. These symptoms and behaviors can be managed through the use of pharmacological, behavioral, psychodynamic and educational interventions. Staff members must collectively gain an understanding of the probable cause for any maladaptive behaviors. They must respond to those behaviors in a way that provides a sense of safety for all consumers, contains the anxiety that may have given rise to the behavior, and provides a therapeutic milieu for the patient to gain an understanding and experience of mental health and sobriety. At St. John's Riverside Hospital Behavioral Health Services in Yonkers, New York, our staff utilizes the Crisis Intervention Services' Model of Non-Violent Crisis Intervention as a means of formulating interventions to help a client manage anxiety. Minkoff (1998) further recommends that clients who are discharged for non-compliance or substance use be encouraged to return.

Consumers with co-occurring disorders need specialized program content and structure. Many consumers may be operating at their baselines, and yet may still be experiencing internal stimulation and negative symptoms, such as poor social skills and isolative behavior. These consumers will need a flexible structure that adapts to the changing nature of their symptom manifestation. One patient with frequent rape-related flashbacks may need to have increased staff monitoring or a peer "buddy" to minimize dissociation. Consumers with borderline personality disorder may need to have increased structure and written assignments with concrete and definable goals.

Group work is the modality of choice for treatment with this population. They should include: psycho-educational groups with an emphasis on building coping skills, learning about psychiatric symptoms, and managing medication; short Support Groups to generate connection among peers and to normalize living with co-occurring disorders; 12-Step groups that normalize the use of psychotropic medication, as in "Double Trouble" groups; and Relapse Prevention Groups that integrate a disease and recovery model for both disorders, minimizing shame regarding the relapse process. This model also increases hopefulness: recovery can be framed to applaud decreased use, decreased time between treatment episodes, and increased length of sober time.

Treatment providers have an opportunity at this juncture to spearhead an important treatment approach for our individuals with co-occurring disorders. We must initiate this venture with a keen attention to the multiple needs of our consumers, the development of excellent care for our consumers, and providing essential support of our staff members. Such an approach will result in continuing improvement in the service provision for all of our consumers. □

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an individual with both severe mental illness and severe substance abuse are available and accessible. Integrated services are often offered through a single-service agency, whose staff have been cross-trained and are competent to respond to the unique challenges of co-occurring disorders.

Unfortunately, integrated services are not currently available in most communities. Consequently, many individuals who would benefit from integrated treatment find themselves in hospital emergency rooms, jails, prisons, and other non–health-oriented settings that may not meet their needs.

There is growing support for the work being conducted by the State Mental Health and Substance Abuse Directors. In 1999, SAMHSA issued a policy statement that enthusiastically supported the conceptual framework for its ability to capture all levels of functional impairment related to mental illness and substance abuse, and indicates a need to provide such services on a broader, more systematic basis.

Cultural Competency

A key responsibility of behavioral health care systems is to deliver effective services in an environment that is both welcoming and responsive to individual needs, irrespective of ethnicity, national origin, language, race, religion, age, disability, gender, sexual orientation, or socioeconomic standing. Because the nation's population is shifting rapidly, this challenge is becoming more complicated.

Today, for example, one in three Americans are non-white. By 2050, projections place the population of non-white and/or Latino individuals at 47 percent. According to *Mental Health*: *Culture, Race and Ethnicity; A Supplement to Mental Health – a Report of the Surgeon General* (DHHS, 2001), minorities are less likely than whites to receive needed mental health services and more likely to receive poor quality care. Minorities are over-represented among the nation's most vulnerable populations (people who are homeless, incarcerated, or institutionalized), with higher rates of mental disorders and more barriers to care. These and other findings suggest it is more important than ever that persons with co-occuring mental and substance-abuse disorders be offered services that are culturally sensitive and tailored to their unique needs.

Credits: This article was excerpted from "Co-occurring Mental and Substance-Abuse Disorders: A Guide for Mental Health Planning and Advisory Councils," 2003. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services: www.samhsa.gov □

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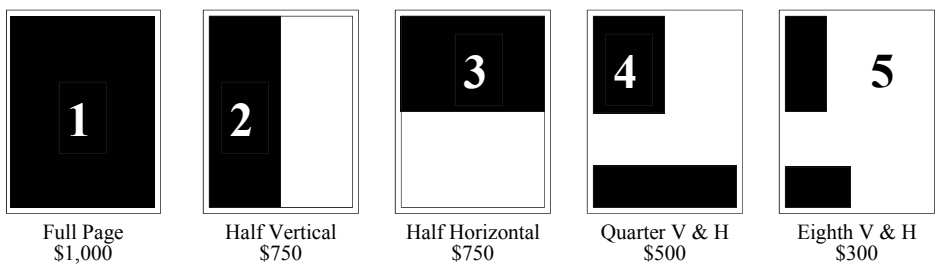

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