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Managing Mental Health Crises

Jack Carney DSW, Senior Director
City-wide and Brooklyn Case Management Programs
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When we first begin to work with consumers, many seem to become involved in crisis after crisis. These individuals are often labeled as "attention-seeking", "help-rejecting", and "manipulative" and frequently frustrate mental health professionals who seek to help them.

Interrupting the crisis pattern and replacing it with effective help-seeking behaviors are the principal objectives of crisis management. It is crucial that mental health professionals and other care providers remain objective and help consumers remain connected to services that can change their pattern of repetitive crises.

Dr. Marsha Linehan, in her work with persons suffering from borderline personality disorder (Linehan, 1993), developed a useful and broadly applicable conceptual paradigm, wherein the crisis-ridden individual is depicted as oscillating between the poles of a dialectical dilemma. On the one hand, the individual beset with "unrelenting crises" lacks the problem-solving and interpersonal skills required to secure help. Consequently the consumer is viewed by those from whom help is sought—whether family members, friends or professionals—as willful and as the principal source of the problems precipitating the crisis. The consumer feels overwhelmed and isolated, has no effective support system, and resides in what Linehan terms an "invalidating environment."

This same individual's capacity to grieve is severely inhibited. Invariably, persons who seem to experience continuous crises are those who have suffered grievous losses in their lives, yet are unable to feel the pain associated with these losses. This affective numbing or blocking is often aided and abetted by substance abuse, which, in turn, loosens behavioral inhibitions, increases impulsivity, often leads to anti-social behaviors, and serves to exacerbate the problems at the center of the crisis. The key to resolving these dilemmas and continual crises is acceptance: acceptance by the individual of the life events and the emotional pain at the root of the crises, coupled with acceptance of the need to change and learn new and more effective skills and behaviors (c.f. Hayes, et al, 2004).

We recently admitted a young woman, with bi-polar disorder, whom we will call Jane, to the F.E.G.S. City Wide Case Management Program. She was living in a homeless shelter for women, following a brief stay at Riker's Island, where she had been incarcerated for threatening a family member. Jane had a long history of being physically and sexually abused through childhood and into adulthood; had lost custody of her only child shortly after the child's birth; had a long history of abusing intoxicants; had been arrested and incarcerated several times for assault; had alienated family members and friends; and had never committed to mental health treatment.

When her case manager first met her, Jane had ceased taking her prescribed medications, had resumed abusing intoxicants and was beginning to evidence impulsive and aggressive behaviors. The case manager's first task was to secure her client's safety as well as that of the other shelter residents. Jane was soon hospitalized in a nearby psychiatric facility and began a course of psychopharmacological therapy, the necessary first step in her treatment and in the management of her current crisis. Next will come engagement by the case manager, which requires repetitive "validation", or active, non-judgmental listening, followed by the construction over time of a "validating environment", i.e., a treatment and support network similarly accepting and non-judgmental (c.f. Linehan, 1993). Both are approaches that we have used to great effect when we treated impulsively aggressive individuals during a five year-long F.E.G.S. Forensic

see Managing Crises on page 28

Children's Mental Health: A Guide For Parents

The National Institute of Mental Health (NIMH)

Children are in a state of rapid change and growth during their developmental years. Diagnosis and treatment of mental disorders must be viewed with these changes in mind. While some problems are short-lived and don't need treatment, others are persistent and very serious, and parents should seek professional help for their children.

Not long ago, it was thought that many brain disorders such as anxiety disorders, depression, and bipolar disorder began only after childhood. We now know they can begin in early childhood. An estimated 1 in 10 children and adolescents in the United States suffers from mental illness severe enough to cause some level of impairment. Fewer than one in five of these ill children receive treatment. Perhaps the most studied, diagnosed, and treated childhood-onset mental disorder is attention deficit hyperactivity disorder (ADHD), but even with this disorder there is a need for further research in very young children.

There has been public concern over reports that very young children are being prescribed psychotropic medications. The studies to date are incomplete, and much more needs to be learned about young children who are treated with medications for all kinds of illnesses. In the field of mental health, new studies are needed to tell us what the best treatments are for children with emotional and behavioral disturbances.

Questions and Answers

Q: What should I do if I am concerned about mental, behavioral, or emotional symptoms in my young child?

A: Talk to your child's doctor. Ask questions and find out everything you can about the behavior or symptoms that worry you. Every child is different and even normal development varies from child to child. Sensory processing, language, and motor skills are developing during early childhood, as well as the ability to relate to parents and to socialize with caregivers and other children. If your child is in daycare or preschool, ask the caretaker or teacher if your child has been showing any worrisome changes in behavior, and discuss this with your child's doctor.

Q: How do I know if my child's problems are serious?

A: Many everyday stresses cause changes in behavior. The birth of a sibling may cause a child to temporarily act much younger. It is important to recognize such behavior changes, but also to differentiate them from signs of more serious problems. Problems deserve attention when they are severe, persistent, and impact on daily activities. Seek help for your child if you observe problems such as changes in appetite or sleep, social withdrawal, or fearfulness; behavior that seems to slip back to an earlier phase such as bed-wetting; signs of distress such as sadness or tearfulness; self-destructive behavior such as head banging; or a tendency to have frequent injuries. In addition, it is essential to review the development of your child, any important medical problem he/she might have had, family history of mental disorders, as well as physical and psychological traumas or situations that may cause stress.

Q: Whom should I consult to help my child?

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**"Hope is a good thing.
Maybe the best of things.
And a good thing never dies."**

**Andy Dufresne
From the Movie
The Shawshank Redemption**

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Letters To The Publisher

Closing the Door on Latino Immigrants: A Mental Health Crisis

It is unfortunate that recent state government cuts have compel local government officials to practically diminished outreach and advocacy services to the Latino immigrants. The loss of services has sparked discussions in the elevator by clients who are heard saying "Who's going to advocate for me now? Or, "Esa trabajadora me ayudaba resolver muchas cosas y se tiraba conmigo para todos los sitios." The translation is: "That worker escorted me to many places and helped me resolved many things"

Is government so ensnared in its own politics that it fails to see the specific plight of an underserved population that if not reached with timely advocacy services will only serve to swell the number of poorly functioning families and children?

As the Executive Director of Fordham Tremont Community Mental Health Center I find it necessary to advocate for Latino Advocacy programs that through out the years have connected thousands with comprehensive services and promoted the social inclusion of Latino immigrants with mental illness.

Many of you will recall that it was the unfortunate "Happy land Night Club" fire, which resulted in the fatal deaths of Latino immigrants that prompted local government officials and service providers to unite as partners in addressing a service gap to this marginalized population.

The promotion of mental health care and advocacy with this underserved population was done by reaching out to the Latino immigrants in the barbershops, the beauty salons, churches, health and community fairs, walking the streets and, by eventually gaining the trust of a population (generally from Central America and the Caribbean) that would not have voluntarily approached our Center.

It is common knowledge that this population has a legitimate fear of social institutions, thus tend to avoid them.

The Center's experience revealed that many of these individuals, who do seek services, are generally experiencing a crisis; suffering from post traumatic stress disorder and, in a desperate way, need to be connected to benefits. Overall, most had a need for mental health services either for themselves, or their children.

However, many were both blind to what a mental health system was or could offer them. Further, reluctant to approach a much-needed system of care for fear of deportation and/or other un- intended consequences e.g. loosing their job

The Center's task was not always easy nor did it always yield timely outcomes. However, the Center's tenacity to reach out to this population was rewarded by knowing that through preventive efforts, outreach and advocacy; many families (some for the first time) were connected to benefits and services.

The Center educated and empowered this vulnerable underserved population on accepting mental health services in order to address their mental health needs. The use of a holistic approach, assisted many families on the process of navigating a complex social and health care system to access health care and health care benefits, immigration and legal services, social benefits, HIV and AIDS services and housing. Did the Center reach everyone? The sad answer is no, because for the Bronx, the poorest borough in the City of New York, that's only a globule in the bucket.

Even sadder, is the fact that according to the Office of Minority Health's recent conference, Hispanics are falling further behind whites in getting quality medical care, while other minority groups are closing the gap (Associated Press, January 9, 2006).

The areas where Hispanics were slipping include treatment for diabetes, mental illness and tuberculosis. Unfortunately, officials don't know why disparities in health care are growing for Hispanics but narrowing for Blacks, Asians and American Indians.

The fact that we know that this is going on should prompt our local, state and federal government officials to set a plan for change in motion, that preserves existing preventive programs, whose aim is to provide this vulnerable population with timely access to care. Let us not forget, that the emergency room and hospital recidivism rates for people with limited or no access to care is sky-scraping. Therefore, in the long run, health conditions that may be prevented end up costing all of us more money.

In summary, local, State and Federal governments must commit it self to good practices for combating social exclusion for underserved populations with mental health problems, capacity building and mental health promotion and prevention strategies. My personal opinion is that government must develop an affection for process, prevention, systemic and consequential thinking.

Let us not forget that with out mental health there is no health.

Evelyn J. Nieves, PhD

Death By Unintended Consequences: America's Homeless and Mentally Ill

I saw him as I left the closing supermarket at 8 PM on New Year's Day. He was sitting outside among the shopping carts. His hands and lips were shaking as he sat shivering in the cold. In the light from the store, I could see his lips were blue and his teeth chattering as he spoke. His eyes were sunken, open wide and staring. In front of him on a box was a crumpled dollar bill, a cigarette lighter and a half full cup of cold coffee. He was emaciated. Dressed much too lightly for the winter, his shirt unbuttoned and over that only a light cotton zippered jacket. The temperature was in the 30's, just barely above freezing.

When we spoke he seemed confused. His name I learned was John and he appeared to be about 30. I suggested he needed to go to a warmer place, but he seemed not to understand. I told him I would try to find something warm for him and returned to the supermarket. They were closing, but a young clerk immediately understood when I explained the need to cover the guy outside and found me a large piece of heavy plastic wrap to use. He said the man had been there for days, just sitting and staring. The clerk tapped his forehead to his temple indicating that the man was not of sane mind. A police officer entered the store to buy cigarettes, and I told him that the man outside appeared to have mental illness and required a psychiatric evaluation and shelter before he died from hypothermia.

The officer said he couldn't take the man in unless there was a "code blue," and that the temperature had to be below freezing before you could take someone in. He explained he couldn't violate the man's civil rights, and had orders not to bring anyone in unless they wanted to go. We walked over to John. The policeman spoke to him briefly. "You want to go to the station?" John seemed not to hear. The policeman said as he walked away, opening the pack of cigarettes he had just purchased, "He don't want to go. There's nothing I can do unless they call a Code Blue."

I helped John with the plastic wrap I got from the store around his shoulders. He held it there for a moment and then let it fall to his feet. He was shaking with the cold. I thought if he didn't have shelter he could die this night. The supermarket had now closed its doors. All the shops were closing.

I had to help this man so I started making calls using my cell phone. After a two hour run-around between the local police and a nearby hospital, an emergency vehicle finally arrived and agreed to bring John to the hospital to receive a psychiatric evaluation.

I reflected on how this disturbing situation had taken so long to be resolved. As I had just returned from Paris, I know that they had a significant homeless problem, although it appears less than in our cities. Over there, mental health programs and ordinary citizens distribute warm blankets and small simple mountain tents to those who are homeless so they won't be left on the street to freeze. At night church groups distribute food and warm drinks directly to those in need.

I wonder how in our rich country, where our Citizens value human life and champion the cause of human rights, that we have so many dying each winter night on our streets? Have we become so accustomed to the sight of the ill and disabled on our streets that we do not press our leaders to do something? When our President shows his concern for the life of Maria Schiavo, by interrupting his vacation to return to the Capitol to sign an Act in an effort to save one persons life, how we can become accustomed to and ignore those dying in our wintry streets? Where are the civil libertarians who have rightfully defended persons with mental illness from unnecessary incarceration, when they realize that partially as a result of their efforts there have been unintended consequences and homelessness?

It is shocking that advocacy to restrict institutional care and treatment has resulted in a situation where thousands of people with mental illness now die from neglect and the freezing weather every year?

It will not be easy to solve the current dilemma nor our lack of enough supportive housing to accommodate people with mental illness and other disabilities. We shall need lots of low income housing for the almost one million Americans now homeless who are now at risk for freezing and death. Surely there is money available to save lives. Surely there is money for persons who are ill and disabled. In the interim, we shall need partial, inadequate solutions. Government needs to arrange matters so that people who do not wish to be transported to a shelter would be offered blankets, food, drink and warm jackets -- the basic elements to prevent illness and death. Currently, many people with mental illness tell me they are fearful of shelters because they are inhabited by many who have been discharged from jails and prison. Some of these individuals have been "toughened" by their experience and have been known to prey on others. However, advocates for people with mental illness should seek permanent resolution of the current situation.

Martin Gittelman, Clinical Professor
Department of Psychiatry, NYU Medical School

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From The Publisher

Moving Forward From Crisis To Recovery

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

It is fitting that the theme of this issue of Mental Health News is devoted to managing mental health crises. Every one of us encounters crises at some time during our lifetime. It almost always happens when we least expect it. A sudden serious illness or death of a loved one, a tragic accident, the loss of one's job, or marriage, are but a few.

Internal and External Crises

Crises exist in two distinct yet inseparable worlds—the world outside of ourselves and the world within our minds.

Most people speak of crises of the outside world—those which occur as a result of human or natural forces around us. The hit-and-run accident, the house fire, or the robbery, rape or murder that we hear about every night on the evening news.

Every so often these daily occurrences are eclipsed by more sizable and horrific events such as September 11th, the Tsunami, and more recently, the hurricanes along the Gulf Coast. Whether we are personally affected or not, crises bring the stark reality of how vulnerable and how fragile we all are into focus. Those killed by roadside bombs each day in the War in Iraq made us cringe when they first began to be reported. How many of us now feel indifferent to numbers we hear every night? However, somewhere, a family, a loved, one or an entire community mourn these individual losses deeply, and will so, for years to come.

The second form of crises are of the internal type—those associated within the realm of psychiatric concern. Each of the psychiatric disorders are delineated in the DSM IV, the Diagnostic and Statistical Manual of Mental Disorders. They may or may not have had an external basis for their onset and persistence, but many of them do. For many who have, or have once experienced a psychiatric illness, these internal crises of the mind can be as harmful to one's daily existence as any serious physical medical illness. Thoughts which make us feel hopeless, worthless or intensely scared can be debilitating and life threatening.

Moving From Crises to Recovery

Academics aside (and assuming that proper psychiatric help is being administered), how does one manage mental health crises and move towards recovery? Recovery is not a simple matter. I can only speak from my own experience, which taught me to think of recovery as a *process of becoming*—sort of in the Zen sense of thinking.

First off, recovery requires a community of support. If you are strong enough and well enough to maintain employment and are seeing a mental health professional on a periodic out-patient basis, you

Ira H. Minot, LMSW

might find comfort in the added connection provided by a support group (many of which focus on particular illness such as bipolar disorder, depression or panic attacks). If, on the other hand, your condition is more severe or persistent, you might find yourself in a day-treatment program several hours a day. While these programs offer a wide range of services, there are other supports available in many communities which can add to your repertoire of recovery oriented activities. Some people find day-treatment programs a safe haven during the initial months of a psychiatric crisis, but may find them stifling as they begin to regain strength and confidence in regaining their pre-illness life.

If you are fortunate to find a peer-run center in your community, drop by and see if you like the scene. Quite often other peers have answers to questions you might have about community services, and the peer center may have an advocate or benefits person who can help you untangle the maze of your entitlements.

There is nothing wrong with attending more than one program during your week, especially if you are not working and have the strength and the desire. In fact, getting out and being around other people is very therapeutic in itself. Whatever you do, try not to sit at home and isolate yourself for hours and days at a time. This is a guaranteed one-way ticket back into the hospital.

Left Foot - Right Foot

"Left Foot - Right Foot" was the advice given to me during my own illness many years ago. I didn't really appreciate the grassroots simplicity of this somewhat trite sounding advice until sometime after I got well. Today, I often repeat the same advice to those looking to get started on their own road to recovery. In order to walk you need to first move your left foot and then your right and then your left again. You can't move forward without taking your first small steps.

There is no simple formula that can guarantee recovery, and everyone has to find what works for them. It may involve medications, electro-convulsive therapy (ECT), talk therapies (including Cognitive Behavioral Therapy), peer support, day-treatment programs, and therapeutic approaches such as meditation, music and art therapy. Exercise and proper nutrition are also very important to maintaining your strength to do the work of recovery.

Step Outside of Your Illness

Surprisingly, one of the most therapeutic things I found which had a profound impact on my recovery, was doing what I call "stepping outside of your illness."

Stepping outside of your illness involves some way that you can find to focus your attention on helping others. This can only be done when you are well enough and are ready to try to do this. By doing this activity you will find that you are not only able to help others, but are being helped as well. To be able to have a mission and a purpose in your daily life (even if it is temporary) is very important to recovery.

Here's one way to start. See if your community has a volunteer center which provides supportive employment (paid or volunteer work) and see if you can sign up. At the core of stepping outside of your illness is eliminating hours of idle time spent in unproductive thinking about your illness and the negative feelings this activity imposes on your mind. If all you do is sit alone and fret about your condition you will never move forward and run the risk of falling further into darkness and despair.

If you live in New York State, check out NYAPRS at www.nyaprs.org. They have a Peer Bridger Program where you can receive training to help other consumers—a real win-win for everyone in recovery. There may be more such programs by different names that may exist in your very own community. If there is a chapter of the Mental Health Association (MHA) or The National Alliance for the Mentally Ill (NAMI) in your community, find out about their programs and services and get involved.

Good luck in your own recovery and NEVER give up trying!

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The Evolution Of A Psychiatric Diagnosis: Psychotic Major Depression

By Barnett S. Meyers, MD, Professor of Psychiatry, Weill Medical College of Cornell University, New York Presbyterian Hospital Westchester

The last fifty years have seen a growing interest in the phenomenon of clinical depression. We have been aware of severe depression for more than two millennia, as evidenced by descriptions of King David in the Bible and the discussions of Melancholia by Hippocrates. Shakespeare's Hamlet and Dostoyevksy's Raskalnikov are only two of the major literary figures whose actions have been attributed to states of depression. Nevertheless, a shift in emphasis, away from psychoanalytic explanations for these disorders and towards the newly-evolving fields of biological psychiatry and psychopharmacology, has caused an interest in clinical depression to burgeon. Research into psychotic depression, the most severe and life-threatening form of depressive illness, came late, with researchers and clinicians alike only beginning to focus their attention on depression with associated psychosis during the last twenty-five years. Most importantly, results from biological and treatment studies made clinicians and investigators aware that patients suffering from depression associated with psychosis appear to have a distinct form of depressive illness that does not respond to standard treatments, requiring treatments designed specifically to treat this form of depression. Although electroconvulsive therapy (ECT) has been the standard 'last resort' treatment for depression for a more than four decades, it has become the treatment of choice for psychotic depression because of the failure of this condition to respond to standard medication approaches. The introduction of new psychopharmacological medications and ongoing studies are changing this treatment landscape.

Study of the Pharmacotherapy of Psychotic Depression (STOP-PD)

The interest of the National Institute of Mental Health in determining the effectiveness of novel (atypical) antipsychotic medications led ultimately to an application, under the leadership of Barnett S. Meyers, M.D. of Weill Cornell Medical College at the New York Presbyterian Hospital in White Plains, to develop an independent grant. The application involved the collaboration of four academic institutions with investigators who have made significant contributions to existing knowledge of psychotic depression. This grant, entitled "Study of the Pharmacotherapy of Psychotic Depression", or STOP-PD, which was funded for six million dollars over five years after successful peer review, was initiated in late 2001 and will continue into 2007. The lead investigators are: Dr. Alastair Flint at the University of Toronto, Dr. Anthony Rothschild at the University of Massachusetts, Dr. Benoit Mulsant and Dr. Ellen Whyte at the University of Pittsburgh and Dr. Barnett Meyers at Cornell.

Barnett S. Meyers, MD

Why study psychotic depression? The background for STOP-PD

Consideration of the need for a treatment study of psychotic depression, must address findings from studies of major depression carried out in the 1970's and 1980's, a time when antidepressant medications were found to be effective. Seminal work carried out by Alexander Glassman at the Psychiatry Institute in New York City found that severely depressed patients requiring hospital treatment were highly responsive to high blood concentrations of the tricyclic antidepressant imipramine – "unless the patients had identifiable delusional ideas". Delusions had been known to occur in up to 20% of patients with severe major depression, but the clear and profound effect of concomitant delusions on treatment response had not been demonstrated previously. Both clinicians and researchers had approached delusions as a severe form of the pessimistic and unrealistic preoccupations that generally accompany depression. It is expected that a depressed individual will see the world through "melancholic glasses", viewing the glass as half empty rather than half full. It required antidepressant studies to demonstrate that the depression associated with severe and fixed forms of these ideas was essentially unresponsive to antidepressant treatment alone and carried a poor clinical and functional prognosis.

Once attention was given to how patients with psychotic major depression differed from those with nondelusional depression, additional clinically significant findings emerged. For example, patients who develop delusions during one episode of severe major depression are at high risk for having a psychotic form of depression during subsequent episodes. Patients with the more common form of nondelusional major depression are unlikely to ever have an episode associated with fixed irrational ideas. And these ideas matter, beyond their impact on limiting responsiveness to antidepressant treatments. Patients with psychotic forms of illness have a far greater risk of suicide, perhaps as high as fourfold. This should not be surprising: a depressed patient who is convinced that he will never recover, has an incurable physical disease, or blames himself for an imagined misdeed, would be expected to be at higher risk for suicide than a depressed patient who has these feelings or thoughts but knows that they are arising from the deep feelings of depression.

Unfortunately, the distinction between delusional and nondelusional depression is easier to describe than to make in a clinical situation. One of the first findings from the STOP-PD study was that admitting psychiatrists missed the fact that a delusional idea was present in 20% of patients who were subsequently identified as having depression with delusions by the systematic research interview. It is not uncommon to hear of a suicide in which the patient was treated with an antidepressant leading to some improvement in mood, but with the patient subsequently completing a suicide attempt, apparently because of the persistence of an unrecognized delusional idea.

Biological studies have added to this picture by demonstrating that dysregulation of the system regulating steroid secretion, particularly that of cortisol, is frequently and often severely impaired during episodes of psychotic depression, with the system normalizing when patients recover. The fact that Cushing's Disease and other medical conditions that are associated with high cortisol concentrations, are also associated with psychotic depression provides additional evidence that cortisol abnormalities may contribute to the clinical picture. The relationship to cortisol dysregulation has led to the development of medication approaches to block brain cortisol receptors. Mifepristone is one such agent. This compound, which blocks brain cortisol receptors at high doses, and serves as the anti-progesterone birth control pill RU486 at lower doses, is being studied specifically for psychotic depression. Early results have demonstrated rapid moderate improvement in psychotic symptoms, although the benefits for the concomitant depression are less clear.

Additional information was generated from studies of the dopamine system. It had been known since the 1970's that all of the original antipsychotic medications block the action of dopamine, and that illicit drugs such as cocaine can cause psychotic symptoms by increasing brain dopamine activity. Studies of psychotic depression built on this knowledge and demonstrated abnormalities in dopamine system genetics and dopamine metabolism among patients with psychotic depression. Nevertheless, these differences have been subtle and difficult to replicate, underscoring the need for further studies to elucidate the mechanisms causing the occurrence of delusions in a subset of individuals who become severely depressed.

Why the STOP-PD trial?

The poor responsiveness of psychotic depression to antidepressant treatment alone (monotherapy), led to research studying the combination of two types of medication. In the mid-1980's, Spiker and his colleagues at the University of Pittsburgh demonstrated that patients with delusional major depression responded robustly when high doses of the tricyclic antidepressant amitriptyline were combined with high doses of the conventional antipsychotic medication perphenazine. Despite the 78% remission rate associated with combination treatment, the incidence of significant side effects, particularly severe motor side effects due to the blockade of dopamine receptors by the antipsychotic medication, has limited the application of this approach. A subsequent debate in the scientific literature centered on the argument of tolerability as supporting ECT as the treatment of choice for patients with psychotic depression. The limitations of combination treatment using traditional agents received further support from studies published by collaborators in the STOP-PD trial. Mulsant conducted a study of psychotic depression in older adults that paralleled the methods used by Spiker. His study failed to demonstrate that combination treatment was superior to monotherapy with an antidepressant among older patients with psychotic depression. Similarly, Meyers found that the use of combination treatment with a conventional antipsychotic and a tricyclic antidepressant for patients who had completed a successful course of ECT did not decrease relapse rates, but did result in a high incidence of significant neurological side effects in older patients. The poor response and low tolerability among older patients treated with these medications may explain the disproportionately high use of ECT in geriatric patients. Furthermore, Mulsant reported in 1992 that only 4% of young adults with psychotic depression received the dose and duration of an intensive combination of medications (pharmacotherapy) that are considered adequate for psychotic depression, before resorting to ECT. It is clear that the practical application of guidelines recommending combination treatment for psychotic depression have been difficult for psychiatrists to follow and have been of limited benefit to patients.

Fortunately, advances in psychopharmacology have provided more tolerable medications at our disposal. The efficacy of selective serotonin-reuptake-inhibitors (SSRI's) has been well documented. Although the relative efficacy of these medications compared to the less commonly used traditional tricyclic agents remains arguable, the SSRI's are certainly better tolerated, particularly at high doses. Despite the documented greater tolerability, an increased risk for treatment-emergent suicidal ideation or behaviors (but not suicide) associated with these medications has emerged when the data from studies of adolescents have been pooled. It may well be that a small subset of children, adolescents and elderly patients have difficulty tolerating the activating effects of SSRI's, and the role of excessive psychological and/or motor activation in producing suicidal impulses in these individuals will require future study. Good clinical practice dictates that depressed patients should be monitored carefully for emergent suicidality, whether or not an SSRI has been prescribed.

see The Evolution on page 37

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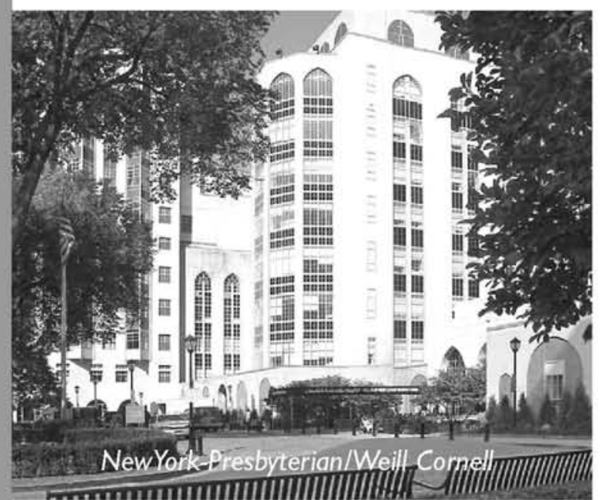
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MENTAL HEALTH NEWSDESK

NYS Office of Mental Health Applauds Pataki Budget Proposals: For Statewide Suicide Prevention and Children's Mental Health Plans

Staff Writer
Mental Health News

New York State Office of Mental Health (OMH) Commissioner Sharon E. Carpinello, RN, PhD, commended NYS Governor George E. Pataki for including the first line item for suicide prevention in NYS history and for proposing the largest one-year investment in new children's mental health services in NYS history, in his 2006-07 Executive Budget proposal.

Suicide Prevention Proposal

The $1.5 million allocation would increase the number of localities that have developed and implemented a local suicide prevention plan tailored to meet the needs of their communities and allow OMH to expand upon an already successful suicide awareness and education campaign.

"Never before has a New York State budget included monies specifically designated for suicide prevention efforts," Commissioner Carpinello said. "By becoming the first Governor to recommend doing so, Governor Pataki answers the call of mental health professionals, who in recent years have strived to break through the stigma associated with mental illness and begun to get people talking not only about mental illness, but about suicide."

Dr. Sharon Carpinello

By continuing to provide support, informational materials and implementation guidance to communities statewide, OMH will be able to reach more New Yorkers who may be contemplating suicide, or know someone who may be contemplating suicide. In addition, OMH will continue to implement new initiatives to increase awareness of the prevalence of suicide, as well as increase the public's understanding about the causes, effects, and treatment of emotional disturbances that underline suicidal ideation and behavior.

"This allocation is an invaluable step toward improving the public's awareness of suicide risk factors and prevention strategies," Commissioner Carpinello said. "I want to thank Governor Pataki as well as our stakeholders for their unwavering dedication to and advocacy for those afflicted with mental illness. It is through our collective efforts that we can maintain a public mental health system that is second to none."

Child Mental Health Proposal

Included in the Governor's 2006-07 Budget, unveiled Tuesday, is $62 million annually for the Office of Mental Health (OMH) to implement a new initiative: *Achieving the Promise for New York's Children and Families.*

Achieving the Promise for New York's Children and Families is composed of a highly interrelated series of fundamental changes, in service provision, access, and clinical quality. The initiative includes Child and Family Clinic Plus, an Evidence Based Treatment Dissemination Center; significant expansion of the Home and Community Based Waiver Program, and Telepsychiatry for children in our rural communities and a 2.5 percent cost of living adjustment (COLA) for residential and community support programs.

"The emphasis on prevention, early recognition and quality treatment will be felt not only by today's children, but for generations to come," Commissioner Carpinello added. "This unprecedented budget allocation by Governor Pataki will provide funding for new and innovative services for the children of New York State. This commitment will ensure that our families have the tools they need to succeed in helping their children grow

see Budget on page 36

Pediatric Bipolar Disorder Study

National Institute
Of Mental Health (NIMH)

Recent findings from the multi-site, NIMH-funded Course and Outcome of Bipolar Illness in Youth (COBY) study are helping to shape the understanding of three major subtypes of bipolar disorder that affect children and adolescents and how this diagnosis may affect them as adults. Also known as manic-depressive illness because of its recurring episodes of mania and depression, bipolar disorder is a serious, chronic illness which causes shifts in a person's mood, energy, and ability to function. Before the COBY study, there had been few studies on the symptom patterns and course of the disorder in the pediatric population. Understanding the effects of bipolar disorder early in life may lead to better treatments and improve long-term outcomes as these children and adolescents become adults.

Overall, bipolar disorder appears to affect children and adolescents more severely than adults. Study participants had comparatively longer symptomatic stages and more frequent cycling (changing from one mood to another) or mixed episodes. Children and adolescents also converted from a less severe form of bipolar disorder to a more severe form at a much higher rate than seen in adults.

This study comprises the largest pediatric bipolar population to date, following the course and outcome of 263 children and adolescents, ages 7-17 years. These findings were published in the February 2006 issue of the Archives of General Psychiatry. Future reports will cover in more detail the characteristics of bipolar spectrum disorders in children and adolescents, the longer-term disease progression, predictive factors of disease outcome, such as co-occurring disorders or family psychiatric history, and the effects of different types of treatments.

Over the follow-up period, 20 percent of those with BP-II converted to BP-I; of those with BP-NOS, 18.5 percent converted to BP-I and 6.5 percent converted to BP-II.

Compared to adults with BP-I, COBY participants with BP-I spent significantly more time in a symptomatic stage and had more mixed and cycling (changing from one mood to another) episodes, mood symptom changes, and polarity switches. Also, the rate of conversion between BP-II and BP-I found in COBY is higher than the rate of conversion commonly reported in studies on adults. Furthermore, this is the first study to suggest the relative instability of the BP-NOS subtype, due to the number of participants who converted to BP-I or II.

Peg Moran New SVP at F.E.G.S.

Staff Writer
Mental Health News

At F.E.G.S. Health and Human Services System, the appointment of Margaret (Peg) Moran to the position of Senior Vice President, Behavioral Health Residential Services and Special Initiatives comes with much excitement.

Ms. Moran joins F.E.G.S. on the heels of an accomplished career in both public office and the private hospital sector. Most recently, she was Vice President for Behavioral Health Services at St. Vincent's Medical Centers. Prior to that, she served in executive positions at Mt. Sinai Medical Center and Four Winds Hospital. Her background includes many years with the New York State Office of Mental Health and, formerly, with the Association for Retarded Children. Moran has a Masters degree in Social Work, held an academic appointment at New York Medical College, and served on numerous boards and public committees, including the Mental Health News, New York Academy of Medicine, and the Mental Health Association of New York State.

At F.E.G.S., Ms. Moran will oversee the agency's extensive and diverse behavioral health housing operation, which serves more than 600 individuals a day throughout the greater New York metropolitan region. She will also be responsible for the housing operations of the recently merged New York Society for the Deaf, which provided specialized residential care to 250 individuals who are deaf and/or elderly, including those who reside in the Tanya Towers complex in Manhattan. As Senior. Vice President, Ms. Moran will be involved in the broad scope of the agency's operations, which reach more than 100,000 individuals a year, some 10,000 each day throughout the New York region.

Margaret (Peg) Moran

Understanding Psychiatric Inpatient Admissions

By Steven Shainmark, MD, Chief
Evaluation and Referral Services
St. Vincent's Hospital Westchester

As the director of a psychiatric evaluation service, I frequently work with individuals undergoing an acute crisis. Hospitalization is one of many options the person has for resolving the crisis. While some people come to the evaluation service asking to be hospitalized, others find the thought of hospitalization to be intimidating and even scary. Sometimes the first thing such people will ask me is, "You're not going to lock me up, are you?" The truth is that I, like most psychiatrists, go to great lengths to help people resolve their crisis outside of the hospital. Doing that is made easier by both the wide range of services that St. Vincent's and other facilities offer for outpatients and also by the advances that have been made in medicines and psychotherapy techniques in recent years.

In any first meeting with a patient, a psychiatrist will try to get the fullest possible understanding of the individual, in order to recommend the treatment that best fits his or her needs. That includes both their recent story, leading up to the moment they came to be in the office, as well as their personal and family stories. In a psychiatric crisis, this process begins with figuring out how the patient can be kept safe, and whether this can be done without having to be admitted to the hospital. Psychiatrists in an emergency setting look at three factors that help determine whether the crisis can be resolved outside of the hospital:

1) How severe is the illness, and particularly, how dangerous is the illness?

A patient whose illness is particularly severe, debilitating, or dangerous may need to stay in the hospital to assure round-the-clock monitoring and the most intensive treatment.

2) How well allied is the patient with treatment?

If a patient doesn't think he has a problem, and doesn't want to be treated, managing his care outside of the hospital is much more difficult to do safely.

3) How strong and broad are the patient's supports, and therefore how much help do the patient and I have in moving towards relief of the problem?

If a patient has supportive family, friends or group home staff available to help her stay safe, we can all breathe easier arranging for outpatient treatment than if the patient lives alone and has no supports.

For some people the best treatment recommendation is to begin their care on an inpatient unit. Sometimes a person knows that his past crises have required inpatient treatment. Sometimes, people simply don't have the resources and supports to face the urgency or danger of their illnesses without help from an inpatient hospital staff. It is important to be aware of what an inpatient unit has to offer for people with the most severe need. On an inpatient psychiatric unit, you will be able to meet with your psychiatrist more frequently (five to six times per week at St. Vincent's), and you will also have nursing staff present twenty-four hours a day, seven days a week. A full schedule of therapeutic groups and activities helps the psychiatrist monitor your progress. Your family will be contacted and taught about your illness and how best to help with your recovery. If you have medical problems, they can be treated along with the psychiatric problem. It is also important to remember that being in the hospital means that you can step away from an outside situation that may have contributed to your problem.

Of course, some people don't want to come into the hospital, even if their relatives think that they should. In most cases, after a discussion with the psychiatrist, an agreement can be reached about the best course of action. Most people admitted to the hospital sign themselves in voluntarily. The only way people can be hospitalized when they don't want to be is if their illnesses make them imminently dangerous to themselves or others, or their illnesses globally and totally incapacitate them (so severely that they can't secure the basic essentials of life or stay out of harm's way). An example of the first case is a person who has made a suicide attempt and received the necessary medical care, but continues to wish she had died. An example of the second case is a person who has withdrawn to his room and not bathed, changed clothing or eaten for days or weeks. Patients who don't want to stay in a psychiatric hospital always have the right to speak to a mental hygiene attorney, who can arrange for a court hearing before a judge.

Working in a full service psychiatric facility, I am fortunate in being able to meet people again after their illnesses have eased and they have been discharged from the hospital. It is reassuring to hear that even though a person may have been reluctant to come into the hospital, that she now sees the hospitalization as an important first step in her recovery.

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Our 2006 Agenda for Action

By J. David Seay, Esquire
Executive Director
NAMI-New York State

J. David Seay, Esqire

In New York the 2006 legislative season is upon us. Being an election year, the political dynamic shifts somewhat, especially with the Republican majority in the Senate nervous about keeping their grip on power. And we all know that we will have a new Governor by year's end. So let the "fun" begin. There is no shortage of issues affecting New Yorkers with serious mental illness and their families.

NAMI-NYS kicked-off its 2006 advocacy efforts with our Legislative Conference in the Legislative Office Building on February 7th. Speakers from the Legislature, Office of Mental Health and our own NAMI-NYS leaders addressed the crowd. Our 2006 Action Agenda was unveiled at that time. It includes both our Legislative and Budget priorities for the year. Our issues and advocacy strategies are shaped by our very capable leadership -- NAMI-NYS President Michael Silverberg and Government Affairs Committee Co-Chairs Muriel Shepherd, Ione Christian and Judith Beyer, with much able assistance from First Vice President Sherry Grenz and Second Vice President Patricia Webdale. Here is the 2006 Agenda for Action:

LEGISLATIVE PRIORITIES
"DEMAND JUSTICE & RESPECT"

"BOOT THE SHU" LAW

NAMI-NYS calls for passage of Assemblyman Aubry's and Senator Nozzolio's bills 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 and provide needed medical care instead. It is time to end this barbaric practice. Ask your Assemblyman and Senator to vote to "Boot the SHU." DEMAND JUSTICE & RESPECT: BOOT THE SHU!

SEXUAL PREDATORS

NAMI-NYS calls for a law to ban the use of state psychiatric hospitals as holding pens for violent sexual predators released from prison. Hospitals are for medical care and not intended for this use. Using them this way risks the safety of patients and their caregivers, drains dollars and clogs beds in an already strained system and exacerbates the stigma of mental illness. DEMAND JUSTICE & RESPECT: KEEP SEXUAL PREDATORS OUT OF PSYCHIATRIC HOSPITALS!

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. Timothy would be alive today had New York's laws prohibited insurance discrimination against persons with mental illness. Urge the Legislature to reach an agreement on Timothy's Law now. DEMAND JUSTICE & RESPECT: PASS TIMOTHY'S LAW!

HOUSING WAITING LIST LAW

No one can know the full extent of the need for community mental health housing (with services) without a waiting list. Ask your elected officials for a law to require a waiting list for community mental health housing. DEMAND JUSTICE & RESPECT: PASS A HOUSING WAITING LIST LAW!

BUDGET PRIORITIES
"DEMAND JUSTICE & RESPECT"

HOUSING

Increase the budget for housing with services for New Yorkers with mental illness. Thousands are in adult homes, jails, prisons, homeless shelters and nursing homes while others live at home with aging parents terrified of what will happen when they can no longer care for them. Estimates show that 35,000 - 70,000 more housing units are needed. NAMI-NYS calls for a commitment to 3,500 new units a year and a long-term plan for housing and services. DEMAND JUSTICE & RESPECT: FUND MORE HOUSING!

RESEARCH

Demand that the State stop efforts to slowly starve the research budget through staff cuts and attrition. Keep the world-class Nathan S. Kline and Psychiatric Institutes intact, fully staffed and working toward cures for mental illness. Research is our

see Agenda on page 39

A Voice of Sanity: A Consumer Advocacy Column

What We Call Ourselves

By Joshua Koerner
Executive Director
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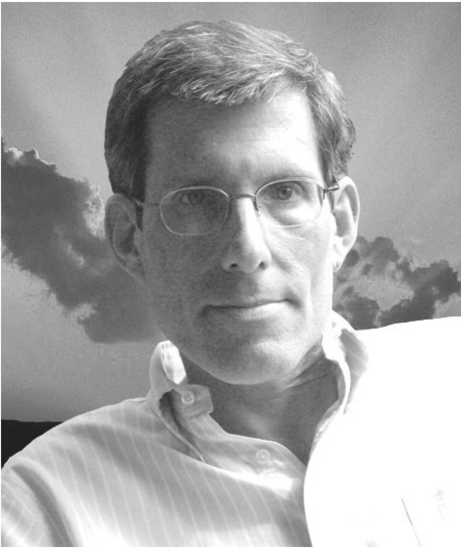


Joshua Koerner

25 years ago I became bipolar because doctors said I was bipolar; disabled because the government said I was disabled, and mentally ill because my family said I was mentally ill. And, after that first trip to a locked unit, when I found out that people really do get put into strait jackets (although they are not called strait jackets on the unit, they get to be "camisoles"), I knew that I was a mental patient. You would think that "mental patient" was an epithet, but it's still seen on the front page of the paper of record, *The New York Times.*

Back then, I wasn't aware there were any other terms of self-description for what had happened to me. I wasn't aware there was a movement of people who had been through what I had and were now looking to change the system, redefining themselves in the process. It wasn't until years later that I became aware of another sobriquet: "c/s/x" consumer/survivor/ex-patient. I liked it; it had an insider, code-word feel. Eventually, it got shortened to consumer, perhaps because it's not just what in-group members call themselves; it's what they in turn can convince outsiders to call them, and mental heath care providers were never going to adopt either survivor or ex-patient.

Consumer, however, was acceptable. It made the whole messy, imbalanced process that defines we-who-are-normal-and-give-care and you-who-are-aberrant-and receive-care into an egalitarian, business-like transaction. We're selling services, you're buying them. You're choosing the services and who you get them from. An educated consumer is our best customer.

Not everyone saw it that way. Some advocates saw "consumer" as having unfortunate echoes of "useless eaters," the Nazi term for the disabled, who were first labeled, then euthanized, in what became the pilot murders of the Holocaust. Even if you think that's a stretch, there's no getting around the fact that to consume means just what it says: to eat or drink up, to use up, to purchase, but also to squander and to totally destroy, as by a fire. Being a consumer and being the provider are hardly equals; they are still opposites, us and them all over again.

The fact that We the Diagnosed still struggle with self-description hardly makes us unique; witness the evolution from "colored" to "Negro" to "black" to "Afro-American" to "African-American" to "of color". The term I hear used most often beside "consumer" is "peer". It has the advantage of not having to reference the relationship with the other, unequal partner. It is a way of saying We are Us. But who are we? The Peer Accreditation Association of New York State, now defunct, struggled with that question for four years, and came up with the following:

Someone who has been affected by

- A psychiatric label and prejudice associated with it.
- Determination by other (e.g. relatives, service providers) to lack competency and negative valuation as a result of diagnosis.
- Discrimination from family, friends, treatment providers and society in general.
- Major life disruptions such as homelessness, repeated unemployment, extended isolation, loss of important relationships, childhood and adult trauma, loss of civil liberty through institutionalization or other forms of confinement.
- Major, protracted experiences such as disabling fear, anxiety, depression, hopelessness, helplessness, stemming from having a diagnostic label or from traumatic life events and inhumane mental health treatment.
- Significant positive altered states associated with energy, creativity, spirituality, and other like phenomena.

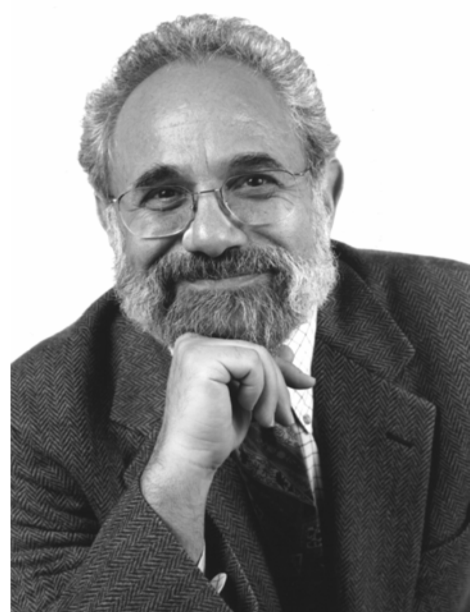
I love that last one. It looks as though, when they got through all the other aspects of peer-dom, they realized the whole list was profoundly negative. It's like they had to put <u>something</u> positive in there. Even in carefully defining ourselves, we could come up with almost nothing that wasn't about loss. Note that there is no consensus among people who have been labeled as being mentally ill that mental illness is a demonstrable disease state. Where are the blood tests?

see What We Call on page 42

POINT OF VIEW

The Promise of Geriatric Mental Health in New York State

By Michael B. Friedman, LMSW



Michael B. Friedman, LMSW

New York State has taken major steps to confront the mental health challenges of the elder boom. In 2004 The Office of Mental Health (OMH) and The Office for the Aging (SOFA) made geriatric mental health a priority. (Thank you Commissioner Sharon Carpinello and Director Neal Lane.) In 2005 The NYS Legislature passed The Geriatric Mental Health Act nearly unanimously. (Thank you Senator Nick Spano, Assemblyman Peter Rivera, Senator Thomas Morahan, Assemblymen Steven Englebright, and Senator Marty Golden.) The Governor signed the Act into law and included $2 million in his budget request for 2006-7 to implement the Act. (Thank you Governor George Pataki.)

The proposed funding for geriatric mental health is designated for the start-up of services demonstrations programs. This is exciting because it is so clear that meeting the mental health needs of older adults will require substantial innovation as well as increased service capacity. And there is an abundance of wonderful ideas for new service approaches. $2 million won't fund them all, but there will be some great proposals to choose from.

The legislation calls for demonstrations in 9 areas: (1) community integration, (2) improved quality of treatment in the community, (3) integration of services, (4) workforce, (5) family support, (6) finance, (7) cultural minorities, (8) information clearinghouse, and (9) staff training.

Here are just a few of the possibilities in each category.

Community Integration

- Projects that prevent the need for placement in institutions or facilitate transition to the community.
- Projects using innovative approaches to manage behavioral problems—such as self-neglect, rejection of care, and hoarding—that frequently result in institutionalization.
- Projects that improve mental health treatment and rehabilitation in nursing and adult homes.
- Projects using housing models for older adults with psychiatric disabilities that are designed to provide access for those with physical disabilities, to prevent injuries due to falls and other accidents, to provide assistance with activities of daily living, and to provide care for the lifetime of the older adult—including end-of-life care.

Improved Quality of Treatment in the Community

- Projects that use evidence-based and other state-of-the art practices.
- Projects designed to prevent suicide among older adults.
- Projects that provide mobile mental health services both in the home and in community settings such as senior centers and naturally occurring retirement communities (NORCs).
- Projects that promote increased life expectancy among people with serious mental illnesses through improved health care and health promotion.
- Projects that adapt models of recovery and rehabilitation to meet the developmental needs of older adults with psychiatric disabilities.
- Projects adapting social and medical adult day care to the needs of people with psychiatric disabilities.
- Projects that provide innovative ways to manage psychiatric crises.
- Projects that address problems of addiction, especially alcohol and prescription drug abuse.
- Projects that educate the public about mental illness, addictive disorders, and treatment.

Integration of Services

- Projects that provide screening for mental health problems in health and aging programs.
- Projects integrating mental health with primary, specialty, and/or home health services.
- Projects co-locating mental health services in community settings such as NORCs, senior centers, and supportive housing sites.
- Projects offering "one-stop shopping."
- Projects that establish local networks integrating mental health, health, and aging services.
- Projects that link response to mental health and spiritual concerns.

Workforce

- Projects to entice people to careers serving older adults with mental health problems.
- Projects to improve education about geriatric mental health in social work, medical, nursing, and psychology programs.
- Projects reflecting effective recruitment and retention of bi-lingual, bi-cultural, or culturally competent staff.
- Projects developing service roles for paraprofessionals and volunteers, including peers and family members, under professional supervision.

Family Support

- Projects providing support groups, counseling, affordable treatment, respite, and support in times of crisis for:
  - Family members who care for older adults with physical and mental disabilities.
  - Older parents providing care for their adult children with psychiatric disabilities.
  - Grandparents raising grandchildren.
  - Projects in which family support organizations reach out to older adults in need of support.

Specialized Populations

- Projects designed to reach out to, provide mental health education for, engage, and provide effective treatment for cultural minorities including, racial and ethnic groups, the hearing or visually impaired, and the lesbian, gay, bi-sexual, and transgender (LGBT) community.
- Projects that establish innovative services in minority neighborhoods.

Finance

- Projects using new financing models to support state-of-the art and innovative practices.
- Projects that pool funding from the mental health, health, and aging systems.
- Projects that maximize Medicare income.

Information Clearinghouse

- A project to compile and disseminate information on service innovations and policy developments to improve the care to older adults with mental disabilities.

Staff Training

- Training in evidence-based and other state-of-the-art geriatric mental health practices.
- Training to enhance cultural competence.
- Training of health, mental health, and aging personnel in the identification of risk of suicide and in prevention strategies.
- Training of health, mental health, and aging personnel in the identification of mental illness, appropriate intervention, and resources in the community.
- Training of long-term care health providers regarding the treatment and management of behavioral problems that make it difficult for older adults to live in the community.
- Training regarding financing opportunities.

This is quite a laundry list of possibilities, and I'm sure I have overlooked some very good additional ideas. It reflects the challenge that The Office of Mental Health and other state agencies will have to confront to identify the priorities for the first round of grants. But this is the kind of problem one wants to have—too much to choose from rather than too little. And it means that once state officials select their priorities, New York State will be well on the way to modeling excellence in geriatric mental health for the rest of the nation.

Michael B. Friedman is the Director of the Center for Policy and Advocacy of The Mental Health Associations of NYC and Westchester and The Chairman of the Geriatric Mental Health Alliance of New York. The opinions expressed in this column are his own and do not necessarily reflect the positions of the MHAs. Mr. Friedman can be reached at center@mhaofnyc.org.

THE MENTAL HEALTH LAWYER

Legal Aspects of Guardianship For The Mentally Retarded and The Developmentally Disabled

By Carolyn Reinach Wolf, Esquire
and Douglas K. Stern, Esqire

Carolyn Reinach Wolf, Esquire

According to the American Association of Mental Retardation, approximately 1% to 3% of the general population carries a diagnosis of mental retardation or developmental disability. Parents with a child diagnosed with mental retardation or a developmental disability face many challenges when that child reaches the age at which the law deems one responsible for decision-making. In New York, the general rule of law is that an individual who is eighteen years of age or older is deemed capable of making their own decisions unless there is a judicial determination that they lack decision-making capacity. Until this determination is made, many financial institutions, benefit and healthcare providers will not recognize a parent as having decision-making authority. What is a parent to do when there is no legal determination of incapacity and their adult child cannot make decisions for him/herself due to a diagnosis of mental retardation or developmental disability?

Article 17-A of the Surrogate's Court Procedure Act ("17-A" hereinafter) provides the statutory framework for the implementation and maintenance of a guardianship for an individual deemed to be mentally retarded or developmentally disabled. Prior to 1989, a "17-A" guardian could only be obtained for individuals considered to be Mentally Retarded. In 1989, the New York State legislature recognized the fact that a developmentally disabled person's ability to make legally competent decisions might be impaired by their disability and included them within the statute.

Generally speaking, the "17-A" guardianship is considered to be a long-term planning tool for mentally retarded and developmentally disabled individuals who will likely not be able to care for themselves or have legal capacity to make decisions. The "17-A" guardianship process is under the sole jurisdiction of the New York State Surrogate's Court, compared to similar guardianship statutes which are administered through other branches of our judicial system. (Guardian for the Mentally Ill - Mental Hygiene Law Article 81-generally administered through the Supreme Court; and Law Guardians for Children - Family Court Act – concurrent jurisdiction by the Supreme Court and Family Court). The presiding Judge in a "17-A" proceeding is called the Surrogate who will oversee the entire implementation and administration of the guardianship process. The Surrogate is guided by statute to appoint a guardian who will have broad authority over the disabled person's property and person only when it is in that person's best interest. The applicant (Petitioner) has the burden of proving the nature of the disability which leads to incapacity and the need for a guardian to be appointed.

The statute defines the diagnosis of mental retardation as "a person who has been certified by one licensed physician and a licensed psychologist, or by two physicians at least one of whom is familiar with or has professional knowledge in the care and treatment of persons with mental retardation…as being incapable to manage him or herself and his or her affairs by reason of mental retardation and that such condition is permanent in nature or likely to continue indefinitely." S.C.P.A. §1750. It should be clear that courts will draw a distinction between a diagnosis of mental illness and mental retardation/developmental disability and will not entertain a "17-A" guardianship application for an individual solely diagnosed as being mentally ill. From a clinical perspective, the American Psychiatric Association and the Diagnostic and Statistical Manual of Mental Disorders IV (commonly known as the DSM-IV), define the clinical diagnostic criteria for mental retardation as follows: A) a significantly sub-average intellectual functioning with an IQ of 70 or below; B) Current deficits of impairments in present adaptive functioning in at least two of the following area: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety; and C) Onset before 18 years of age.

The Statute defines the diagnosis of developmental disability as "a person who has been certified by one licensed physician and a licensed psychologist, or by two physicians at least one of whom is familiar with or has professional knowledge in the care and treatment of persons with developmental disabilities, having qualifications to make such certification, as having an impaired ability to understand and appreciate the nature and consequences of decisions which result in such person being incapable of managing himself or herself and/or his or her affairs by reason of developmental disability and that such condition is permanent in nature or likely to continue indefinitely and whose disability: 1) is attributable to cerebral palsy, epilepsy, neurological impairment, autism or traumatic head injury; 2) is attributable to any other condition of a person found to be closely related to mental retardation because such intellectual functioning or adaptive behavior to that of mentally retarded persons; or 3) is attributable to dyslexia [under certain circumstances]; and 4) originates before such person attains age twenty-two, provided however, that no such age of origination shall apply for the purposes of this Article to a person with traumatic head injury." S.C.P.A. §1750-A.

A Petition for a guardianship for a mentally retarded or developmentally disabled person can be made when that individual is eighteen years of age or older by a parent or any other person eighteen years of age or older who is "interested" in the person's care. S.C.P.A. §1751. The Petition must contain information relating to almost every aspect of the mentally retarded or developmentally disabled person's life. For example, the Petition should include the following: a list of relatives, information regarding the proposed Guardian(s), the subject's level of functioning and physical health, a listing of assets and income, etcetera. Once the Petition is filed and properly served, the court will set a date for a hearing. While a full adversarial hearing is not required, there are circumstances when there is a dispute that will necessitate a hearing and quite possibly a jury trial. Once the Surrogate has determined that the developmentally disabled/mentally retarded individual's best interests will be suited by the appointment of a guardian, one will be appointed, generally for an indefinite period of time, with plenary authority over matters relating to the individual's personal needs and

see Legal Aspects on page 29

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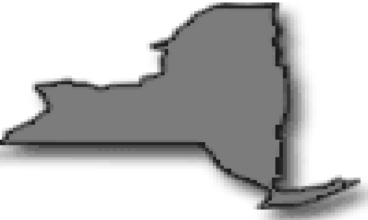
The NYSPA Report



The “Commission on Health Care Facilities in the 21 Century” and the Public Mental Health System in New York State

By Barry B.Perlman, MD, President
New York State Psychiatric Association

While the work of the "Commission on Health Care Facilities in the 21st Century" continues, the Commission has yet to gain the level of visibility and concern it deserves in the mental health community. Created as part of the New York State budget legislation for 2005, the Commission has been likened to the federal government's military "base closings" commission. Ultimately, it was put forward as a vehicle for the reorganization and rationalization of the state's health care infrastructure of hospitals and nursing homes. The legislation does not require the Commission to make recommendations regarding the reconfiguration of the state's public mental health system, the NYS system through which most persons with serious and persistent mental illness (spmi) receive care. Nevertheless, the recommendations of the Commission have the potential to exert a vast impact on the mental health system of our state. While I shall provide supporting data for my argument later on, I would like readers to understand that while mental health services comprise a relatively small part of the entire spectrum of services provided by the state's Article 28 hospitals and nursing homes, those same institutions play an enormous role in the provision of all mental health services in New York. Therefore it is critical that interested professionals and advocates keep a close watch on the deliberations of the Commission. They must insist that those appointed as Commissioners ask the right questions and obtain the data pertinent to the role played by institutions licensed under Article 28 of the Public Health Law in the provision of mental health services which they have been charged with reviewing.

Advocacy organizations, including the New York State Psychiatric Association, interested in New York's public mental healthcare delivery system need to understand the process set in motion by the legislation. The law envisions that through a process involving the Commission, Regional Commissions and related Regional Advisory Committees recommendations on the reconfiguration and "right sizing" of health care facilities will be made to the Governor almost immediately following the 2006 election. The Governor will send the Commission's recommendations to the legislature shortly thereafter. The legislature will then have to vote to reject the recommendations as received, without further amendment, before year's end. A failure to vote to reject will be tantamount to adopting the Commission's recommendations. If adopted, a process of reconfiguration will begin to be implemented. If defeated, the Commission's report, I believe, will continue to influence the course of change for the health care industry in NYS by virtue of the effort expended and the data and analysis embodied in it. While not at the core of the legislative charge to the Commission, the needs of the mental health system must be given full weight in the Commission's deliberations because their recommendations can not but significantly affect the state's system for the delivery of mental health services.

The "Factors Book" distributed to Commission members at their first meeting describes the statistics used which include a categorization of "Major Service Categories". Among the services referenced is "Psychiatric inclusive of: Psychiatric, Drug Detoxification and Rehabilitation, Alcohol Detoxification and Rehabilitation". To those concerned with the mental health system it is clear that related data subsumed in the above over inclusive category will need to be disaggregated and viewed in more detail.

The following information will make clear why a perspective with greater nuance is required. In 2003 the total of expenditures by Article 28 hospitals in NYS was $38 billion. Of that amount, $2.5 billion (7%) was expended on mental health and substance abuse services. Mental health expenditures were: inpatient $1.4 billion (55%), outpatient $ 660 million (26%). Substance abuse expenditures were: inpatient $ 250 million (10%), outpatient $ 242 million (9%). (These data were derived from 2003 institutional cost reports.) These data make clear that mental health and substance abuse services comprise a relatively small part of the total expenditures of general community and teaching hospitals in NYS.

The question which then follows is, "What proportion of all expenditures for mental health care by licensed facilities and programs is accounted for by expenditures by Article 28 hospitals and to what extent do those hospitals serve SPMI adults and SED kids?" To answer these questions we may look to data provided by the 2003 Patient Characteristics Survey as summarized in the table below.

Table 1.

	Total	Art 28	Art 31	OMH
State Totals	$ 4.694 billion	37%	31%	31%
Inpatient	$ 2.541 billion	48%	10%	43%
Outpatient	$ 1.065 billion	40%	44%	16%
Housing	$ 429 million	3%	79%	18%
CSP	$ 387 million	8%	74%	18%
Case Mgmt	$ 155 million	11%	68%	21%
Emergency	$ 116 million	53%	27%	20%
Percent Adult Services for SPMI adults		78%	80%	88%
Percent kids services for SED kids		76%	79%	97%

A final data set worth noting for purposes of this piece's argument relates to inpatient psychiatric capacity and utilization. Currently there are approximately 5800 inpatient psychiatric beds in general hospitals and between 800 and 900 in psychiatric hospitals licensed by OMH. These numbers do not include the number of beds available in the state psychiatric centers. The NYS SPARCS data set, based on information from only the inpatient psychiatric units in Article 28 general hospitals, reveals the following about psychiatric discharges.

Table 2.

Year	Discharges	Days	ALOS
1998	106,174	1,613,209	15.19
1999	108,451	1,647,129	15.19
2000	109,160	1,634,039	14.97
2001	109,815	1,666,072	15.17
2002	111,430	1,669,367	14.98
2003	108,221	1,609,795	14.88

The data in Table 1 elucidate the role played in the public mental health system by Article 28 hospitals. As the largest component of the system, they represent 37 % of all costs including 48 % of inpatient and 40 % of

see The Commission on page 30

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The Case Managers Toolkit

A Quick Reference Guide to Government Benefits and Back-To-Work Programs

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

Jennifer, an MSW Discharge Planner at a large psychiatric hospital logged onto the Social Security Administration's (SSA) website, www.ssa.gov to download form #3368, SSA's primary application form for SSI and SSDI. To her surprise the response to her search was "your search did not match any documents." She knew that wasn't right and tried a number of different searches, to no avail. She wasted thirty minutes, couldn't find the form and the patient, his family and her supervisor were waiting.

Sharon's client Steve had received SSA's Ticket to Work, a program that encourages people who receive disability benefits back into the workforce. He had heard if he enrolled it would prevent a medical disability review for five years. Sharon called SSA's Helpline 1-800-772-1213 for verification. After a ten minute wait Sharon spoke to the operator who told her "the Ticket to Work does not prevent a medical disability review." Confused, Sharon called Maximus, the Ticket administrators, who told her that "the Helpline operator was incorrect and to go ahead and apply." Who was Sharon to believe; SSA or Maximus? What should she advise her client to do?

Harvey's boss wanted to give him a $1,000 Christmas bonus, but Harvey was on SSDI and was already earning near the $830/mo. limit. He was worried that if he accepted the bonus he'd trigger a review and lose his SSDI. Kelly, his caseworker, checked SSA's Redbook but found no mention of a bonus. She then checked SSA's website and again found nothing. What should she advise Harvey to do; accept or turn down the $1,000?

Mary, a caseworker with five years experience at a large community agency was frustrated and confused: she had referred three needy SSI recipients for food stamps and each had been awarded a different amount; $10/mo., $54./mo. and $149/mo. All were single adults living alone and receiving SSI of $666/mo., Medicaid, and did not work. How could she help her hungry clients? The local government units' caseworker wasn't available to explain.

Peter's counselor, Carolyn, had read that Peter was a "dual eligible," he would have to choose from dozens of Medicare Prescription Drug Plans, then, screen thousands of drugs to see which were covered, call his doctor for substitute scripts, and visit his pharmacy to see if they participated in the plan. The counselor understood there could be penalties for not enrolling by January 1st and Peter may not be allowed to change plans. Carolyn, Peter and his parents spent weeks sifting thru websites, booklets, articles, and attending seminars. There were countless phone calls and emails and the more they learned, the more confused and frustrated they became.

Donald M. Fitch, MS

These five case histories actually happened in 2005. They are just a small indication of the countless frustrating incidents that happen to providers and consumers every day, all across the country.

Legislated changes in Government Social Service Programs in 2005 included eligibility, procedure, privatization and consolidation. The rules are likely to become more complex in 2006. Timely, accurate and easy to understand information for providers has become critical if they are to help persons in need acquire basic services.

At the Center for Career Freedom, we believe the ideal solution is a provider guide to government programs. A Toolkit, which would enable case managers to negotiate the complexity of federal, state, and local benefits and back to work programs. A Toolkit that would promote client stabilization in the community and when ready, return to self-sufficiency.

We began our search for a comprehensive resource of federal, state and local benefits and back to work services with an internet search, a provider survey of case managers, government agency personnel, academics, consumers and their families, and a literature survey of the leading vocational research authorities; Bond, Becker, Anthony, Drake and Mowbrey.

While we found a number of sites which contained benefit forms or links to forms, a simple summary of the essential programs for the majority of clients, which contained precise eligibility criteria, benefit amounts, earnings caps, exceptions and allowances from the consumer's perspective and in plain English, were not found.

Thru the internet search and surveys we learned the following:

- The overwhelming majority of consumers, their families, professionals, educators and government officials simply do not know enough about the majority of critical services available to optimize timely treatment. Our surveys of over one-hundred case managers' knowledge of basic benefits (their Benefits IQ) among community, federal, state and local government agencies averaged a grade of only 26 percent !
- Government agencies have different program eligibility criteria, earned income penalties and language which makes it very difficult to comprehend, compare and evaluate.

In response to this universal need for an easy to use quick reference source of accurate, up to date information of the essential benefits, forms and economics of recovery, we developed the Center for Career Freedom - Case Managers Toolkit. It consists of three Guides:

- The Quick Reference Guide to Government Benefits: A hard copy portable case management aide summarizing the essentials of some thirty Government benefits programs for single adults living alone who may be eligible to receive SSI, SSDI, TA (welfare), Medicaid, HUD, and more
- Form-Link: A compilation of over five hundred Federal, State and local application forms for essential benefits
- The Quick Reference Guide to the Economics of Recovery: A Guide-Worksheet to assist recipients of SSI, SSDI, and TA to transition off their benefits to self-sustaining employment.

Derived from the latest Government websites, the Toolkit demystifies the essential Federal, State and County benefit and back to work programs. It empowers tens of thousands of people in New York with psychiatric or physical disabilities, and people with substance abuse problems and who are homeless, to finally have a user-friendly resource to help them understand their own benefits and program opportunities.

The Toolkit is also a must-have for the provider community who interface with consumers and families seeking benefits information on a daily basis.

The Toolkit has been reviewed and verified by state, federal and local government agencies and recently completed a ten month field test. The field test was given to over one-hundred case managers, counselors, social workers, and peer counselors and housing advocates at a dozen sites including two hospitals; White Plains Health Center's Methadone Clinic, and St. Vincent's Hospital's Intensive Case Management Unit in Westchester. It has also been reviewed by numerous community agencies, including: Westchester Independent Living Center, JAWONIO, NAMI-Westchester, The Jewish Board of Family and Children Services, the Hudson Valley Dept. of Labor, the Westchester County Department of Community Mental Health's ACT Team, the White Plains office of VESID, and the Westchester County Department of Social Service's One-Stop Program. The response has been excellent. Some comments from the field test include:

"Summarizing the essential facts and figures of so many government aid programs into one easy to read and easy to understand guide is a common sense idea that helps caseworkers navigate the maze of numerous government aid programs. Having easy and reliable access to it on one page will help caseworkers to more reliably identify the services available to their clients."

"What impresses me most about the Toolkit is the wide range of support it has received from the community. A product that draws support from so many service providers deserves special attention."

"Our case managers recently completed a twelve week field test of the Toolkit and the overwhelming majority found the Toolkit: definitely increased their understanding of government benefits, was easy to understand and use, and case managers learned more from the Guides than they would have from a three day seminar."

"About half of our caseworkers reported the Guides resulted in fewer errors, reduced the stress of acquiring benefits, increased their job satisfaction, increased their professional skills and value to their employer. Over one-third said: "I would definitely spend my own money to have this Toolkit."

"The Guide promotes communication, service integration and teamwork across private and public human service systems. In turn, this benefits the recovery and rehabilitation of the over six hundred-thousand people with severe and persistent mental illness in New York."

The "Quick Reference Guide to the Economics of Recovery" section of the Toolkit addresses the final phase of recovery; how to meet the challenge of self-sufficiency. This last section provides the case manager with a tool for aiding most clients (SSDI, SSI, and TA) to leave the very benefits that stabilized them in the community. It includes:

- A summary of fifty Employment Opportunities from the NYS Department of Labor's "Workforce New York - 2005 Data Base," including: average earnings, qualifications, working conditions and outlook, to help clarify the job choice.
- Individual Employment Plan: a worksheet enabling the counselor and the consumer to create the specific steps required to reach the job goal.
- Benefits Estimation Worksheet: an aide which calculates the total value of benefits to be replaced thru employment, in order to achieve self sufficiency.
- Maximum Income Scenarios: a money management tool designed to educate the consumer about the economics of recovery.

Future Objectives

- To build upon the successful field trials by expanding distribution of the Toolkit to community and local government agencies throughout Westchester and the lower Hudson Valley of New York State.
- To produce two 30 minute webcasts for caseworker training.
- To adapt the toolkit for New York City providers, field test and refine for city-wide pilot test distribution in 2007.

To learn more about the Toolkit send an email to: donfitch@freecenter.org and visit www.casemanagerstoolkit.org our new website now under construction.

2006 VERSION AVAILABLE NOW!

The Case Manager's Toolkit

A quick & easy reference guide to government benefits and applications... AT YOUR FINGERTIPS!

Field tested at two hospitals, four local government units and a dozen community agencies in Westchester and NYC, the Toolkit enables providers to manage the complexity of federal, state and local benefit and back-to-work programs.

Quick Reference Guide To Government Benefi
for People with Disabilities

This guide summarizes important information about local, state and federal benefit programs. Its goal is to increase provider efficiency and empower consumer/recipients. Benefit rates are based on the average for the Centers' population of single adults li alone in Westchester County, New York. Government ben may vary by disability, marital status, household size, inc

Determining Eligibility for Benefits

1 Has the person been diagnosed with a mental/physical disability?

No

Yes

Apply for Temporary Assistance (TA; Welfare)

Typical benefits include:

- Shelter/housing
- Medicaid (includes prescriptions and van)
- $137/mo.personal needs at a shelter
- Up to $149. in food stamps (if included in housing) Food & Meal Allowance
- Job skills training an

Benefit Lin

SSDI
A person can earn

SSI
A person can earn
Maximum allowab

Medicare Prescrip
Saves about half.

For more information, visit
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Center for
Career Freedom

Westchester Mobile Crisis Team: Helping Individuals and Families

By Richard Gallagher, MD, and Cary Wagner, LCSW
Comprehensive Psychiatric Emergency Program (CPEP)
Westchester Medical Center, Behavioral Health Center

An emotional or psychiatric crisis can strike anyone, but certain scenarios are especially worrisome and may warrant immediate professional assistance. That's where a Crisis Team plays an invaluable role.

Recent tragedies involving individuals with long histories of mental illness injuring or killing others , even family members, have revived an ongoing controversy about whether mentally ill individuals have higher rates of violence than the general population. Contrary to popular myth, this has never easily been scientifically proven to be the case. The perception can add a burden of stigma, as well.

Nevertheless, the risk is real that individuals in a severe crisis who are untreated may well progress to violence or, more commonly, self-destructiveness. Especially if the mentally troubled person abuses substances, as unfortunately many do, the danger of an escalation to tragedy is very real.

Sadly, the burden of caring for a person with a serious mental illness can easily overwhelm the resources of the most caring families. On the other hand, the risk is great that the family becomes overly hopeless. Demoralized by years of frustration in their attempt to help and reason with the patient on their own, too commonly families throw up their hands and say, "Nothing can be done." The patient deteriorates.

Fortunately in Westchester, a very easy and practical start to getting help is but a phone call away. The Westchester Mobile Crisis Team is a 24-hour, 7-day-a-week program, made available through public funding precisely to deal with such emergency situations before the worst happens. Based at the Behavioral Health Center at Westchester Medical Center, the Crisis Team can travel anywhere in Westchester. The team can be called by individuals, physicians and even law enforcement to evaluate any and all situations and to offer our experienced advice.

The "emergency" can be an incident as simple as an individual who has become isolated at home, refusing all help. If danger is imminent, or strongly suspected, the Mobile Crisis Team clinicians have special legal authority to deal with the case, always working with the individual and families in the most humane and least restrictive manner.

Because this kind of resource is available in the community, we want families to be aware that they need not become "enablers". Because of their natural sympathy or, rather, perhaps their despair in the face of the great suffering of their family members, relatives often are reluctant to "force the issue" and may, for instance, avoid hospitalization at all costs, even when it would clearly be helpful. Hesitation can be disastrous.

Individuals with schizophrenia, bipolar disorder, a substance abuse history or an overwhelming personality disorder rarely have the insight to reach out for help on their own. Without help, they may come to present a serious risk of injury to themselves or others.

Mental health professionals are eager to provide assistance, but we often need friends or family to take the initiative and make that call for help.

Let's talk about "crises" in more depth. Not all individuals with psychiatric problems have been traumatized, although many have been (and it now appears from good surveys in far higher proportions than used to be thought so, say only twenty years ago). It is safe to say, however, that most people, to some degree, as well as virtually all people with a psychiatric disorder have experienced a crisis in their life at some point, or indeed multiple ones.

Like the eighteen other crisis teams in New York State, the Westchester Mobile Crisis Team (MCT) based at the Behavioral Health Center of the Westchester Medical Center, specializes in the management and brief treatment of these crisis situations. It handles thousands of calls a year and sees a couple of thousand individuals either in our sites or in the community for crisis-related episodes annually. While we have found that the route of a crisis, the "crisis pathway", is quite complex, there are some distinct patterns and generalizations about crises that bear emphasis.

Richard Gallagher, MD, Cary Wagner, LCSW

Generally (with exceptions, of course, especially true in light of the recent events in our country involving the attacks on the World Trade Center), the calls for crisis help do not tend to originate from someone just acutely traumatized, but rather from two other chief sources. One scenario involves an individual who has been functioning more-or-less reasonably well but with some psychological vulnerabilities, and who, while experiencing a stressor, finds him/herself in a seriously distressed state.

The other largest series of cases we tend to see involve individuals with preexisting, frank psychiatric disorders, who then, due to a variety of circumstances, show a marked exacerbation or deterioration. Both groups clearly benefit enormously from the ready availability of immediate and specialized crisis services.

These typical cases examples should not prompt a "pathologizing" of the crisis situation. A crisis, brought on by any of multiple reasons – some commonplace – can be a growth opportunity, as well. Healthy individuals may have their own crisis proclivity, though generally recover without involvement of the mental health system.

The more vulnerable cases outlined above, though, almost invariably do need the help of more specially trained clinicians. Consistent with crisis theory, we try with all our cases, however, to put the emphasis on maximizing strengths and promoting a healthy resolution. We try, for instance to avoid hospitalization, except in emergencies. While we may try to shore up defenses, rather than aim at uncovering techniques, we try to mobilize patients' own inner resources in ways they themselves may not have realized possible. Further, we encourage the patients to utilize their own support systems, as well, whenever feasible, and ideally to return to their usual level of functioning at work, school, and home. As with military psychiatrists earlier in the century, who indeed discovered many of the crisis principles we still utilize today, one tries to have the patient return to the "front", unless clearly contraindicated.

Whatever the precipitating challenge – separation from home and parents, a painful breakup, the need to face finally a developmental step heretofore avoided – we attempt to have the patients (and family, as applicable) work toward a solution of their own, with our guidance and support as needed. We also aim for a "negotiated" resolution – not presuming we should impose a solution, but aiming for genuine dialogue and flexibility with all parties involved.

As opposed to standard practice in more traditional psychotherapies, the crisis approach is active, goal-focused, and time-limited. Classic crisis theory has generally emphasized a six week "window of opportunity" in which most crises either resolve satisfactorily or, unfortunately, can result in the individual's descent to lower levels of health and functioning. Some of our knowledge about the customary timing of crisis resolution comes from the study of previous disasters in our history, such as the Coconut Grove nightclub fire in Boston that resulted in 500 deaths earlier in the last century.

Our main goals are to prevent deterioration and, as noted, even try to make the crisis a promotion of growth, if possible. For all these reasons our own team's involvement is time-limited (and, if the acute distress is more prolonged, it warrants referral elsewhere).

We don't regard it as inconsistent with this non-pathologizing or normalizing way of looking at a crisis, however, to retain also a more traditional medical perspective about these crises and possible emergencies, when common sense dictates. We do know that at times a crisis may completely overwhelm the resources of the patient and his/her support system. This need is especially pertinent when danger is involved and when there is no family. As part of the public safety net we are especially concerned with helping those isolated and indigent.

Fortunately, like most crisis teams around the state, ours has a number of psychiatrists directly involved who can arrange hospitalization when necessary. We have a number of full-time, and quite a few part-time, psychiatrists distributed over three sites in the county, in addition to about thirty other licensed clinicians who are also able to facilitate hospital referrals, if needed. The presence of psychiatrists, nurses, and physician assistants is indispensable when the situation warrants, for instance, when there is a role for immediate, adjunctive medication. Pharmacotherapy can help the crisis patient through their most troubling, acute symptoms, such as pain, psychosis, or severe depression or panic. Severe crises can at times involve the failure to control one's impulsivity or outright self-destructiveness. Crisis clinicians, while respecting autonomy, must also be prepared, therefore, to be decisive when warranted in securing safety, always consistent with the responsibility and commitment to use the least restrictive alternatives possible.

We hope, of course, that the individual's crisis may be handled short of such an eventuality. One thing that is clear is that every case is different and unique. We try to individualize our care for anyone who calls, and fortunately, we have the multi-disciplinary expertise to do so.

For Assistance In Westchester County, New York, call the Mobile Crisis Team for immediate help, call (914) 493-7075, 24 hours a day, seven days a week. Remember, we are only a phone call away.

Richard Gallagher, MD, is the Medical Director and Cary Wagner, LCSW, is the Program Director of the Comprehensive Psychiatric Emergency Program (CPEP), at the Westchester Medical Center, Behavioral Health Center.

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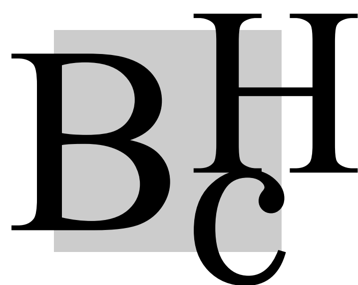

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Scientific advances have resulted in medications that are effective in delaying relapse[1], provide more effective symptom control, fewer side effects, and offer longer-term treatment than in the past.

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1 Fenton WS, Blyler CR, Heinssen RK. Determinants of medication compliance in schizophrenia: empirical and clinical findings *Schizophr Bull*. 1997;234:637-651.

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Unlocking The Chains of Addiction Through Attachment-Based Treatment

By Karen B. Walant, PhD

Neurobiology has given added validation to Winnicott's observation that "there's no such thing as a baby on its own – we're always dealing with a nursing couple." We are social beings, hard-wired for intimacy and connection. Babies are born with 70% of their brains undeveloped – meaning that they rely on the kind and quality of their earliest experiences to 'grow' the physiologic structures of their brains. Harlow's experiments from the 1950's show the devastation that can occur when infant primates are separated from their mothers and raised in isolation – their brains are actually undeveloped in several areas, and they show clear signs of separation distress: rocking endlessly, chewing on their own bodies, incessant finger-biting; hypersensitive to touch, dislike and aggressive tendencies to any social contact, seeking isolation rather than joining other monkeys, and actual brain underdevelopment – such as fewer neurons and fewer synaptic connections among neurons. All of these symptoms can be found with neglected and abused children, too, including diminished intelligence and depression, and an overall smaller brain mass. On the other hand, infant primates who were raised with their mothers have more brain mass, more neural networks and dendrites, and have larger connected neural links throughout the brain.

Without our attachment figures, we will die. Panksepp has shown that separation distress can fundamentally change the brain -- for life. Rat pups who have been separated from their mothers for as little as a few hours, become so stressed, and produce so much cortisol, that they NEVER return to their previous baseline – the architecture in their brain has been permanently altered so as to always remain at a heightened level of stress.

The etiology of addiction is multi-faceted, including both genetic and environmental factors. One of the major roots of addiction lies in separation distress, and in the individual's attempts to quell this distress through self-medication. Substances provide relief from the painfulness of isolation and the shame of unmet attachment needs. Several biochemicals responsible for bringing feelings of pleasure, love, and calm are stimulated by the attachment relationship. For example, oxytocin, the 'love chemical,' facilitates parent-child bonding. The more time the two spend together, the more endogenous opioids, dopamine, and oxytocin are released, bringing an assurance of enjoyment and pleasure for both. Likewise, both oxytocin and endogenous opioids are released into breastmilk, thereby ensuring that the baby encodes pleasure and peacefulness within human relationships. Viewing this symbolically, we can understand that our most intimate relationships are designed to bring us love and joy – that they can alter our mood state – and that without these relationships, we are bereft, isolated, distressed.

Karen B. Walant, PhD

The components of a strong, secure attachment include: empathic attunement and responsiveness, reflective capacity, entrainment, proximity, and consistency. However, the history of childhood, as Lloyd DeMausse has well-documented, has been replete with emotional, sexual, and physical abuse. By today's standards, virtually no child before the 20th century escaped a childhood of insecurity and abuse. What would lead parents, in the name of love, to be the providers of such abuse? The term normative abuse, along with the repetition compulsion, may provide some answers. Normative abuse refers to unempathic treatment proscribed by the dominant society that overrides compassion and attunement. The phenomenon of normative abuse is applicable in many situations. When it comes to the treatment of children in contemporary times, the dominant ideology of independence and self-reliance has over-ridden the attachment needs of children. The result has been increased separation distress, causing children the need to self-regulate. Transitional objects can be seen as a way to compensate for unmet, yet biologically necessary, attachment requests. In cross-cultural comparisons, for example, American babies are left alone 67% of the time in their first month of life, as compared to 8% of babies in the Korean culture. Across the globe, 90% of babies and young children sleep with their parents, and are weaned, on average, at 4 years old (contrasted to 6 months in America).

The good news is that a paradigm shift has already begun, towards a relational model of interdependence away from autonomy. This shift is already occurring in other areas of science and, with research of the neurobiology of attachment, is beginning to take hold within the field of psychology. Understanding the importance of attachment, encourages clinicians to facilitate a deeply- rooted Secure Base. Clinicians understand that substance abusers, in particular, often need to form what we would say is the 'right' need to develop an intense, and strong, Secure Base, in order to withstand impulses and cravings. Within the therapeutic Secure Base lies the same ingredients of attachment, including proximity, attunement, and regulation of affect. Recovering substance abusers, and codependents, are able to thrive within the Secure Base, as it becomes like a safety net – encouraging exploration while maintaining an underpinning of safety and support.

Not only that, but there is growing evidence, although too early to say for sure, that the strength of the therapeutic bond can assist the recovering individual in the growth of new neural networks. This information is exciting for clinicians, as it would validate that which our clinical eye tells us – that recovery is possible, and occurs more often when the clinical relationship has been unique, bonded, and strong.

Spirituality is an important component of recovery, and can be seen as another facet of attachment. Alcoholics Anonymous provides numerous opportunities for increased attachment as well as the release of shame. In terms of neurobiology, prayer and meditation release endogenous opioids while reducing the production of the stress-hormone cortisol. In the terms of attachment, spirituality is an enlargening of the secure base through the process of internalization and expansion. Romain Rolland writes that spirituality is an 'oceanic feeling,' a sense of unboundedness – and a strong belief that 'we cannot fall out of this world.'

Anchoring treatment for recovering substance abusers in attachment principles provides clinicians with an empathic perspective: many recovering individuals have experienced such great separation distress that they are wary of, yet craving, the therapeutic Secure Base. Integrating attachment, spirituality, and neurobiology can bring a wholeness to the therapy as well as to both members of the therapeutic dyad.

Karen B. Walant, Ph.D. is in private practice in Ridgefield, Connecticut. She divides her time between lecturing, providing supervision to other clinicians, and her clinical practice with adults in individual and couples work. She also sponsors an attachment parenting support group in Ridgefield, CT and is on the Board of Directors of Attachment Parenting International. Karen can be reached at 1-203-438-8602.

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

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MARCH 2006

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Friday, March 31st • 9:30 -11:00 am

Death and Dying: Lessons Learned

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Samuel C. Klagsbrun, M.D.
Executive Medical Director, Four Winds Hospital

Participants should:

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- Become aware of potential unrealistic perspectives of families, and techniques to assist the family to avoid undermining the patient's treament.
- Gain an understanding of the benefits and comfort to a patient at the end of life, that the writing of an ethical will or a document to express a legacy or philosophy might bring.
- Gain an understanding of the critical importance of time management in supporting the patient to live productively.

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

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Registration is Required for All Programs.
Please Call 1-800-546-1754 ext. 2413.

APRIL 2006

GRAND ROUNDS

Friday, April 7th • 9:30 - 11:00 am

Anxiety Disorders in Children and Adolescents: Can a Developmental Perspective Assist Us in Treatment Approaches?

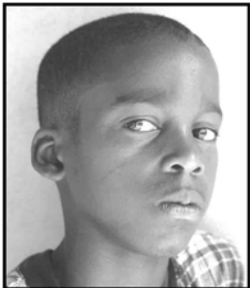
Louise Ruberman, M.D., Assistant Clinical Professor of Psychiatry, Co-Director of Training, Residency in Child & Adolescent Psychiatry, Albert Einstein College of Medicine

The goals of this presentation are to acquaint the audience with:

- The impact of development on the expression of anxiety;
- The impact of the expression of anxiety on development;
- The role of development on the manifestation of anxiety and its comorbidities; and
- To illustrate how, with clinical examples, a developmental perspective can inform our treatment approaches.

Fee: $15.00 payable to Four Winds Hospital

1.5 CME Credits Available



GRAND ROUNDS

Friday, April 21st • 9:30 - 11:00 am

Your Child in the Balance: An Insider's Guide to the Psychiatric Medication Dilemma

Kevin T. Kalikow, M.D., Child and Adolescent Psychiatrist Private Practice, Mt. Kisco, NY; Assistant Clinical Professor in Child Psychiatry, New York Medical College; Author of *Your Child in the Balance: An Insider's Guide to the Psychiatric Medication Dilemma.*

Are psychiatric medicines over (or perhaps under) prescribed to children and adolescents? Dr. Kalikow will review the criteria we use in deciding to change our bodies with medicine and the way physicians evaluate any medicine's benefits and risks. He will then review how we decide whether medicines are appropriately prescribed and his Ten Commandments of Medicine.

This program will enable participants to:

- Gain an understanding of the pitfalls of over and underestimating both the power and side effects of medicine.
- Examine some current controversies in psychopharmacology, such as whether antidepressants cause suicide.

Fee: $15.00 payable to Four Winds Hospital

1.5 CME Credits Available

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 acredited by the ACCME to provide continuing medical education for physicians.

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

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SPECIAL TRAINING

Thursday, May 4th • 9:30 am - 12:00 pm

Child Abuse Identification and Reporting

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

New York State recognizes certain professionals to be specially equipped to hold the important role of mandated reporter of child abuse or maltreatment. These include Mental Health Counselors, Marriage and Family Therapists, Creative Arts Therapists, Psychoanalysts, Licensed Social Workers, Physicians, Dentists, Dental Hygienists, Chiropractors, Psychologists, RN's, School Administrators, Teachers, etc. A State Education Department Certificate of Completion will be given at the end of the class.

Fee: $45.00 payable to the Four Winds Foundation, a not-for-profit organization

MAY 2006

GRAND ROUNDS

Friday, May 5th • 9:30 - 11:00 am

Beyond DBT: Utilizing Mindfulness in Psychotherapy with Children and Adults

Alan V. Tepp, Ph.D., Director of Consultations and Evaluations, Four Winds Hospital; Private Practice, Fishkill, Katonah & Mt. Kisco, NY

As a central component of traditional Dialectical Behavior Therapy (DBT), Mindfulness has begun to emerge as an area of interest for many therapists who work with both children and adults. Further, Mindfulness can serve as a guiding principle of cognitive behavioral therapy, which has evidenced growing popularity as the treatment of choice to augment most pharmacotherapeutic treatments.

This presentation will facilitate participants' ability to:

- Gain a greater understanding of the construct of Mindfulness and its various components.
- Develop an ability to integrate Mindfulness techniques into a variety of Counseling and Therapeutic settings with children, adolescents and adults.
- Understand how Mindfulness can enhance the effectiveness of cognitive-behavioral work with patients.

Fee: $15.00 payable to the Four Winds Hospital

1.5 CME Credits Available

JUNE 2006

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Professor of Public Health, Columbia University College of Physicians & Surgeons

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The Mental Health News
New York City Section

Children's Mental Health Services Are Effective

By Kenneth Popler, PhD, MBA
President and CEO
Staten Island Mental Health Society

The Staten Island Mental Health Society has been providing children's mental health and related services for over 100 years. Each year, we provide direct services to one-in-ten Staten Island families. An important part of our work is to measure the effectiveness of our clinical services with each child and with our program as a whole.

Effectiveness of Community-Based Outpatient Mental Health Treatment With Children and Adolescents

The last several years have witnessed the confluence of studies focusing renewed attention on the effectiveness of community-based outpatient mental health treatment for children and adolescents. Results of research have not consistently shown such treatment to be efficacious in community-based environments.

The Surgeon General's Report (1999) provided an extensive review of normal child development, psychopathology in children, and the effectiveness of treatment. The Report concluded, "A range of efficacious psychosocial and pharmacologic treatments exists for many mental disorders in children, including attention-deficit/hyperactivity disorder, depression, and the disruptive disorders."

Kenneth Popler, PhD, MBA

Meta-analyses (statistical techniques for combining results from multiple studies) have also provided data regarding the effectiveness of treatments. Lipsey and Wilson (1993) found that "...meta-analytic reviews show a strong, dramatic pattern of positive overall effects that cannot readily be explained as artifacts of meta-analytic technique or generalized placebo effects. Moreover, the effects are not so small that they can be dismissed as lacking practical or clinical significance."

However, such positive findings have been called into question by Weisz and Weiss (1993). Based on the results of their research, they assert that, "...the findings raise questions about whether the positive effects of child therapy that have been demonstrated in laboratory studies...are generally replicated in service-oriented clinic and community settings."

As the Staten Island Mental Health Society provides over 80,000 sessions of mental health services each year, it is of considerable concern to us whether the services that we provide are effective.

Who Comes to Us for Services?

Using a sample of 844 consecutive admissions, we found that most the common diagnosis of children referred was Disruptive Disorder (32.8%), closely followed by Mood Disorder (28.1%). Please refer to Table One for a complete list of the diagnostic categories and the percent of children whose primary diagnoses corresponded with that category at admission.

Table One
Major Diagnoses of Children who come to the SIMHS

Major Diagnosis	Number	Percent
Disrupt. Behavior	277	32.8%
Mood Disorders	237	28.1%
Attention Deficit	112	13.3%
Adjust Disorder	85	10.1
Anxiety Disorder	83	9.8%
Other Disorders	50	5.9
Total	844	100.0%

How We Measure Dysfunction And Improvement

The unique aspect of our work measuring the effectiveness of our services conceptualizes the children's disabilities, not as a single condition, to be successfully treated or not. Rather, using the Teacher and Parent versions of the Conners' Rating Scales (1989), the major types of behavioral problems exhibited by each child are able to be differentiated through factor analyses.

At the Staten Island Mental Health Society, the Conners' Scales are routinely administered to all children receiving outpatient or day treatment services. The children's scale results help us formulate treatment plans and measure improvement for each child on an ongoing basis.

What We Measured

The six scores that the child received as a result of the parent completing the Conners' Parent Questionnaire at the beginning of treatment were compared with the six scores obtained at the end of treatment.

Also, the seven scores that the child received as a result of the child's teacher completing the Conners' Teacher Questionnaire at the beginning of treatment were compared with the seven scores similarly obtained at the end of treatment.

Both the Conners' Teacher and Parent Rating Scales allow each child's score to be converted into "T-scores," with a mean

see Children's Services on page 30

Crisis Intervention and the Holding Environment

By James R. Dolan, Jr., DSW, LCSW
Assistant to the Commissioner, Nassau County Department of Mental Health, Mental Retardation and Developmental Disabilities

Imagine that a toddler is scurrying about and in a moment of haste the child darts across the room, and in the process trips and falls. The little girl or boy is not injured but they are startled to find themselves on the floor. Although not in physical pain, the child will cry. In response, the good parent will instinctively pick up the youngster and hold them. No medical aid is provided, yet almost immediately the child feels better.

The psychodynamics of this situation is that the child was frightened. His or her world was suddenly turned upside down; one moment all was fun and joy and the next, the child is feeling shaken by the surprising turn of events. The little girl or boy is overwhelmed by the situation and in turn releases the emotions revealing that they cannot handle what just happened. When the loving caretaker responds, they convey to the child, through their warm hug and composure, that although things seem out of control, the fact is that everything will be alright. The toddler adopts the perspective of the trusted adult and at once internalizes the belief that the situation is manageable. As a result the child becomes hopeful, as evidenced by the improvement in their mood.

We can contrast this with an occasion where the parent reacts to the child's condition with annoyance or anger. We know that a response of this sort will intensify the child's negative emotions. This is because when the child sees that the parent is also upset, they deduce that the situation is as bad if not worse than they thought.

The fact is that, even as adults, we never lose the need to be emotionally held when feeling upset. All person's can attest to times when we erupt and we find ourselves discharging into the environment the overwhelming emotions that have become uncontrollable. The feelings we have on those occasions are likely to be contained, however, if we encounter another who is sensitive to our situation, and is able to reassure that matters will improve. On the other hand, if the message to us is that our negative emotions are part of a larger chaotic scene, then we will feel less secure and less hopeful for a positive outcome.

Crisis theory provides a helpful framework for guiding our intervention with the client who is overwhelmed. It is based on the assumption that as part of one's ego development the individual assembles a repertoire of coping strategies and problem solving techniques. While these may suffice for everyday tasks, sometimes because of an increase in stress, or decrease in one's ability to handle stress, an individual's self righting or homeostatic mechanisms fail and an emotional crisis unfolds.

The two kinds of processes that can lead to this situation are: (1) exhaustion crisis – occurs when the individual may have managed stress effectively for a lengthy period, but suddenly reaches a point where they can no longer cope; (2) shock crisis – entails a sudden change in the social environment that creates an explosion of emotions that overwhelm one's coping mechanism.

When the person is in a state of disorganization or turmoil, the concept of hope becomes important. This is because the client's belief in the probability that they can be helped is essential to motivating them to engage in behaviors that will improve their condition. The hope that is engendered emanates from the practitioners ability to stimulate, in an otherwise confused or anxious client, the expectation of relief.

Although it is desirable to avoid a crisis, the vulnerable state it engenders tends to motivate the person to adopt new behaviors that will alleviate their emotional

see Crisis Intervention on page 36

Psychological First Aid: Assistance In A Crisis

By Benjamin R. Sher, MA, LMSW
Director, Training and Staff Development
Institute for Community Living

According to the dictionary, a crisis is defined as "a turning point or decisive moment in events. Typically, it is the moment from which an illness may go on to death or recovery. More loosely, it is a term meaning 'a testing time' or 'emergency event'." Crises can be as individualized as someone losing their wallet, or as global as a city blackout. On the other hand, a *disaster* is "the impact of a natural or man-made event that negatively affects life, property, livelihood or industry, often resulting in permanent changes to human societies, ecosystems and environment. Disasters are manifested as hazards that exacerbate vulnerable conditions and exceed individuals' and communities' means to survive and thrive." In both crises and disasters, trauma can be experienced by individuals at both the physical and psychological level. Physically, the person experiencing the event may be hurt, unconscious, or in serious pain. For these individuals, CPR and First Aid is needed. In the case where individuals have a cognitive and emotional experience connected to the disaster or crisis event, Psychological First Aid is needed. This article attempts to shed light on this crisis intervention phenomenon.

Psychological First Aid (PFA) refers to a set of skills identified to limit the distress and negative behaviors that can increase fear and arousal (National Academy of Sciences, 2003). It should be as natural, necessary and accessible to people in crisis as medical first aid. PFA, at its core elements, is assisting people with the emotional distress experienced from the crisis, disaster, or life-turning event. PFA can be done by anyone with basic counseling and supportive skills; it does not require advanced training in mental health services, because it is ***not*** psychotherapy or mental health treatment.

PFA aims to address the immediate needs of people in crisis. Therefore, PFA is a field-based activity; it occurs wherever the crisis, disaster event, or traumatic experience has occurred. The main emphasis in PFA is to intervene immediately, or as soon as the environment is safe, to stay focused on the event that has occurred, to help people through this event, and to provide accurate information for people in crisis. The further aims of PFA are to help reduce the physiological arousal (e.g. anxiety or stress) related to the event, to provide access to immediate needs such as shelter and food, to be honest and truthful about what help is available, and to observe the situation and listen supportively.

Maslow's hierarchy of needs appears to be the philosophical linchpin for Psychological First Aid. The idea that higher order activities, such as the development of community and the fostering of relationships cannot be addressed until people's basic needs are met is a crucial element in crisis-related work. The immediate aftermath of a traumatic event is chaos and instability. PFA attempts to return a

Benjamin R. Sher MA, CSW

sense of normalcy to the experience, and is a very strengths-based approach. It is a rapid assessment model that helps to assess the immediate needs of a person in crisis and to tailor supportive interventions to that person in a flexible manner. PFA attempts to be culturally and developmentally sensitive. The needs of children and adolescents may be very different than adults in a crisis, as may be different ethnic and cultural groups. PFA operates on the concept of working where the "person is at" and tries very hard not to intervene intrusively or with a mandate in mind. For these reasons, PFA seems a very positive approach to managing a crisis.

Two models of PFA are presented. One is described by Extreme Behavior Risk Management (2004); the other by the Terrorism and Disaster Branch of the National Center for PTSD (2005). Extreme Behavior Risk Management suggests the P-D-C Approach to Psychological First Aid. The P is for *Protect*; protect the individuals involved from further injury or harm, as well as from further re-traumatization in the event. *Protect* even calls for an assessment of those who may be experiencing serious psychological responses (e.g. suicidal, homicidal, or aggressive behavior) to the crisis, and to help them to get assistance immediately. The D is for *Direct*; provide direction in a clear, concise manner. Here, medical and psychological jargon is avoided; people in crisis may be confused, overwhelmed, disoriented, and have difficulty making decisions. Point people in the right direction for help, and provide direction in a supportive, compassionate manner. Last, the C is for *Connect*; help people with "need-to-know" information in a timely and understandable manner. Help people connect to loved ones and other significant persons, as well as with appropriate resources and supports.

The National Center for PTSD (2005) offers an eight-step approach to Psychological First Aid. First, attempt is made at contact and engagement with people. The goal at this stage is be present for people in crisis, and to let people know that you are there to help in a supportive and non-intrusive manner. Second, provide for safety and comfort of people in need. Here the goal is to address immediate needs (e.g. shelter and food). Third, provide stabilization (if needed). PFA responders are encouraged to use basic calming techniques to orient/assist emotionally overwhelmed or distraught people, with an eye towards those who are in need of greater mental health assistance. Fourth, information gathering occurs when the person is ready, with a focus on immediate needs and concerns. This allows the responder to tailor their interventions to the person served. Fifth, provide concrete assistance. This could take the form of information, a warm blanket, or a hot cup of tea. Sixth, connect the person to natural social supports. Here the goal is to help re-connect the person to their family, loved ones, or the community. This of course is harder if these connections have been seriously broken. Seven, provide information on coping. The aim here is to educate the person (when they are ready) on ways to manage their experience in a healthy and adaptive manner. Eighth, provide linkages to collaborative services. Here, the PFA responder is linking survivors of the trauma to needed services, as well as providing information on future events.

To help put these models into practice, imagine an apartment-building fire. In this scenario, the Psychological First Aid responder will be based at the temporary shelter that is set up for individuals displaced (but not physically hurt) by the fire. The PFA responder goes to the shelter as soon as s/he is able. This helps him or her to prepare for the fire victims, and to gain some basic information on the event. As the victims enter the shelter, the PFA responder introduces him or herself, tells the people s/he is here to help, and offers some concrete item, such as a blanket, some tea, or something to eat. The PFA responder would then step back and allow the person(s) to settle into their new environment. They may be in the area of the victims, but not necessarily interacting with them. If a person seems particularly distressed from the fire, the PFA responder will go to them and offer support. He or she does this without judgment, and is sensitive to how open the person is to talking. The PFA responder's aim here is to help the person to calm. If the person calms, the PFA responder will then focus on what the person needs, be it information, concrete aid, or just some empathic listening. An important point here is that if the fire victim asks for information, such as when they will be able to return to their apartment, and the PFA responder does not know, then the PFA responder is honest about their lack of knowledge. The PFA responder tells the fire victim that they do not know, but they will try to find out for them. The PFA responder then follows through on this request, even if the answer may be never. How much time a PFA responder spends with people will vary from person to person, and he or she will always be sensitive to where the person in crisis appears to be. Once the person in our scenario is calmed and is connected to supports or family, the PFA responder moves on to the next person in need. He or she stays on the scene as long as necessary, but is careful to take care of his or her own needs, so that s/he can remain supportive to those who need immediate help.

In any situation like the one described above, the Psychological First Aid responder attempts to be responsive to at-risk populations. According to the National Center for PTSD (2005), these include the following:

- Children (especially children whose parents or legal guardians have died or are missing)
- Those who have multiple relocations and displacements
- Medically frail adults
- The elderly
- Those with serious mental illness
- Those with physical disabilities or illness
- Adolescents who are known to be risk-takers
- Adolescents or adults with substance abuse problems
- Pregnant women
- Mothers with babies and/or small children
- Professionals or volunteers who have participated in the disaster response and recovery efforts
- Those who have experienced significant loss
- Those exposed to grotesque scenes or extreme life threat.

Economically disadvantaged persons may be exposed to pre-disaster trauma, such as poverty, violence in the community, and infrastructure neglect. These experiences may affect the person's willingness to connect with support during a major crisis or disaster event, including their trust and confidence that those in power will assist or help in the appropriate manner. These pre-disaster experiences may affect how a PFA responder is perceived, and the responder needs to be sensitive and aware of these issues.

Care should be taken when working with children and adolescents who have survived a disaster or traumatic event. According to Wasserman, Naglieri, and Merydith (2001), Psychological First Aid with children and adolescents must be geared to where the child's developmental level is perceived to be. These authors encourage PFA responders not to assume that kids do not know about the event, even if it is something happening in another part of town or not directly to them. PFA responders should be accessible and approachable to children. They should listen to what kids have to say (at their physical level) about the event and be ready to clear up any misunderstandings

see First Aid on page 39

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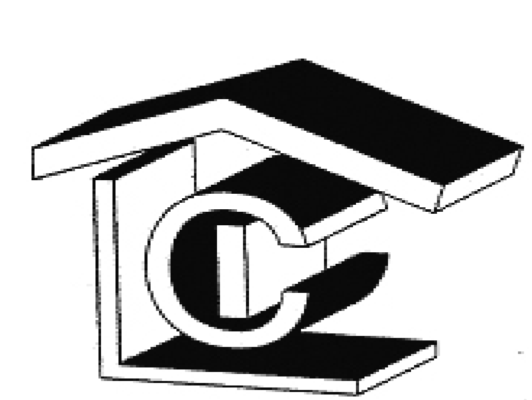

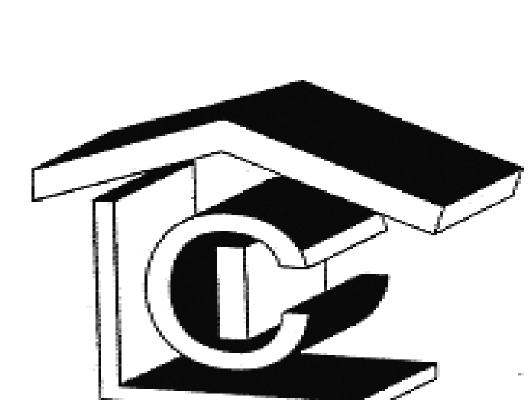

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Managing Crises from page 1

Dialectical Behavior Therapy project at our Manhattan and Queens clinics. We learned that validation is the essential reinforcer for the behavioral change which is at the heart of an individual's rehabilitation and recovery. Validation also serves as the emotional corrective to the aversive life experiences of those individuals served by the public mental health system.

Prior to Jane's hospital discharge, the case manager will complete with her a Risk (or crisis management) Assessment. This is a clinical interview schedule, originally developed to be used with our Forensic DBT clients, and since adopted by our City-based case management programs and several FEGS treatment programs. It is not predictive in nature or intent, but rather designed to identify clients with histories of high-risk behaviors or pertinent risk factors (i.e., the past and current patterns of those behaviors, including precipitants and consequences [c.f. Monahan and Steadman, 1994]). The Assessment concludes with a Risk Management Plan. The Plan underscores current risk factors; lists members of the client's support system; and provides contact phone numbers important to the clients overall care-plan, should the client engage again in the high risk behaviors identified in the Assessment.

The Risk Assessment gives clients the opportunity to reflect on their maladaptive behaviors and assume responsibility for aversive consequences. The concluding Plan requires a commitment to learning and using new skills and behaviors. The Risk Assessment, together with the case management program's formal assessment and service plan, constitutes the contract and includes objectives to be pursued. This contract will guide the client and case manager's relationship over the next several months.

We have learned that the opportunity to reflect and accept in a non-judgmental and protective context proves to be an invariably validating experience for the clients. They learn that there are explanations for their behaviors and that there are remedies that can be developed. They also learn it is possible to have hope and to trust others. Trust and hope, we must remember, are at the root of all change.

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financial affairs. Such authority includes but is not limited to: decisions relating to routine and major medical and dental treatment and treatment providers, choosing social programs and residential placement, property management, investments, budgeting income, benefit applications and paying bills. The Guardian is generally empowered to make all of the decisions that the disabled person made prior to the child reaching the 18 years of age. Guardianship orders can be modified by the Surrogate to address the needs of the individual and may be terminated upon good cause shown.

The Healthcare Amendment of 2003

On July 29, 2003, the New York State legislature expanded the power of a "17-A" guardian to include the ability of the guardian to withhold or withdraw life-sustaining treatment. S.C.P.A. §1750-b. While not expressly prohibited by statute, the legal consensus was that a guardian did not have this authority prior to the 2003 amendment. It should be noted that this amendment applies only to guardians for the mentally retarded and not to the developmentally disabled. To date, the right of a guardian to make end of life decisions for their mentally retarded ward has passed legal and constitutional muster. However, the Statute expressly warns that this provision is "not intended to permit or promote suicide, assisted suicide or euthanasia; accordingly nothing in this section shall be construed to permit a guardian to consent to any act or omission to which the mentally retarded person could not consent if such person had capacity." S.C.P.A. §1750-b. The Statute clearly defines the standard by which the guardian should make end of life decisions. It mandates that certain factors be considered such as religious beliefs, health status, relief of suffering and preservation of dignity, while certain elements should never be considered such as monetary or logistical considerations or making a presumption that retardation diminishes one's right to dignity and equal treatment.

Once a "17-A" guardian has made a determination that life-sustaining treatment should be withheld, and the plan is appropriately witnessed, the Statute sets forth specific guidelines before the plan is actually implemented. The Statute requires that sufficient advanced notice be given by the guardian to appropriate individuals, including the mentally retarded individual. This advanced notice suspends the plan and allows for any objections to be made and if necessary for the objecting party to seek judicial intervention. Finally, this amendment insures that treatment providers and guardians alike will be immune from criminal or civil liability for their decisions and provision of healthcare services if these actions were reasonable and made in good faith.

Conclusion

The "17-A" guardianship is a powerful legal tool to insure the continuity of care for a mentally retarded or developmentally disabled individual. Furthermore, this statute helps to preserve the financial status quo for parents and/or other care providers when the disabled person reaches 18 years of age.

Footnote: The DSM-IV provides for degrees of severity of Mental Retardation relative to the level of impairment of intellectual functioning as follows: (1) Mild Mental Retardation - IQ level of 50-55 to approximately 70; (2) Moderate Mental Retardation - IQ level 35-40 to 50-55; (3) Severe Mental Retardation – IQ level 20-25 to 35-40; (4) Profound Mental Retardation IQ Level below 20 or 25.

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Kathleen Sweeney Leaves Legacy

Staff Writer
Mental Health News

A visionary with over four decades of public service, Kathleen Sweeney passed away on January 10, 2006. During her memorial service, Dr. Peter C. Campanelli, President and CEO of the Institute for Community Living (ICL), spoke of his soon-to-retire COO: "Kathy contributed significantly to the growth of mental health recovery, to ICL, to the lives of countless individuals with serious mental illness and to the women she found time to mentor. Her wise council and innate ability to reconcile discordant voices allowed us all to forge vital pathways and innovative approaches." Throughout her career, Kathy participated on countless industry-wide task forces and working groups for the benefit of the mental health system. Kathy Sweeney leaves behind a legacy of progress, vision and optimism for those with mental illness and for those who work on their behalf.

Kathleen Sweeney

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of 50 and a standard deviation of 10. According to the Conner's Rating Scales Manual, a clinically elevated test score is one that is above 65. There were 146 cases that were closed during the 18-month period under review.

Our Findings

Pairs of Conners' Parent Scales were available for 103 children. The T-score that each child obtained on the earliest Conners' Parent administration in the child's case record (i.e., the one closest to the admission date) was compared to the last Conners' Parent Scales (i.e., the one closest to the termination of treatment).

The results of the comparisons of the six Conners' Parent Scales are listed in Table Two. For each of the six factors, there was a significant decrease between the first Conners' Parent score as compared to the last. Each of the scores of the three scales that were at or around a T-score of 65 at admission, which Conners describes as the "problem level," was substantially and significantly reduced by the time the last Conners' Parent Scale was administered.

Table Two
Changes in Conners' Parents' Scores (N=103)

	First Conners	Last Conners	
Variable	**Mean**	**Mean**	**P(2tail)**
Conduct Problem	67.71	60.36	<0.00002
Learning Problems	64.90	56.50	<0.000001
Psychosomatic	59.50	53.79	<0.001
Impulsive-Hyperactive	59.13	56.06	<0.05
Anxiety	56.18	51.71	<0.000001
Hyperactivity Index	64.96	57.16	<0.000001

Pairs of Conners' Teacher Scales were available for 110 children. The results of the comparisons of the seven Conners' Teacher Scales are listed in Table Three. For six of the seven factors, there was a significant decrease between the first Conners' Teacher score as compared to the last. Each of the three scales that had T-scores above the problem level of 65 at admission was substantially and significantly reduced by the time the last Conners' Teacher scale was administered.

Table Three
Changes in Conners' Teachers' Scores (N = 110)

	First Conners	Last Conners	
Variable	**Mean**	**Mean**	p(2 tail)
Hyperactivity	63.33	58.59	<0.0002
Conduct Problem	67.07	61.46	<0.0005
Emot-Overindulgent	66.33	61.30	<0.001
Anxious-Passive	51.99	47.03	<0.00001
Asocial	57.48	53.68	<0.016
Daydream-Atten Prob	60.89	58.71	N.S.
Hyperactivity Index	69.48	65.34	<0.009

Does Treatment Really Help Or Does Time Heal? (Regression To the Mean)

A second study was undertaken to see whether the Conners' scores regress to the mean as a function of time, without treatment. A review of our records found children who received a Conners' Parent Scale at intake and had eight or fewer sessions of face-to-face service of any kind at the Staten Island Mental Health Society. Parents were contacted and asked to complete a Conners' Parent Rating Scale. We received 30 responses with newly completed Conners' scales.

We found that there were no significant differences between the first and last Conners' Parent scores.

Table Four
Control Group: Conners' Parents' Report (N=30)

	First Conners	Last Conners	
Variable	Mean	Mean	p(2tail)
Conduct Problem	65.77	61.23	<0.19
Learning Problems	67.13	69.13	<0.57
Psychosomatic	54.93	59.50	<0.34
Impulsive-Hyperactive	58.03	57.77	<0.93
Anxiety	56.37	54.27	<0.38
Hyperactivity Index	64.07	62.03	<0.52

What Does It All Mean?

Our approach substantially differs from typical research studying the effectiveness of therapy. Rather than grouping children with behavioral or psychological problems into a homogeneous population to be treated, the current study, using the Conners' Teacher and Parent Rating Scales, was able to differentiate the problems of children referred for treatment. Then, for each of the factors of problems elicited by the two Conners' Rating Scales, the effectiveness of outpatient therapy on the specific problem areas could be individually measured.

Of the six factors with T-scores that were high enough to be within the problem range at admission, five were low enough to be out of the problem range at discharge (while the sixth was only very slightly into the problem range at discharge).

For the "no treatment" control group, we found that without treatment there was no improvement.

For those children and adolescents receiving outpatient clinical services in our community-based environment, we found significant positive changes in the children's functioning as measured on both the Conners' Parents' and Conners' Teachers' Scales.

Kenneth Popler, PhD, MBA, a clinical psychologist, is the President and Chief Executive Officer of the Staten Island Mental Health Society, an organization that provides mental health and related services to Staten Island children and their families.

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outpatient costs and they served a population with almost as many seriously and persistently ill adults and seriously emotionally disturbed children. The data in Table 2 demonstrates the relatively narrow range of discharges, days in hospital, and average length of stay (ALOS) from inpatient psychiatric units in general hospitals over the 6 most recent years for which data is available. Since 2003 a number of hospitals with inpatient psychiatric units haveclosed and other hospitals have closed their inpatient psychiatric units. As a result, the pressure on the inpatient system has grown.

In conclusion, these data demonstrate that Article 28 licensed hospitals, key among the facilities slated for review by the "Commission", play a very prominent role in the state's public mental health system. Indeed, the current system rests on the contributions of all three provider sectors, the Article 28s and 31s and the OMH facilities. As practitioners and advocates know there is virtually no excess capacity in the overall system. Community based inpatient units as well as those in the state psychiatric centers are full and hard pressed, outpatient clinics must maintain waiting lists, psychiatric emergency services are often overflowing and stressed, supported housing remains scarce despite welcome, recently announced additions to the pipeline, and case management, CSP, and ACT services are unable to handle all of those in need. Children's services at all levels remain scarce and difficult to access. It is clear that mandating change of the Article 28 hospitals' capacity to provide any category of mental health service without a complete overview of the change's consequence on the entire system would have a potentially devastating impact on the state's public mental health system. *Primum non nocere*, "First, do no harm", is a dictum familiar to physicians. It should apply as much to those seeking to change health care systems as to those treating individuals patients. It is for this reason that the work of the "Commission" deserves the laser like focus of interested mental health professionals and advocates.

the mental health association of new york city, inc.

1-800-LIFENET
Crisis Intervention That Restores Hope And Saves Lives

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

Giselle Stolper

Mental health crisis calls are all in a day's work for 1-800-LIFENET, New York City's official 24/7 multilingual mental health crisis, information and referral hotline. But they are hardly routine.

1-800-LIFENET, operated by the Mental Health Association of New York City (MHA of NYC) is staffed by licensed, trained and experienced mental health professionals. LifeNet referral specialists spend most of their time sharing information about mental illness and drawing on the LifeNet database of more than 4,000 resources to provide referrals to local mental health services.

Yet among the 6,000 calls that LifeNet referral specialists field each month, between 60 and 70 will entail a situation that could prove harmful or life threatening. Some examples:

- A woman in the Southeast U.S. called because her friend in the Bronx sent her a farewell email, announcing he had disconnected his phone and was planning to kill himself that afternoon, and alluded to having a ready supply of sleeping pills. She googled "crisis hotline, New York City" to find help for him nearby.

- An elderly woman's middle-aged son, who had a history of schizophrenia and multiple hospitalizations, destroyed several pieces of her furniture, then shed his clothing and ran outside, naked, and stood in the middle of the busy street. She called the police to take him to a hospital but by the time they arrived her son was dressed and articulate, and told the police it was his mother who was delusional. Since there appeared to be no immediate threat, the police left. Now the woman feared for her own safety.

- The social worker in a housing shelter called LifeNet on behalf of a young mother of three children who had just lost triplets, still-born the prior week. She and her husband were in terrible emotional pain. As the mother expressed both a wish to die and a commitment to take care of her living children, her husband, in his grief and rage, blamed her for the deaths of the babies.

While the crisis calls are often harrowing, LifeNet referral specialists are equipped to help bring callers back to safety. Since its launch in 1996, the LifeNet has honed variety of approaches to address crisis calls:

- techniques to engage callers at their most distressed and distrustful;

- standardized assessment tools to gain a dispassionate reading of the key issue at hand; and

- formalized, well-tested links to New York City's mobile crisis units and emergency services, bringing services to the door when callers cannot take the next step on their own.

When a Mental Health Problem is a Matter of Life and Death

Of the 30,000 Americans who commit suicide each year, the National Institute of Mental Health reports that 90 percent have a diagnosable mental illness. Therefore, when LifeNet referral specialists receive a mental health crisis call, they treat it as if it were a life or death situation. LifeNet referral specialists must quickly identify the core problem and determine whether it presents an immediate danger.

The first step is to build trust by acknowledging the important and difficult step callers have taken to reach out for help. If the caller is too upset to speak, the specialist will help them calm down so they can talk.

LifeNet referral specialists will then conduct an assessment process couched as a conversation, gently asking questions about the caller's current state of mind and how it is reflected in daily habits over the past several weeks: Are they eating and sleeping properly? Are they able to tend to basic hygiene, go to work, address a medical condition, pay bills?

Referral specialists will also probe to learn about the caller's previous health history – whether they have been diagnosed with a disorder, if they are in treatment, on medication or hospitalized, for instance. Specialists will avoid using clinical terms which can carry a stigma for the caller and cause them to withdraw. Finally, the referral specialist will determine whether the caller is harboring thoughts of harming themselves or others, or if the risk is inherent in his behavior. If they are talking about wanting to commit suicide, have they devised a plan? Do they have the means to carry it out? Have they attempted to hurt themselves or others before?

At this point, the LifeNet referral specialist is ready to recommend a course of action to quell the crisis, and will use every means possible to assure the caller's agreement before taking the next step.

Intervention: Mobile Crisis Units and Emergency Medical Services

While referrals to services are effective and appropriate during a routine referral call, crisis calls often require on-site assistance. LifeNet referral specialists are able to draw on the New York City's mobile crisis units and 911 emergency medical services (EMS) as the situation requires.
If the caller is clearly in need of further evaluation or treatment and danger does not seem imminent, the specialist may recommend that the caller allow a mobile crisis unit to visit with them.

Each community district in New York City houses a mobile crisis unit team comprising nurses, social workers and medical staff. They will travel on site to meet with residents who are experiencing a mental health crisis and who are incapable of traveling, but do not present an immediate danger to themselves or others. If the caller agrees, the LifeNet referral specialist will serve as a conduit to the mobile crisis team, and provide a phone number the caller can use to schedule a home visit. If there is a problem with meeting at home, the team can meet nearby to preserve anonymity.

When a caller can't "promise" they won't hurt themselves in the next 24 hours, or if the referral specialist ascertains that there is a threat to another individual – a child or other household member, for instance – the LifeNet referral specialist will draw on EMS to bring the individual to a hospital for evaluation right away. In this case, the referral specialist will remain on the phone with the caller while another LifeNet specialist places the call to 911 and provide the necessary information.

Due to regulations that preserve the confidentiality of patients, most of the time LifeNet referral specialists do not know what finally becomes of those in crisis who reach out for help. But they do not end a call until they are certain the caller is in good hands, whether through an impending mobile crisis unit visit or admittance to a hospital whether skilled professionals can mitigate the immediate threat of danger. No call is ended until it has reached an appropriate resolution.

- The man in the Bronx who had written a farewell to his friend was indeed on the verge of committing suicide. The LifeNet referral specialist found that he had disconnected his phone, but his friend had a home address. EMS took the man to the hospital where he was admitted for further evaluation.

- In talking with a LifeNet referral specialist, the elderly woman who was fearful of her son learned how to obtain a court order, based on his prior hospitalizations and her testimony, to have her son taken to a psychiatric hospital for treatment.

- The couple in pain over the loss of their infants agreed to visit by a mobile crisis unit who could assess whether there was a potential domestic abuse situation between husband and wife, and evaluate the mother's crippling depression.

We urge New Yorkers every chance we get: don't wait for the crisis. If you, or someone you know, is feeling emotional distress of any kind, don't wait until the feelings are overwhelming. Call 1-800-LIFENET, anytime of night or day and talk with a trained professional.

Dr. Gillian Murphy, Director of LifeNet operations; Jesse H., Adele M. and Francine DW., LifeNet referral specialists, contributed to this article.

In English:
1-800-LIFENET
(1-800-543-3638)

In Spanish:
1-877-AYUDESE
(1-877-298-3373)

In Chinese:
Asian LifeNet
1-877-990-8585

Helping Clients Confront Emotional Crises: JBFCS Day Treatment Programs Offers Strategies For Coping

Staff Writer
Mental Health News

A person in crisis needs human connectedness and other people who can support them during a trying time. "A crisis can provide opportunities to learn something or fix something," says Rebecca Wulf, Program Director for Coney Island Community Support Services, a program of the Jewish Board of Family and Children's Services (JBFCS).

Pay Attention To Early Warning Signs

It may not seem like much at first: A day when someone doesn't want to venture out, or a moment when someone believes people are talking about them or becomes easily angered and argumentative with anyone nearby. But for some, these are often the first clues that they may be approaching a psychiatric crisis.

"The most common symptom of distress we see among our clients at continuing day treatment programs is withdrawal from activities that he or she usually does," says Rebecca Wulf, Program Director for Coney Island Community Support Services, a program of the Jewish Board of Family and Children's Services (JBFCS) and a provider of services to adults with mental illness at three Coney Island-based mental health clinics and two continuing day treatment programs.

While clients at continuing day treatment programs are living with severe and persistent mental illness, attention to early warning signs of distress is also a necessary part of wellness self-management for anyone struggling with depression or other difficult life situations.

Make A Relapse Prevention Plan

"The symptoms will be different for everyone," says Susan Bear, LCSW, Division Director of Adult Services: Housing, Day Treatment and Clinics for Adults with Mental Illness, a network of day treatment, residential and counseling programs throughout Brooklyn, Manhattan, Bronx, and Queens. "In all of our programs, when a therapist meets with a client, they can work together to help identify the individual's unique behaviors that develop when someone is heading toward a crisis."

Indeed, recognition of these signs is a critical part of any relapse prevention plan. A therapist and client create such a plan to help assess if a client is approaching a psychiatric crisis and to find ways a client can prevent a further decline in functioning.

Client Joan Storfer (seated) at JBFCS's Coney Island Community Support Services. Staff member Eileen Starzecpyzel (standing) helps clients create a comforting environment during the holiday season—an especially difficult time for many clients in distress.

Identify Coping Skills

Often the first step someone can take in coping with distress is to tell a therapist, friend or family member what they're feeling and ask for help.

If someone is withdrawing from their routine, friends and family can provide practical assistance such as walking or driving the person to the first activity of the day. When someone thinks people are talking about them, friends and family can serve as a trusted source to ask if this perception is true.

With the help of a therapist, a client can also learn to recognize their feelings of discomfort and make the decision to continue on with their plans despite overwhelming emotions. A therapist can help a client recognize their anger and figure out a way to delay a response and walk away before they lash out at other people.

These are just a few examples of how friends, family and therapy can make a difference in someone's ability to cope at critical moments.

"Coping is really about recognizing feelings and asking, 'What do I do with them?'" explains Ms. Wulf. "Our therapists in the clinics and day treatment programs help clients learn to ask, "How can I deal with that feeling and that situation effectively?'"

Evaluate Medications

When a client is in crisis, an important part of the evaluation process is to have a psychiatrist determine if medication is needed, and, if so, which one. If a client is already taking medication and approaching a crisis, the psychiatrist would re-evaluate to see if there needs to be an adjustment to help manage symptoms and also to check that a client is taking medications as prescribed.

At our programs, a psychiatrist sees clients at least once a month to review medication issues, and more often if needed.

Be Aware Of Triggers

"Triggers are events, life changes or feelings that can bring a crisis." says Ms. Wulf, "For example, a family member gets sick or there's a death or loss of a loved one. Or an individual finds out they have a medical problem, or they are near the anniversary of a sad event in their lives."

Sometimes the trigger is a situation that brings change that in and of itself is not a negative experience. "Someone can have a change of roommates, move or have something different in their environment. Those are situational changes that can cause a crisis. Anything we have to adjust to or deal with can be triggers," adds Ms. Wulf.

Some people may not be able to recognize their triggers and that is when a social worker can help a client identify their feelings and focus on coping skills.

For people with chronic mental illness, there is not always a clear connection to a trigger from outside events or situations. Ms Wulf notes, "Clients can become psychiatrically unstable, but there isn't always a real, clear explanation for why."

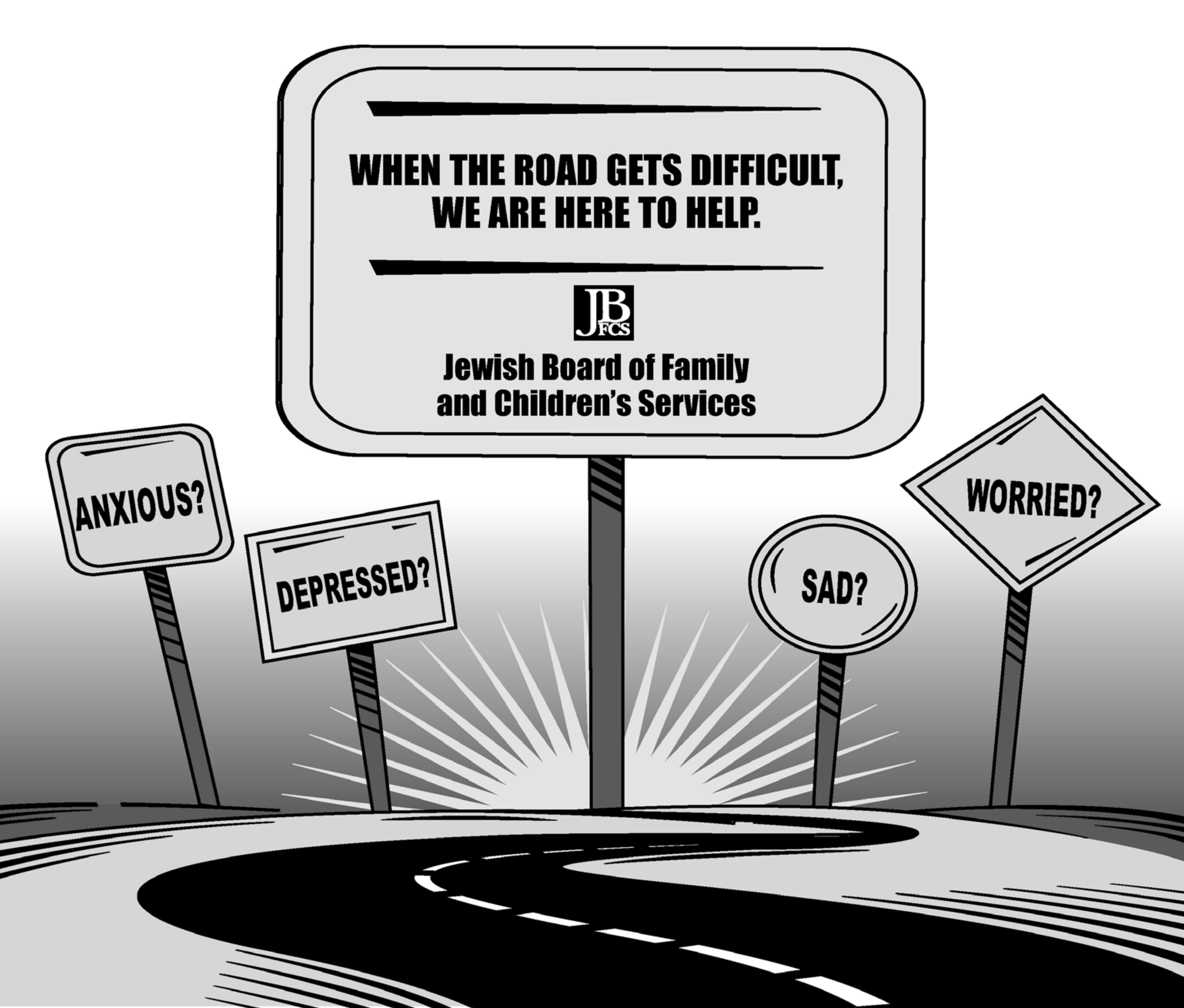
The JBFCS Coney Island continuing day treatment program can provide a safety net for persistently and mentally ill clients. The program operates six days a week for five hours a day with each client's schedule developed according to individual need. The program offers psychoeducation groups throughout the day that cover topics including interpersonal skills, health and nutrition, philosophy of healing, ways of recovery, options for work, or are organized around common experiences such as groups for men of color or women of color. A Spanish-speaking group is also available. The continuing day treatment program provides a collaborative, team approach with a social worker, psychiatrist, supervisor and director assigned to every case. There is ongoing training for all staff. The program receives referrals from hospitals and medical crisis units and makes every effort to see someone as soon as possible.

Consider Turning To A Community Clinic

For people who may be struggling with life crises, a community clinic can be a helpful source of support. Many community resources are available to help—be sure to take advantage of them in a time of need.

"A lot of people think of us as only working with adult home residents, who are chronically mentally ill adults. But we also work with people who live in the surrounding neighborhood who need mental health counseling services," says Ms. Wulf. "We are in the process of expanding our community clinic in Coney Island for people dealing with life struggles that are affecting their mental health. We have immediate availability."

The Coney Island CSS Mental Health Clinic is located at 3312 Surf Avenue between 33rd and 34th Streets in Coney Island, Brooklyn, and can be reached by calling 718-372-3300.



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- *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.

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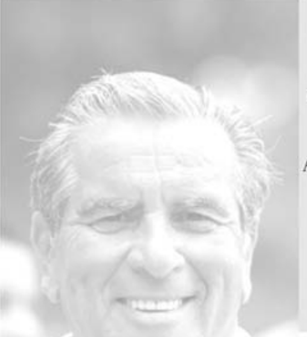

GUEST PRESENTERS INCLUDE:

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Budget from page 9

into strong New Yorkers."

Child and Family Clinic Plus, for which $33 million will be invested, transforms the children's mental health system. This initiative provides for the systematic, early recognition of emotional disturbance with comprehensive assessments for children who need them. Children requiring treatment will find that Clinic-Plus brings improved access, in-home services and treatments that have been shown through science to work. Under this initiative, up to 400,000 children will be screened each year. For those needing treatment, this initiative will more than double the capacity of current programs to admit children.

Suicide Prevention: To further strengthen its suicide prevention campaign, OMH recently held the *New York State Summit on Suicide Prevention* to aid and provide community representatives with knowledge and skills that will help them to develop local plans to reduce the number of suicides in their communities. The Summit, held in November, 2005, was the first of its kind in New York State, bringing together more than 250 individuals who represented suicide prevention stakeholder organizations, survivors, and governmental officials to discuss suicide prevention strategies and share helpful materials and guidance for implementation of these strategies.

In December, 2005, OMH published all three volumes of *Saving Lives in New York: Suicide Prevention and Public Health*, a comprehensive, data-driven report on suicide, its risks and prevention. The report can be downloaded and printed online, at: www.omh.state.ny.us/omhweb/savinglives.

More people die from suicides than from homicides in the United States every year. Suicide is now the 11th leading cause of death for all Americans, and the third cause of death for young people, aged 15-24. In addition, 90 percent of suicide victims have a diagnosable mental illness and/or substance abuse disorder.

Child Mental Health: The Evidence Based Treatment Dissemination Center, for which $620,000 is provided, will create a sustained clinical training model in evidence based treatment protocols and in specialized consultation that will support the organizational changes necessary to transform the way in which mental health services are delivered. No other State has implemented an initiative of this scope to ensure that scientifically proven treatment approaches are available to front line clinicians statewide. This center will engage as many as 400 clinicians across the state and has the potential to affect the treatment of as many as 20,000 children and their families each year.

Expansion of the Home and Community Based Waiver Program, in the amount of approximately $21.5 million, will increase capacity by 450 slots (300 OMH funded and 150 OCFS supported), enabling us to serve a total of 2,140 children throughout the state each year. This represents nearly a 50 percent expansion. Through the Waiver, children and their families can access an array of services, provided in the most integrated community setting possible. The intensity of services ensures that children who are at risk of hospitalization are able to remain at

see Budget continued next column

Budget from previous column

home with their families. New York State is one of only five states in the nation to offer this highly successful program.

Achieving the Promise for New York's Children and Families would also utilize $450,000 provided by the Executive Budget to make Telepsychiatry a reality in rural areas of New York State. Through a combination of enhanced technology and a dedicated child psychiatrist, the designated sites will be provided with up to 600 comprehensive evaluations and clinical consultations each year, giving children and their families access to expert consultation on diagnosis and medication use.

An additional $6.28 million will be used to fund a 2.5 percent Cost of Living Adjustment (COLA) for various children's community based programs, promoting the recruitment and retention of staff within these important local programs.

Crisis Intervention from page 25

pain. The skilled practitioner must recognize this opportunity and build upon their trusting relationship with the client to help them learn new and more effective coping patterns. The goal being that in the future the client will be more successful at problem solving and managing stress.

The awareness of how the holding environment benefits the child is instructive because we never outgrow the need for emotional reassurance. As we mature we accrue problem solving skills that help prevent a crisis; however the acknowledgement that we too need to be emotionally held promotes empathy and enhanced insight. When these qualities are combined with professional competence we are better able to stabilize the situation and facilitate the client's return to either their pre-crisis functioning or an improved state resulting from the learning that occurred during the crisis period.

James R. Dolan, Jr., DSW, LCSW

Mental Health News Upcoming Themes & Deadline Dates

Summer 2006 Issue:
"Understanding Autism Spectrum Disorders"
Deadline: May 1, 2006

Fall 2006 Issue:
"The Psychological Dimensions Of Physical Illness"
Deadline: August 1, 2006

Winter 2007 Issue:
"Managing Life Transitions"
Deadline: November 1, 2006

Spring 2007 Issue: "Who Will Help?"
"The Challenge Of The Mental Health Workforce"
Deadline: February 1, 2007

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The Evolution from page 6

The introduction of atypical antipsychotic medications has made it easier for psychiatrists to address the long-neglected psychotic dimension of delusional major depression. These agents do not have the motor side effects of the conventional agents and are generally more tolerable, even at high doses. Although most of the atypical antipsychotic medications possess important metabolic side effects, resulting in weight gain and occasional increases in glucose and cholesterol levels, the effects on glucose and lipids are generally modest. Weight gain is particularly important for some patients and requires both monitoring and dietary control. The mood stabilizing properties of most atypical antipsychotic medications provide additional potential benefits. Most have been approved for the acute or prophylactic treatment of mania and there is increasing evidence that many atypical antipsychotic medications have antidepressant properties. Related to this, long-term studies of schizophrenia have found that atypical antipsychotic medications decrease the risk of suicide in these patients. The STOP-PD trial was developed to apply the better risk/benefit ratio of these newly available forms of antidepressant and antipsychotic medications to provide an alternative to ECT as an acute treatment and offer a medication treatment that could be introduced early in the evolution of a depressive episode or to prevent relapses.

The STOP-PD trial

As in all randomized, controlled, research, a placebo-controlled design is needed to demonstrate the superiority of a particular treatment. The experience of studying Type IC anti-arrhythmia highlights the importance of conducting such controlled trials. Because anti-arrhythmia drugs were thought to decrease the risk of sudden death after a myocardial infarction, it was suggested that drugs of this class should to be used routinely on a prophylactic basis for these patients. The Food and Drug Administration required the customary double-blind, placebo-controlled trial prior to allowing the marketing of the Type IC form of drugs for this purpose, despite the concern that patients randomized to placebo would be more likely to suffer a fatal arrythmia. Surprisingly, the opposite finding emerged, with a significantly higher mortality rate occurring in patients assigned to the anti-arrhythmia medications. An analogous experience occurred during the women's health initiative, with women assigned to estrogen hormone replacement having a higher incidence of various adverse outcomes than those who received placebo. The STOP-PD uses treatment with the atypical antipsychotic medication olanzapine for all participants and provides sertraline versus placebo as the control condition to determine whether combination therapy is superior and comparably tolerated. Olanzapine was selected because of the documented mood stabilizing properties and the suggestion of additional antidepressant benefits. The main risk of olanzapine results from its known association with weight gain and metabolic side effects. Sertraline is a generally well-tolerated SSRI antidepressant that is effective for the ruminations of obsessive compulsive at high doses. Because of the tolerability of these medications, the psychiatry investigators are able to achieve clinically effective doses rapidly. More than 180 participants have enrolled in the study thus far and they are easily tolerating doses that far exceed those prescribed by most psychiatrists in community settings. Side effects are monitored carefully and doses titrated accordingly. The goal is to determine the response rate when these medications are used optimally, which will provide a fair comparison with ECT. Furthermore, individuals can participate as outpatients, depending entirely on the severity of illness. Support of psychiatrist time from the NIMH and the donation of olanzapine from Eli Lilly and of sertraline and placebo by Pfizer enables us to conduct the study with no costs to participating subjects. Subjects receive up to twelve weeks of acute treatment from one of the lead psychiatrists followed by twelve weeks of stabilization treatment for those who improve significantly and wish to continue.

Summary

Psychotic depression remains one of the most intriguing psychiatric conditions. The question of why some individuals develop severe disturbances in two domains, those of mood and thinking, simultaneously, and yet think, feel and behave completely normally when well remains to be answered. The solution to this riddle will help clarify the causes of psychosis itself. While STOP-PD investigators continue to explore the underlying mechanisms that cause psychotic depression, it is hoped that the recruitment of the 315 participants needed to complete the study will provide clinicians and future patients with the information to guide effective treatment for this pernicious psychiatric disorder that should be associated with full recovery.

For further information on the study, please contact Michele Gabriele, MSW, at 914-997-8681 or Judith English, MA, at 914-997-8636.

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A Guide from page 1

A: First, consult your child's doctor. Ask for a complete health examination of your child. Describe the behaviors that worry you. Ask whether your child needs further evaluation by a specialist in child behavioral problems. Such specialists may include psychiatrists, psychologists, social workers, and behavioral therapists. Educators may also be needed to help your child.

Q: How are mental disorders diagnosed in young children?

A: Similar to adults, disorders are diagnosed by observing signs and symptoms. A skilled professional will consider these signs and symptoms in the context of the child's developmental level, social and physical environment, and reports from parents and other caretakers or teachers, and an assessment will be made according to criteria established by experts. Very young children often cannot express their thoughts and feelings, which makes diagnosis a challenging task. The signs of a mental disorder in a young child may be quite different from those of an older child or an adult.

Q: Won't my child get better with time?

A: Sometimes yes, but in other cases children need professional help. Problems that are severe, persistent, and impact on daily activities should be brought to the attention of the child's doctor. Great care should be taken to help a child who is suffering, because mental, behavioral, or emotional disorders can affect the way the child grows up.

Q: Which mental disorders are seen in children?

A: Mental disorders with possible onset in childhood include: anxiety disorders; attention deficit and disruptive behavior disorders; autism and other pervasive developmental disorders; eating disorders (e.g., anorexia nervosa); mood disorders (e.g., major depression, bipolar disorder); schizophrenia; and tic disorders. Under some circumstances, bed-wetting and soiling may be symptoms of a mental disorder.

Q: Are there situations in which it is advisable to use psychotropic medications in young children?

A: Psychotropic medications may be prescribed for young children with mental, behavioral, or emotional symptoms when the potential benefits of treatment outweigh the risks. Some problems are so severe and persistent that they would have serious negative consequences for the child if untreated, and psychosocial interventions may not always be effective by themselves. The safety and efficacy of most psychotropic medications have not yet been studied in young children. As a parent, you will want to ask many questions and evaluate with your doctor the risks of starting and continuing your child on these medications. Learn everything you can about the medications prescribed for your child, including potential side effects. Learn which side effects are tolerable and which ones are threatening. In addition, learn and keep in mind the goals of a particular treatment (e.g., change in specific behaviors). Combining multiple psychotropic medications should be avoided in very young children unless absolutely necessary.

Q: Does medication affect young children differently from older children or adults?

A: Yes. Young children's bodies handle medications differently than older individuals and this has implications for dosage. The brains of young children are in a state of very rapid development, and animal studies have shown that the developing neurotransmitter systems can be very sensitive to medications. A great deal of research is still needed to determine the effects and benefits of medications in children of all ages. Yet it is important to remember that serious untreated mental disorders themselves negatively impact brain development.

Q: If my preschool child receives a diagnosis of a mental disorder, does this mean that medications have to be used?

A: No. Psychotropic medications are not generally the first option for a preschool child with a mental disorder. The first goal is to understand the factors that may be contributing to the condition. The child's own physical and emotional state is key, but many other factors such as parental stress or a changing family environment may influence the child's symptoms. Certain psychosocial treatments may be as effective as medication.

Q: How should medication be included in an overall treatment plan?

A: When medication is used, it should not be the only strategy. There are other services that you may want to investigate for your child. Family support services, educational classes, behavior management techniques, as well as family therapy and other approaches should be considered. If medication is prescribed, it should be monitored and evaluated regularly.

Q: What medications are used for which kinds of childhood mental disorders?

A: There are several major categories of psychotropic medications: stimulants, antidepressants, antianxiety agents, antipsychotics, and mood stabilizers. For medications approved by the FDA for use in children, dosages depend on body weight and age. The Medications Chart at the end of this article shows the most commonly prescribed medications for children with mood or anxiety disorders (including OCD).

Stimulant Medications: There are four stimulant medications that are approved for use in the treatment of attention deficit hyperactivity disorder (ADHD), the most common behavioral disorder of childhood. These medications have all been extensively studied and are specifically labeled for pediatric use. Children with ADHD exhibit such symptoms as short attention span, excessive activity, and impulsivity that cause substantial impairment in functioning. Stimulant

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medication should be prescribed only after a careful evaluation to establish the diagnosis of ADHD and to rule out other disorders or conditions. Medication treatment should be administered and monitored in the context of the overall needs of the child and family, and consideration should be given to combining it with behavioral therapy. If the child is of school age, collaboration with teachers is essential.

Antidepressant and Antianxiety Medications: These medications follow the stimulant medications in prevalence among children and adolescents. They are used for depression, a disorder recognized only in the last 20 years as a problem for children, and for anxiety disorders, including obsessive-compulsive disorder (OCD). The medications most widely prescribed for these disorders are the selective serotonin reuptake inhibitors (the SSRIs).

In the human brain, there are many "neurotransmitters" that affect the way we think, feel, and act. Three of these neurotransmitters that antidepressants influence are serotonin, dopamine, and norepinephrine. SSRIs affect mainly serotonin and have been found to be effective in treating depression and anxiety without as many side effects as some older antidepressants.

Antipsychotic Medications: These medications are used to treat children with schizophrenia, bipolar disorder, autism, Tourette's syndrome, and severe conduct disorders. Some of the older antipsychotic medications have specific indications and dose guidelines for children. Some of the newer "atypical" antipsychotics, which have fewer side effects, are also being used for children. Such use requires close monitoring for side effects.

Mood Stabilizing Medications: These medications are used to treat bipolar disorder (manic-depressive illness). However, because there is very limited data on the safety and efficacy of most mood stabilizers in youth, treatment of children and adolescents is based mainly on experience with adults. The most typically used mood stabilizers are lithium and valproate (Depakote®), which are often very effective for controlling mania and preventing recurrences of manic and depressive episodes in adults. Research on the effectiveness of these and other medications in children and adolescents with bipolar disorder is ongoing. In addition, studies are investigating various forms of psychotherapy, including cognitive-behavioral therapy, to complement medication treatment for this illness in young people.

Effective treatment depends on appropriate diagnosis of bipolar disorder in children and adolescents. There is some evidence that using antidepressant medication to treat depression in a person who has bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer. In addition, using stimulant medications to treat co-occurring ADHD or ADHD-like symptoms in a child with bipolar disorder may worsen manic symptoms. While it can be hard to determine which young patients will become manic, there is a greater likelihood among children and adolescents who have a family history of bipolar disorder. If manic symptoms develop or markedly worsen during antidepressant or stimulant use, a physician should be consulted immediately, and diagnosis and treatment for bipolar disorder should be considered.

Q: What difference does it make if a medication is specifically approved for use in children or not?

A: Approval of a medication by the FDA means that adequate data have been provided to the FDA by the drug manufacturer to show safety and efficacy for a particular therapy in a particular population. Based on the data, a label indication for the drug is established that includes proper dosage, potential side effects, and approved age. Doctors prescribe medications as they feel appropriate even if those uses are not included in the labeling. Although in some cases there is extensive clinical experience in using medications for children or adolescents, in many cases there is not. Everyone agrees that more studies in children are needed if we are to know the appropriate dosages, how a drug works in children, and what effects there are on learning and development.

Q: What does "off-label" use of a medication mean?

A: Many medications that are on the market have not been officially approved by the FDA for use in children. Treatment of children with these medications is called "off-label" use. For some medications, the off-label use is supported by data from well-conducted studies in children. For instance, some antidepressant medications have been shown to be effective in children and adolescents with depression. For other medications, there are no controlled studies in children, but only isolated clinical reports. In particular, the use of psychotropic medications in preschoolers has not been adequately studied and must be considered very carefully by balancing severity of symptoms, degree of impairment, and potential benefits and risks of treatment.

Q: Why haven't many medications been tested in children?

A: In the past, medications were not studied in children because of ethical concerns about involving children in clinical trials. However, this created a new problem: lack of knowledge about the best treatments for children. In clinical settings where children are suffering from mental or behavioral disorders, medications are being prescribed at increasingly early ages. The FDA has been urging that products be appropriately studied in children and has offered incentives to drug manufacturers to carry out such testing. The NIH and the FDA are examining the issue of medication research in children and are developing new research approaches.

Q: Does the FDA approve medications for different age groups among children?

A: Yes. However, this is based on the data provided to the FDA by the drug manufacturer and the policies in effect at the time of approval. For example, Ritalin® is approved for children age 6 and older, whereas Dexedrine® is approved for children as young as 3. When Ritalin® was tested for efficacy by its manufacturer, only children age 6 and above were involved; therefore, age 6 was approved as the lower age limit for Ritalin®.

Q: Can events such as a death in the family, illness in a parent, onset of poverty, or divorce cause symptoms?

A: Yes. When a tragedy occurs or some extreme stress hits, every member of a family is affected, even the youngest ones. This should also be considered when evaluating mental, emotional, or behavioral symptoms in a child.

From the NIMH Booklet: "Treatment of Children with Mental Disorders"

MEDICATIONS CHART

Stimulant Medications

Brand Name	Generic Name	Approved Age
Adderall	amphetamines	3 and older
Concerta	methylphenidate	6 and older
Cylert*	pemoline	6 and older
Dexedrine	dextroamphetamine	3 and older
Dextrostat	dextroamphetamine	3 and older
Ritalin	methylphenidate	6 and older

*Because of its potential for serious side effects affecting the liver, Cylert should not ordinarily be considered as first line drug therapy for ADHD.

Antidepressant and Antianxiety Medications

Brand Name	Generic Name	Approved Age
Anafranil	clomipramine	10 and older (for OCD)
BuSpar	buspirone	18 and older
Effexor	venlafaxine	18 and older
Luvox (SSRI)	fluvoxamine	8 and older (for OCD)
Paxil (SSRI)	paroxetine	18 and older
Prozac (SSRI)	fluoxetine	18 and older
Serzone (SSRI)	nefazodone	18 and older
Sinequan	doxepin	12 and older
Tofranil	imipramine	6 and older (for bed-wetting)
Wellbutrin	bupropion	18 and older
Zoloft (SSRI)	sertraline	6 and older (for OCD)

Antipsychotic Medications

Brand Name	Generic Name	Approved Age
Clozaril (atypical)	clozapine	18 and older
Haldol	haloperidol	3 and older
Risperdal (atypical)	risperidone	18 and older
Seroquel (atypical)	quetiapine	18 and older
(generic only)	thioridazine	2 and older
Zyprexa (atypical)	olanzapine	18 and older
Orap	pimozide	12 and older (for Tourette's syndrome). Data for age 2 and older indicate similar safety profile.

Mood Stabilizing Medications

Brand Name	Generic Name	Approved Age
Cibalith-S	lithium citrate	12 and older
Depakote	divalproex sodium	2 and older (for seizures)
Eskalith	lithium carbonate	12 and older
Lithobid	lithium carbonate	12 and older
Tegretol	carbamazepine	any age (for seizures)

From the NIMH Booklet: "Treatment of Children with Mental Disorders"

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hope for the future. DEMAND JUSTICE & RESPECT: FULLY FUND RESEARCH!

10% RATE INCREASE

Increase by 10% the rates paid to local providers of community mental health and related services. They have not had an increase in nearly a decade. Their costs are climbing, demand for their services is overwhelming and their staff turn-over rate is staggering. NAMI-NYS urges the State to fund these services. DEMAND JUSTICE & RESPECT: FUND A 10% RATE INCREASE FOR COMMUNITY SERVICES!

HOLD THE DUAL-ELIGIBLES HARMLESS

Under the new Medicare Part D drug benefit, New Yorkers eligible for both Medicare and Medicaid will actually LOSE benefits: They now have co-payments for drugs where before they did not. This can be costly to persons with mental illness, often on numerous medications and of limited means. NAMI-NYS demands the state "wrap-around" Medicare Part D and continue to pay the co-pays under Medicaid. DEMAND JUSTICE & RESPECT: PAY CO-PAYS FOR DUAL-ELIGIBLES!

All NAMI members and friends and supporters are urged to write to their Senators and Assemblyman on these important issues. Let your voices be heard in Albany this spring before the Legislature heads home and to the campaign trail. Demand justice and respect for New Yorkers with serious mental illnesses and their families. We deserve nothing less.

And it is not too soon to mark your calendars and make plans to attend the NAMI-NYS 24th Annual Meeting and Educational Conference on November 3-5, 2006, at the Crowne Plaza Hotel in White Plains, New York. Brochures will full information will be in the mail this summer.

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See Page 43 For Details

First Aid from page 26

or misperceptions in a manner in which the youth can hear the information. They might encourage kids to use creative ways to express themselves; younger children may need to draw, tear paper, or play through dolls and toys. Older youth may want to talk. Again, knowing the child's level of development will be important to the work done through PFA. The PFA responder will help the child to feel safe. Here, they are realistic about the experience and those bad things that happened, as well as the level of safety that the child can experience right now. PFA workers should be ready to look for feelings beyond fear; fear is a universal response to traumatic events. Behind the fear may be anger, confusion, anxiety, embarrassment, or another emotion altogether. The PFA responder should reach for these feelings in a supportive and understanding fashion. It may be helpful to have the children and adolescents to take some sort of immediate action in the aftermath of the event – can they help set up the temporary shelter or give out concrete items, for example? Getting people up and moving about helps them not to dwell on the crisis at hand. Of course, this is done with complete empathy towards the child and the level of distress that he or she may be experiencing in the short time after the crisis.

Adolescents may have their own special needs. Adolescents appreciate having their feelings, concerns and questions addressed in an adult-like, rather than child-like manner. PFA responders will respect this, and will aim not to talk down to the youth after the crisis. They will be realistic about what is going on, and will pay attention for certain behavioral signs of serious psychological distress. These may include a desire to continuously reenact the event through play or talk; a general numbness beyond a few hours after the event; a loss of interest in regular activities; detachment and withdrawal; intrusive memories; reliving of the event over and over in one's mind; daydreams, nightmares, and bad dreams; and a total avoidance of reminders of the event. As for all people affected by a crisis (both young and old), when the symptoms above persist over time, and when symptoms of anxiety or increased arousal (e.g. sleep difficulties or irritability) persist for a timeframe greater than one month, referral to a qualified mental health practitioner is crucial for proper assessment and diagnosis. The symptoms described are manifestations of the DSM-IV-TR diagnoses of Acute Stress Disorder and Post-Traumatic Stress Disorder (PTSD). Treatment that is more long-term, trauma-focused, and emphasizes cognitive-behavioral therapy with or without medication is needed for individuals experiencing this level of reaction to the crisis event.

A final point should be made that all Psychological First Aid care occurs in a culturally competent manner. Different ethnic and cultural groups have different ways of grieving, experiencing loss, and dealing with emotions and cognitions. PFA responders must be sensitive to these concerns and know something about the way the cultural or ethnic groups affected by the crisis respond to traumatic events. For example, different cultural groups have definitions of what is personal space. Some groups may like close physical contact, others may shy away from this. PFA responders should know this ahead of time so that they can gauge their level of closeness to the survivor. Cultures also mourn loss differently. Some groups are expected to openly express their pain, while others may be asked to stoically maintain their composure. Again, the PFA responder would be sensitive to this issue. Finally, knowing something about the rituals associated with death and loss would be crucial as well (if that is an issue in the crisis event). This way a PFA responder can honor the person's experience of death while being supportive to them as well. Of course with all cultural competence, universal assumptions are never made; the individual may or may not manifest reactions that are common to his or her heritage.

Psychological First Aid is a relatively new language for something that has always been known; people in crisis have both physical and cognitive/emotional needs. As a holistic approach informed by evidence from the field that empathy, support, stress reduction, and a return to some normalcy is what helps people best get through a disaster or crisis, Psychological First Aid as a way to help in a crisis is a phenomenon whose time has come.

In this world of terrorism, everyday crises, violence, war, and natural disasters, it is clear that a little compassion and care go a long way to helping people through the worst of times. This is what Psychological First Aid is all about.

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What We Call from page 12

Where are the verifiable criteria that do not rest on interpretation? The official, clinical definitions of mental illness were made up in a series of negotiations.

The Bible of Psychiatry is the DSM, the Diagnostic and Statistical Manual of Mental Disorders, now in its fourth edition. It's 900 pages long and sells for $83. But back in 1968 it was a 150 page paperback and cost $3.50. The man most responsible for making the DSM into the power it is today is a psychiatrist named Robert Spritzer, the chair of the DSM-III task force. He had the idea that you should have these discreet diagnoses which could be described by checklists of symptoms. And doctors on this task force had arguments and negotiations about what should be included. Was "atypical child" a diagnosis? What about homosexuality? It was Spitzer who brokered a compromise that eventually led to the removal of homosexuality as a diagnosis in the DSM. That fact alone – that it took until 1973 for them to stop diagnosing homosexuality as a mental illness – is both damning of psychiatry as a whole but also points up how much of what is presented as clinical, verifiable mental illness is in fact just made up.

However, as someone who has experienced mental illness, and who has benefited enormously from good treatment (when I finally got it) and the right medications (when I finally got them) I am a believer in the reality of mental illness. As the brain is perhaps the most complex object of human inquiry in the entire universe, including the universe itself, I can accept that mental illness can be real even if our instrumentation cannot yet observe it in the same way as a fracture or a heart attack.

Having a mental illness isn't like being a particular race, or having a particular sexual orientation. It's not something with which I identify, not in the same way I identify with being male, or straight, or Jewish. I would not give up any of those things; I'd drop being mentally ill in a heartbeat, being an addict even faster. If I were no longer an addict I could have a drink once in a while, like a normal person.

Peers aren't really peers of each other anyway, even if they have the same diagnosis, went through the same system or suffered the same losses. Recently, I attended the Veteran's Administration's first conference on peer support, held in Memphis, Tennessee. Participants included administrators, researchers, case managers, psychiatrists, and veterans who have been working as peer providers. It wasn't hard to pick out the veterans. The VA staff all had that shiny, scrubbed, buttoned down professional look. Many of the veterans had piercings or tattoos, beards or mustaches, maybe not the thousand yard stare but they were clearly guys who had been there and back. The first night I arrived I walked into a ballroom where everyone was having dinner. I looked around and for the first time at a peer conference, I felt completely out of place. No way was I a peer of these men.

I had been invited to speak because in many respects the Veterans Administration is now where the mental health system was a decade ago: struggling to understand and incorporate the contributions of the people whom they are mandated to serve. In some respects I had something in common with everyone there: as an administrator, I'd had to contend with developing policies and procedures to address conflicts of interest, boundary issues and a host of other concerns that can arise when consumers become providers. And yet, when considering the veterans, I felt like a total outsider. I've never been in combat. I've never been shot at, and I've never shot at anyone. I've never been in a military unit, nor had anyone I was close to in a unit killed in front of me. I have nightmares, but not those nightmares.

It was strange to be on the outside looking in. But when it came to recovery, we all spoke the same language. All of us had gone somewhere and come back someone different. And we'd faced the process of redefining ourselves: creating a new, coherent, internal narrative that could integrate everything we had been through and which defined us as someone whole. A big part of recovery is throwing off the internal and external messages that you are broken, and reclaiming your own life story.

I've heard the term "people in recovery." It's person-first, it has recovery right in there. I've never been thrilled with it. Do we really need an Us to be different from Them? Not as much as each of us needs a Me.

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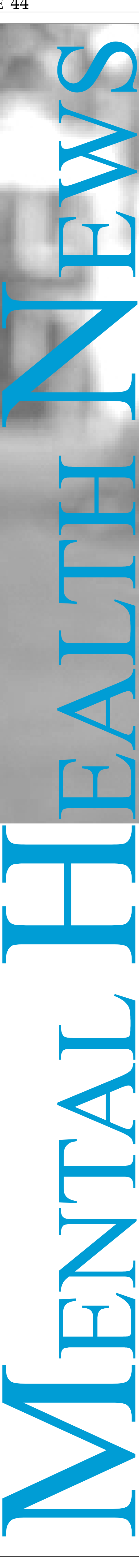

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