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SPRING 2009

FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE

VOL. 11 NO. 2

Providing Essential Care & Services Following Psychiatric Hospitalization

By Barry B. Perlman, MD
and John Turtz, PhD

In this article we will address the discharge planning process. Affecting a proper discharge plan is an important continuation of the care rendered during the inpatient psychiatric hospitalization. This observation is especially true as the length of inpatient stays has become briefer. What an individual can expect upon leaving the hospital is a direct consequence of the insurance coverage they have. Persons having commercial insurance, in general, have a more limited range of post discharge options than those insured by Medicaid and/ or Medicare. It is also largely the case that persons suffering with the most serious and complex mental illnesses are most often covered by Medicaid and/ or Medicare. Persons lacking insurance represent a third group when considering aftercare options. These latter 2 groups are often treated by the public mental health system. This article will address the aftercare possibilities for those whose care is received through the public sector.

The services indicated for a soon to be discharged consumer insured under Medicaid and/ or Medicare are a clinical matter,



while which services they can actually access on a timely basis are matters of geography and availability. New York State has made great strides in creating an array of post-discharge levels of care to which individuals can be referred. Ours is a state of vastly differing environments from the densely urban regions such as New York City, to suburban regions exemplified by

such counties as Westchester or Nassau to the rural regions in its Western and Northern reaches. We in Westchester County are fortunate that our county has among the broadest array of programs at each care level recognized by the NYS Office of Mental Health. Other counties may not have all levels of care and may not have enough capacity of any given type of pro-

gram. Appropriate housing remains an obstacle across all parts of our state.

Clinically relevant issues to be discussed by patients and/ or their families with the staff of the units on which they are being treated include whether the consumer would fare best being treated at a clinic, continuing day treatment program or partial hospital program after discharge, and whether case management services of any of several levels of intensity are indicated. The possibility of seeking court-ordered treatment through Assisted Outpatient Treatment (AOT) under Kendra's Law may also be considered. It is also useful to ask about whether the consumer would benefit from longer acting injectible antipsychotic medications. In brief, aftercare planning is a process of cobbling together a plan most suitable for the individual from the several relevant categories of care available.

The psychiatrist, social worker, and/ or discharge planner should have a clear perspective of what the clinical precipitants were leading to the need for admission. For example, many who work in the field of inpatient psychiatry are aware that when patients stop taking their psychoactive medications they become vulnerable to

see Discharge Planning on page 32

Building a Responsive, Accountable, Recovery-Focused System of Care

By Robert Myers, PhD
Senior Deputy Commissioner
NYS Office of Mental Health

I wish to briefly describe what is on the horizon for the Adult Mental Health system in our state. The New York State public mental health system is among the most well funded in the country, yet outcomes are of concern. In the middle are people who struggle with mental illness and want to lead peaceful and fulfilling lives. I do not believe anyone familiar with this mental health system is satisfied with the results of our collective efforts.

The positive news is we are beginning to come together to transform these resources into a more responsive, accountable, recovery-focused system of care. A restructuring process has begun with broad stakeholder involvement. Phase one of this is clinic reform. The goals here are

to improve access to clinic services by reforming the approach to funding, and improve quality by providing incentives for positive outcomes, by refocusing oversight towards good clinical practice and by providing technical assistance to improve clinical competencies. Initial efforts in this area include wellness self management, where over 100 agencies are engaged in learning collaborative's, and a web-based curriculum for training in integrated dual disorder (MH/SA) treatment will begin this year.

Phase two of reform will focus on the more specialized and intensive services available for people living with serious and persistent mental illness. The goals here are to assist people to succeed in life (work, housing, school, friends, wellness). The approach will be more integrated, accountable care with all services coordinated from a single plan; more mobile services that meet people in their houses and community, responsive to resolving

crises; close coordination with physical health care; and a strong emphasis on employment and education.

In December 2008, the Office of Mental Health (OMH) received a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to research and design recovery centers which could be consumer operated, or have strong consumer involvement in service provision. Recovery centers, working in collaboration with treatment staff, will have the charge to assist and inspire people to move forward with recovery goals.

In many areas of the State, psychiatric centers are a major resource. The OMH psychiatric center directors have begun work to make these facilities more responsive to the needs of the broader mental health system. People who no longer need to be in the hospital are starting lives in the community. Access to many of these facilities has improved. In the coming year, OMH field office and facility

directors will begin work with counties and other mental health providers to plan how the psychiatric centers can help fill service gaps in ambulatory care, collaborate as a system partner, and serve as a valuable resource to achieve the transformation we all seek.

Housing, too, is going through a change. More OMH resources are going toward integrated housing projects and we are partnering with providers to design more flexible, individual housing support services. Housing services will be a resource for broader system transformation. In these times of tight budgets it is encouraging that the mental health community in New York is coming together to redesign how we use our resources to move toward a more responsive, recovery focused system of care.

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D6-K0198H March 2008

From the Publisher

Some Essentials on Surviving a Mental Illness During and Following Hospitalization

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

I am very pleased that we are addressing the topic *Providing Essential Care and Services Following Psychiatric Hospitalization* in this issue of *Mental Health News*. I want to thank the many people and organizations who helped make this issue possible.

According to the National Alliance on Mental Illness (NAMI), mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), post traumatic stress disorder (PTSD) and borderline personality disorder. In addition to medication treatment, psychosocial treatment such as cognitive behavioral therapy, interpersonal therapy, peer support groups and other community services can also be components of a treatment plan and assist with recovery. The availability of transportation, diet, exercise, sleep, friends, and meaningful paid or volunteer activities contribute to overall health, wellness and a meaningful path to recovery. The good news about mental illness is that recovery is possible. As a survivor of a prolonged and serious mental illness myself, I would like to share with you some of the things that I learned during my ten-year journey to recovery.

A Very Thin Line

One thing I realized when I first became ill with depression, was how thin the line between normal and abnormal mental wellbeing could be. It was a line I fell off of so suddenly and without warning. My first suspicion that there was something wrong was an unexplained feeling of fear, and anxiety, which I brushed off as a quirky feeling or a passing mood. When these troubling feelings persisted and began to interfere with my daily routine, I really didn't know what to do, so I made an appointment with a psychiatrist I found in the phone book and was given some medication and told to return in several weeks. In my case, things spiraled quickly out of control in a matter of days because the medication I was given was not what I needed. This is not that uncommon in severe cases of depression which I didn't realize I had. Had I known, my best choice should have been to get a referral to a more skilled psychiatrist that was an expert in diagnosis and psychopharmacology. As my mood worsened, I was having trouble just hanging on, so I had to be admitted to a nearby hospital's psychiatric unit.

Making the Most of Your Hospitalization

If you are now in the hospital or are about to be admitted, there are a few things I learned from the several experiences I



Ira H. Minot, LMSW

had as an inpatient, that might help you. First of all you must understand that treatment for mental illness is not an exact science, but rather a combination of the right medication(s), psychotherapy, and outpatient care. Although you would like your ordeal to be over in a week or two, it just doesn't always work that way. For example, many medications your doctor prescribes may take several weeks to work, so be patient. Your job is to communicate as honestly as you can to your doctor and treatment team as to how you feel on a day-to-day basis. As your symptoms may interfere with your thinking and daily routine, it may be helpful to have a simple spiral notebook where you can keep daily notes on what medications you are on, how you are feeling, and any questions you might have. Then you can review these notes with your doctor and other members of your treatment team.

When you are admitted to the hospital, become familiar with your treatment team. The team usually includes your psychiatrist, psychologist, social worker, nurses and other unit staff. List your team members names in your notebook so you can remember who they are and what each person is helping you with, including: medications, individual, group and family therapy, medical insurance and entitlement benefits (SSI, SSD, and Medicaid for example), and discharge planning. Each day in the hospital is structured so that patients have a daily schedule of activities. Often you will have free time during the day, and if you are able, use this time to read an inspirational book or information about your illness that your doctor might recommend. It will be time better spent than sitting in front of the TV in the day-room. Do the best you can every day and push yourself to participate in the daily routine on the unit even if you are so depressed you don't feel like getting out of bed. The enemy of recovery is "ruminating" or persistently focusing on your problems over and over again in your head. Activity (moving forward) is the key, and part of the healing and recovery

process. Think of it as learning how to walk for the first time all over again. Start with your left foot then your right foot, and so on. If you keep working at it, soon you will be moving right along.

A Sensible Discharge Plan

As soon as you are admitted to the hospital you and your team are theoretically working toward your eventual discharged back into the community. Find out who you will be working with to plan how you will return to the community. If you are fortunate to have the support of your family and employer, you may be returning to your home and when ready have a job to return to as well. For some, however (including myself), you are not so fortunate and have to find your own way. This can be a very scary prospect in addition to having to cope with your illness. If you do not have a family, home, or job to return to, your task is much more difficult. Proper planning in this situation is critical so that enough of a support network is set in place to help you cope with the many issues involved with life back in the community. You will need all the basics including housing and government assistance to help you pay for food, transportation and health care, and all the other basic expenses necessary to survive back in the community while working on your recovery. In most cases, you will need to continue in treatment in either a private or an outpatient clinic setting. For those needing a more structured daily outpatient treatment plan, referral to a continuing day-treatment program (CDT) is what is required. The CDT program may provide the daily structure that you need to continue working on your recovery.

Returning to Your Community With Hope and Pride

Enduring and surviving a psychiatric episode or relapse is nothing to be ashamed of. You must understand that, and I can't stress it more. Having a psychiatric illness is a medical condition that scientific research has shown to be caused by chemical imbalances in the brain at the synaptic level.

Unfortunately, stigma towards people with mental illness is outside the realm of science yet still does exist and can really hurt. Be it from family, friends or employers, stigma is caused when the people around you do not fully understand what you are going through and why. Even people you love may say things to you like: "Why don't you just snap out of it?" or "There's nothing wrong with you." Since mental illness is invisible on the surface, most people can not comprehend that something is really wrong with you. If your arm was in a cast or you were in a wheelchair, these visible abnormalities would enable people to be more understanding than when someone's psychological wellbeing is broken. The key here, is to expect stigma and move ahead in your recovery in spite of it. Don't let it bring you down and do not expend any

unnecessary emotional energy defending against it. You will need all your energy to get better. If there are people in your life that want to ridicule you or make you feel bad or responsible for your condition, you must tell them to stop! If that doesn't work, try to avoid these people at all cost. I've been there and I can tell you that it took time for me to accept my illness and allow myself to heal. I was then able to tell understanding people about my experience which seemed to open many doors for me. It was then, that I decided for my own continued mental health that there would be no room in my life for any toxic or negative people. Telling my story to understanding people was very therapeutic for me and it increased my self confidence. My shame disappeared and I found that most of the people I spoke with understood what I had gone through, and often shared their own personal experience with mental illness, or a similar experience that a member of their own family had gone through.

Be Proactive in Your Recovery

If you are fortunate to live in a metropolitan area, there is a good chance that there are other beneficial programs or services that you can hook up with in addition to your outpatient therapy or CDT program. If you have access to a computer, go to NAMI's website at www.nami.org, and Mental Health America's (formerly the Mental Health Association) website at www.nmha.org. Both national associations have useful information on their sites, and you can find the location of your local community chapter, which may offer other therapeutic programs. There may also be "consumer-run" programs such as clubhouses and drop-in centers in your community where you can meet and learn from others who are also working on their recovery. Beware of poorly run CDT's or consumer programs where you are not challenged to work on useful recovery activities every day. If everyone is either going outside to smoke every five minutes or loafing on couches napping or watching TV — find another program fast!! If you have lost your job, find a supportive employment program that can help you regain the confidence and skills you will need to find your way back to meaningful employment. If you have a choice, you deserve to be in the best programs available in your community so remember you have a right to shop around.

I wish there had been a newspaper like *Mental Health News* at the time of my illness twenty years ago. There wasn't, and so I started this newspaper. It took years for me to fully recover, but during that time I discovered that there are many wonderful people in the community that care about you and are there to help—many of whom you will read about in every issue of *Mental Health News*.

Mental health is about all of us. Good luck in your recovery, and never give up.

Have a wonderful spring season.

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Family Support is Key When a Member is Hospitalized

By Barbara Faron, LMSW, CPRP
CEO, Federation of Organizations

Enduring a hospitalization as a result of a mental illness can be a traumatic experience not only for the patient, but for the family, as well. This is true whether it is a first hospital stay or one of many. In an effort to assist caregivers in their roles, Federation of Organizations, in conjunction with NAMI, offers the Family-to-Family education program in Suffolk County. This 12-week program, which is free for family members, partners and friends of individuals with mental illness, is structured to help caregivers understand and support individuals with serious mental illness while maintaining their own well-being.

The course is taught by trained NAMI family member volunteers who know what it is like to have a loved one struggling with a brain disorder. Subjects covered include how to take care of oneself in order to be able to take care of a loved one; medications; crisis management; empathy and understanding; available resources; and more. Having the information provided by people who have already lived through the same experience provides attendees with a different perspective than if the classes were taught solely by professionals. The ability to share experiences and solutions with others who have been in the same position – without fear of being judged – is a key element in



Barbara Faron, LMSW, CPRP

the success of the group. Often, when a member tells the group about something that occurred, it is met with a response of “That happened to me, too,” followed by a discussion of how each family handled the situation, what worked, what didn’t work, etc. Ellen Tollefsen, NAMI member and group facilitator, noting the all-encompassing nature of the course, said, “I feel this course gives people everything

they need to improve their lives and the lives of their family members.”

Because of the nature of the psychiatric hospitalization of a family member, notably that it is often against the will of the patient, or the patient may be in denial regarding his or her mental illness, the course includes such subjects as HIPAA laws and how important it is to have the patient sign a release form. If the patient is unwilling to do so, Tollefsen notes that it is important to speak with the doctor and either write a letter or speak with the patient’s social worker regarding symptoms and what behavior was observed prior to hospitalization. The empathy portion of the course touches upon the period of time after the family member’s hospitalization, explaining that the hospitalization can be both mentally and physically devastating, and that caregivers must allow their family member to “just be” for a period of time, rather than trying to encourage him or her to “snap out of it.” Being as prepared as possible for this occurrence enables the family to better endure the varying dynamics of a member’s psychiatric hospitalization.

For many attendees, the experience with the Family-to-Family group is the first time that they have had the opportunity to be with other family members of people who have been diagnosed with a mental illness. The fear of the stigma associated with society’s views of mental illness is nonexistent within this group; rather, it is replaced with support and un-

derstanding. Often, when a family member is diagnosed with a mental illness, the resulting feelings for family members are anger, confusion and a lack of hope. Because of the resources provided by this group, these same people now know where to turn for information and support, which alleviates many of these negative feelings. In addition, being able to learn at least some of what to expect from people who have “been there” can help the family to better prepare and cope, thereby helping to improve their mental health during a family member’s hospitalization and in the future.

Many attendees also join Federation of Organizations’ family support group in order to maintain ongoing contact and support. This group, which meets the second Tuesday of each month, is less structured, and geared entirely toward support, rather than formal instruction. Attendees come to the group to share feelings and stories about things that may be going on at home, and are assisted in their coping by the other members who share resources and experiences. Federation’s family support group is facilitated by Tracy Falkner, LMSW, CPRP, Federation’s Director of Community Services and a facilitator of the Family-to-Family group.

For further information regarding the Family-to-Family group, please contact Deborah Mayo at 631-675-6831; for information regarding the family support group, please contact Tracy Falkner at 631-447-6460 x2124.

Recovery Can Begin On The Inpatient Psychiatric Hospital Unit

By Pablo Sadler MD
Yves J Ades PhD
and Robert Goldblatt LCSW

Post discharge services start the day a person is admitted to an inpatient unit. Usually, when people stay for a few days in the hospital, staff focuses mainly on medication issues. Many studies of people suffering from severe mental illnesses show an association between non-adherence to medication and higher rates of hospitalizations. When individuals stop taking their medications as prescribed, their chances of being readmitted to a hospital increase dramatically. There are many reasons that individuals stop taking medications. For some people, medications do not provide as much help as one would hope for. Others have difficulty tolerating the side effects of medications that have been tried. Some people do not take medications for personal reasons or because of stigma attached to using psychotropic medication and to mental illness. Non-adherence to medication often occurs along with individuals’ disengagement from mental health service providers. Ultimately, re-admission to a hospital might be required. Yet the common theme for every person who is admitted to the hospital is that no one wants to be there.

Mental health professionals generally agree to use the biopsychosocial model as a way to explain psychiatric disorders. We acknowledge the influence of biological factors that make people vulnerable to psychiatric illness; that is why we offer medications to help people suffering from psychiatric problems. The psychological part of this model involves the effects that social and environmental factors have on a person’s state of mind. It describes the changes in the person’s behavior and interactions with the outside world. The social aspect refers to the way the environment, (shelter, relationships, work, education, etc.) affects an individual.

When a person is hospitalized one or more of these factors have changed in a negative way. Therefore, it would make sense to explore in depth the three parts of the bio-psychosocial model. However, more often than not, the issue that takes the largest amount of human and financial resources is the biological (medications) one. The reasons for the medication-centered approach are complex and beyond the scope of this article. However, the emphasis on medication has significant ramifications for the consumer’s discharge plans. Although the culminating event that triggers a crisis could be the consumer’s ceasing to take medication, underlying causes of the crisis are often not clear, and therefore might not be ade-

quately addressed. A significant result of not addressing psychosocial needs as aggressively as the biological ones is a breakdown in the communication between providers and consumers. Paradoxically, because of this deterioration in communication, even the medical interventions are less likely to succeed.

With the obvious exception of shelter, the most important component in a discharge plan is having access to medications and a follow up appointment with a psychiatrist. As established earlier, chances are that adjusting medications by itself is not going to make a difference for the person that was just hospitalized for a crisis.

What could be done differently? Many times the goal of hospitalization is to get the person “clinically stable”. Instead, the system should be centered on recovery. Hospital staff should focus on an individual’s needs beyond medications. We suggest that in addition to safety, the goal of hospitalization should be to help the person regain control of their life. For someone to benefit most from a hospitalization and follow up care there should be a focus on goals from the beginning of the admission process. For this to occur, outpatient programs need to supply information to the hospital team beyond medication and recent progress notes. A individual’s treatment goals should be communicated to the inpatient team so that all interven-

tions proposed at the hospital are in harmony with their life goals.

For those people hospitalized without community based services in place prior to admission, it is essential for staff to identify, together with the patient, what interventions will make a difference in their future. Staff should refrain from establishing goals for an individual. Furthermore, symptom centered goals should not be a part of a treatment plan. In those situations when people only speak about their symptoms, they should be asked what areas of their life they would like to focus on.

At that point medication takes its rightful place in the overall picture of recovery, as one more tool to regain control of the person’s life. Once the discharge plan is centered on the person and not on the symptoms, other treatment options and rehabilitation interventions can emerge as first tier needs. As a individual identifies their needs, they should be educated about the different services available in their community, such as clubhouses, case management, advocacy and employment programs.

In the hours and days that immediately precede the traumatic trip to the psychiatric emergency room, a person’s experience is usually one of chaos and terror,

see Recovery on page 27

POINT OF VIEW

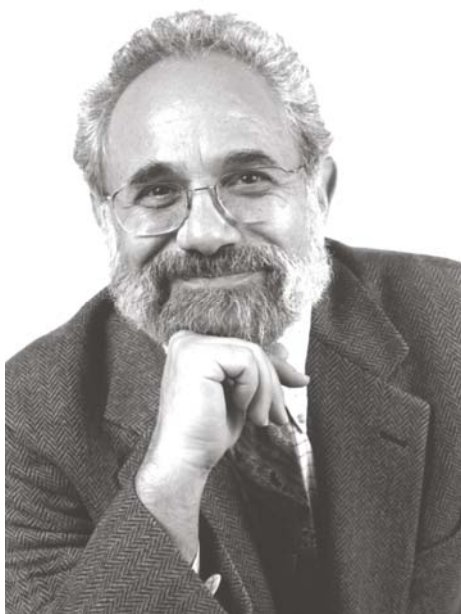
Mental Health Policy in a Time of Economic Crisis

By Michael B. Friedman, LMSW

Do we need to shift mental health policy in this time of economic crisis? I think we do. I think we need to worry about the impact of economic decline on people with serious, long-term mental illness, and I think we need to build concern about the emotional well-being of the American people into the economic rescue plans now underway.

For the past 50 years we have pursued an incremental community mental health policy in the United States and in New York State. We have established the expectation that people with serious, long-term mental illnesses will live freely in the community, and we have gradually been making it possible for more and more people to lead secure and satisfying lives by incrementally increasing the services and supports that are available to them. Life is better for some, perhaps even many; but we have a very long way to go to meet the needs of people with serious mental illness. We need more supportive housing. We need more services oriented towards rehabilitation and recovery. We need more integrated mental health and substance abuse services. We need to increase the quality as well as the quantity of outpatient treatment. We need to assure that inpatient care is available and of high quality when people need it and that outpatient and community-based alternatives are available for those who are in hospitals because there are too few decent alternatives. We need far more attention to meeting the physical health needs of people with serious mental illness, who die much younger than the general population in large part because of poor health and poor health care. Over the years we have chipped away at these needs—some years more than others, but the basic expectation has been that each year we address more of the unmet needs.

Now we are confronted with an economic crisis unlike anything we have experienced in 80 years. Fortunately in this, the first year of the crisis, funding cuts for mental health services in New York are projected, rather than current, spending. That is, improvements promised in prior years have been put on hold, hopefully only temporarily. New housing for people



Michael B. Friedman, LMSW

with serious mental illness will be delayed, despite the fact that stable housing is the single most important precondition of recovery. Cost of living adjustments that do not come close to making up for the erosion of base funding that took place during the 1990s and early in the current decade have also been put on hold despite the fact that the mental health workforce has been strained in the extreme because of low wages and poor benefits.

All this is not good, but it is probably tolerable—for a year. What will happen next year and the year after and the year after that if the economy does not recover rapidly? We know what has happened in the past. Depressions in the 19th and 20th centuries contributed mightily to the dreadful conditions that came to exist in state asylums and hospitals in the years after the Civil War and again in the 1930s. We need to be on guard, it seems to me, that this does not happen to our hospitals again, that the squeeze to get through a tough year does not become tolerance for terrible care and treatment in either state or general hospitals.

We also need to be on guard now against vast decay of outpatient and community-based services. These services are not adequate now. There are too many people with serious mental illness on the streets, in jails and prisons, in squalid housing, in institutions such as adult homes and nursing homes where care is

uneven—to put it delicately. What happens if the economic crisis persists? We need to worry about this. We need to have a fallback plan that is built on a premise other than a rapid return to incremental improvement year after year. We need to contemplate the possibility that our state and our nation are entering a period in which life will get worse for all of us, and, if history is any guide, worse still for people with serious mental illness.

This brings me to my second thought about mental health policy in a time of economic crisis. What is the impact of the crisis on the emotional well-being of average Americans? My guess is that all of us have reacted with considerable emotional turmoil. Losing a job, a home, a pension, a sense of security about the future—these take their emotional toll. Should we expect our government—our public mental health system—to respond to this in some way or is it just a private matter?

This is debatable to be sure, but in the aftermath of the terrorist acts of 9/11/2001, our nation and our state mounted a considerable effort to help people to manage emotionally. I think we should consider a similar response to the economic crisis.

I understand that the two events are not identical. Disasters or acts of terrorism happen and are over. Reactions unfold in fairly predictable stages, and over time most people are able to regain lives that were disrupted by the disaster, even when they have lost someone whom they loved, even when their sources of livelihood have been ended, and even when their homes have been destroyed. This economic crisis is not an event of that kind. It does not happen and end in a brief period that is followed by a period of recovery. This economic crisis has already gone on for months, and it may go on for years. Job losses, foreclosures, retirements no longer possible—all will continue to happen for a totally unpredictable period of time. I cringe to think of it.

What can the public mental health system do? First, it can acknowledge that the economic crisis does contribute to emotional turmoil that can be quite destructive to individuals, families, productivity at work, and more. Second, it can bring together the best thinkers about mental health systems in much the same way that President Obama has brought together the best economic minds in the country.

Third, it can devise a responsible policy built on what we know about helping people deal psychologically with crises based in real, uncontrollable events.

Frankly, I am not sure what policy would emerge from such a process. But I'd guess that, like the response to disasters, it would emphasize providing emotional support in the context of people trying to hang on to their houses, get jobs, and devise retirement plans based on what they have left. It would emphasize education about what we can do to manage our emotions ourselves. It would emphasize the value of joining with others in our communities to face new realities together. It would emphasize suicide prevention. And it would include helping those people who would benefit from treatment to get access to it, without expecting that there will be a huge increase in need for formal treatment.

I am just speculating, of course. But don't you think it would be useful to get good thinkers together to develop a mental health policy and a plan related to those of us who are taking big economic hits with hard consequences for us and our families?

I hope, of course, that this would all prove to be a waste of time, that the economic recovery is more rapid than a planning process would be. I hope that we will get back to what we regard as normal in the United States and the rest of the industrialized world. But I am now clear that we have no right to assume the best. And it only makes sense to me to prepare ourselves for the worst and to prepare too for how we as a society will protect people with serious, long-term mental illnesses if the economy does not bounce back soon. Economic recovery plans without regard for the most vulnerable among us are just not good enough in a nation that wants to reclaim moral, as well as economic, leadership in the world.

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The NYSPA Report:

NYS Governor's Executive Budget Proposal: Issues for the Mental Health System

By Barry B. Perlman, MD
and Seth Stein, Esq.

This edition of the NYSPA Report focuses on the Governor Paterson Executive Budget Proposal for the 2009-2010 fiscal year. Customarily, the Governor's annual budget proposal is released in January of each year. However, because, in the words of Governor Paterson, the state is facing the most serious financial crisis since the Great Depression, the Governor released his budget in December in the hope of stimulating urgent attention and spurring the Legislature to act expeditiously. The budget proposal can be viewed by on the Internet at: www.assembly.state.ny.us/comm/WAM/20081216/a158.pdf.

In addition to proposals for cuts in spending, the Governor's budget proposal also includes proposals for significant changes in the NYS Medicaid program that are intended to "reform" the program and generate savings. This article will review three proposals for change in the Medicaid program. Our goal is to bring these proposed changes to the attention of advocates, patients and their families.

The NYS Medicaid Drug Formulary

New York has established a Drug Utilization Review Board which is charged with advising the Department of Health on which medications from different classes of medications shall be included in its list. Under the new statutory proposals, the DURB will now be asked to recommend guidelines for specific therapeutic regimens for specific diagnoses which practitioners may prescribe without requirement of prior authorization. The key change in the budget bill (Section 45(7), p. 81) eliminates the current right of the prescribing physician to override Medicaid prescribing restrictions. If the change is enacted into law, a shift will occur and the Medicaid program's decision will be final rather than the physician's. Although a physician may appeal from a denial of coverage, the decision by the Medicaid program is final. Despite national outcries against the increasing insertion of bureaucrats between doctors and patients, NYS is about to take a giant step in that direction. NYSPA opposes this change. Our longstanding policy requires that generally accepted medical practice must prevail over bureaucratic cost-cutting.

Pharmacy Benefit Managers (PBM)

The Governor has proposed an entirely new statutory scheme (p. 88) that would regulate pharmacy benefit managers – the companies that are hired by health plans to oversee and manage the prescription drug benefit part of a health plan. Many patients are surprised to learn that a PBM employed by their health plan has contacted their physician requesting that the doctor "switch" the patient's prescribed medication from the drug prescribed by the physician to another drug



Barry B. Perlman, MD

suggested by the PBM. Too often such requests are made for the financial benefit of the PBM or health plan rather than for the clinical benefit of the patient.

The proposed statute would require a PBM to notify the patient (or the patient's guardian) before contacting the patient's physician about switching the patient's prescription and when the PBM contacts the physician, must provide the physician with clinical and financial information regarding the drug switch. It then requires that prescribers make their decision based on the whether the proposed "switch" is in the patient's best interest. Seems good! Seems patient centered! But is it? The answer lies in the definition of "switch" in §4450 (12). Under the proposed statute, the definition of a switch has two elements. First, a switch is an attempt by a PBM to switch multiple patients because of clinical considerations or the economic benefit to the PBM. However, the definition then states that an attempt to change a prescription excludes an attempt to switch the patient to "a lower or equally priced therapeutically equivalent drug." "Lower or equally priced" refers to the participant's co-payment or co-insurance amount.

By defining "switch" to exclude attempts to switch patients to another drug when there is no cost to the patient, the bill's apparent patient friendly appearance is stripped away. The definition defines "switch" in such a way as permit PBMs to continue to act as they currently do so long as the patient's out of pocket payment is not increased. NYSPA advocates for the removal of (b) from the definition of "switch" and opposes the section as presently written.

Reducing the Influence of Drug Companies

The Governor also has proposed sweeping new provisions that would seek to protect physicians and other prescribers from the undue influence of pharmaceutical

companies. Proposed laws would restrict gifts to physicians, impose disclosure requirements relating to drug manufacturers' provision of things of value to prescribers, and limit the influence of drug companies and medical device manufacturers on continuing medical education.

While some may argue against the details and burden created by the proposed restrictions on continuing medical education and recommend that New York wait until anticipated federal action addressing these concerns, the goal of insulating prescribers from undue manufacturer influence seems to be in the broad public interest. However, the state's thrust seems less far ranging than it might have been. In the PBM section, there are specific (although inadequate) restrictions on PBM activities and the health plan must give permission for attempts at switching. What is strikingly absent is a requirement that the prescriber agree to be solicited regarding switching. As a result, drug manufacturers will be able to continue targeting physicians to urge them to prescribe products based on the company's profit goals based on detailed knowledge of the doctor's prescribing pattern. The only way to prevent drug companies from attempting to improperly influence physician decision making is to deny drug companies access to physician prescribing data. NYSPA urges adding lan-

guage preventing the sale or distribution of physician specific prescribing information and patterns to manufacturers. NYSPA is advocating for the changes in the "language" section of the bill and urges other advocates to join with us in this endeavor.

Proposed Budget Cuts for Hospitals

Finally, we wish to point out another danger to the mental health delivery system. To no one's surprise the income and expenditure projections laid out in the budget bill are beyond harsh, mirroring the state's present reality. Perhaps unexpectedly, the OMH budget shows a small increase. However, if you look further and recognize the broad role played by the Article 28 licensed facilities, such as hospitals, in providing mental health service in the state, the picture becomes more ominous. Even when departments of psychiatry in particular hospitals may remain profitable or at least break even, the hospitals of which they are a part may be severely, adversely impacted as the proposed budget severely reduces Medicaid rates. The consequence may be the closing of institutions which are important providers of mental health services to the communities they serve.

see Budget Proposal on page 27



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The Economics of Recovery

What Recipients Want: A Look at Aligning Agendas

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

I find most people's agendas are predictable; big corporations want more profits, politicians want to be re-elected, bureaucrats want more job security, professionals want better outcomes, academics want more research, unions want, well, just more. But what do recipients want? Medications without side effects? 24/7 talk therapy? A cure from their illness?

For the past ten years we have asked hundreds of recipients what, in their opinion, are the most important factors for their recovery? What is at the top of their agenda?

When you have to survive on thirteen dollars a day for food, transportation, clothes, shoes, toiletries, etc. – after you paid the rent and utilities, the answer is always the same: “money.” (From this perspective, the 75¢ a day the State plans to cut from SSI recipients' June 09 COLA, is a lot of money)

But they told us they just don't want more money from the government, they want to be part of a permanent solution; to acquire work skills, a good job and for the Social Security Administration to stop taking half of their pay (www.ssa.gov). While “money” is everyone's top priority this year, to folks living on \$700/month, money will always be the number one issue, every year.

Recipients also told us that the unresolved issues; “money, emotional health, work skills, physical health,” etc. should be our leaders' top priorities on their agenda. These issues, they feel, require a greater effort, innovative solutions and more resources.



Donald M. Fitch, MS

On the other hand, the recovery factors recipients are “most satisfied” with are their Therapeutic Team; their Psychiatrist, Therapist and Case Manager (Congratulations!). They are also very satisfied with the “accessibility and quality of health care” they receive, food and other basics.

To most recipients, these recovery factors have been achieved. Additional resources are not needed. They feel it is time to move on to those issues (in the middle and right hand columns of the chart) that have not yet been resolved.

When we probe the reasons why recipients rate the “somewhat satisfied” group of factors (middle column), we gain a fuller understanding of the recipients' predicament; medications have side-effects, recovery is frustratingly slow, their housing is often in poor and in dangerous neighborhoods, health plans have limits, etc.

“Romance,” while probably not on most Commissioner's agendas, is felt to be elusive among the women in our studies--- an indication of the lack of opportunities for socialization. Sadly, the lack of “privacy” mentioned refers to many of the women's inpatient experiences.

In the fall of 2008, The Center for Career Freedom initiated a national on-line tracking survey to quantify the inpatient experience of the recipients' last psychiatric hospitalization. Stories of in-patient abuse, especially among young women, were frequently reported at intake – yet, formal complaints, criminal charges, lawsuits or published studies were rare. These victims were being punished by their own and the system's silence. The “elephants in this room” are toxic; the failure to report and correct these crimes perpetuates and deepens the tragedy.

After consulting legal counsel, we initiated a three part data collection strategy; at intake, direct mail and on-line. You can view this survey on our website at www.economicsofrecovery.org/survey.php.

Early results show that over ninety percent of the recipients' inpatient experience is positive and professional. However, unresolved issues include a lack of privacy, safety and trust. Five to ten percent reported incidents of verbal, physical or sexual abuse.

President Obama's agenda for persons with disabilities is four fold: 1) education, 2) equal opportunity (ADA Enforcement), 3) employment 4) independent, community-based living (housing). To achieve these and other goals, he has promised some eight billion dollars for New York's providers of health care, education, infrastructure and more.

There are restrictions to the money of course; it is not to be used to prop up our dysfunctional system but for “investments in ideas that work over ideology”, “new

public-private partnerships to support innovation,” and “system reforms that promote transparency, accountability and reduced waste.”

A recent survey the Center conducted of professional, union and recipient association websites failed to find any mention of “system reform, transparency or accountability goals for 2009.” Maybe it is too soon. However, we did find many statements that promised to “study, plan, collaborate, explore, improve, involve, and focus on”, etc., “in a timely fashion.”

It will be interesting to see how the new administration's program auditors view our state's love of vague lexicon – will they bring in for-profit consultants to teach us linear thinking? To teach us how to quantify objectives? Will they help us overcome our fear of responsibility? (hypengyophobia). Didn't Machiavelli warn that transparency and responsibility could be harmful to one's career?

President Obama's objective of investing in education and employment for recipients aligns perfectly with their own objectives to permanently resolve their financial predicament.

Now instead of convening committees to wrangle over which issues to allocate precious time and money, we can move forward rapidly and efficiently because we already know what recipients need.

Sound research marginalizes the political pushing and shifts the focus to the quality of the ideas. A new paradigm emerges; real debates about real solutions. Suggestions based on personal prejudice and guesswork doesn't survive factual, transparent collaboration. Finally, change we can believe in.

The Center for Career Freedom is located in White Plains, New York and can be reached at (914) 288-9763. Visit us at www.economicsofrecovery.org

Consumer Satisfaction of Factors "Very Important to My Recovery"

MOST satisfied

- Psychiatrist, Therapist, Case Mgr., Counselors
- Quality of Health Care
- Access to Health Care
- Respect
- Food, Transportation, Toiletries
- Participation in Treatment
- Friends, Family

SOMEWHAT satisfied

- Medications
- Rate of Recovery
- Housing
- Romance
- Health Plan
- Education
- Advocacy
- Person Centered
- Privacy

LEAST satisfied

- Money
- Emotional Health
- Work Skills / Job
- Physical Health
- Gov't Benefits
- Safety
- Motivation
- Boredom

Source: A Meta-Analysis of 250 factors across twelve studies, 2002-2008

THE MENTAL HEALTH LAWYER



Assisted Outpatient Treatment: A Helping Hand in the Community

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

Living with a loved one afflicted with a mental illness who does not comply with his or her treatment plan can have a tremendous negative impact on the family as well as the individual. Assisted Outpatient Treatment, or "Kendra's Law," is a valuable tool for families and others who seek to help individuals who often refuse services in the community and are frequently hospitalized. The law was enacted in November, 1999, after earlier that year a man suffering from chronic schizophrenia, with repeated hospitalizations, pushed Kendra Webdale in front of a subway resulting in her death. The intention of Kendra's Law is to prevent incidents of violence as a result of outpatient treatment non-compliance, as well as the revolving door of hospitalizations that so many clients experience. According to New York's Office of Mental Health, it appears that Kendra's Law has been largely successful in these goals. However, Kendra's Law is not without its flaws. This article will address the question of who qualifies for services under Assisted Outpatient Treatment, how a petition is initiated, who is a proper person to be a petitioner, and a review of the services that are typically provided to an individual who is the subject of an Assisted Outpatient Treatment Order. Furthermore, this article will delve into some of the statistics maintained on Kendra's Law indicating its success as well as some difficulties that Kendra's Law has created.

The Nuts and Bolts of Obtaining Assisted Outpatient Treatment

To successfully obtain an Assisted Outpatient Treatment Order, there must be a proper applicant (the Petitioner) and subject (the person in need). There must also be a plan of treatment approved by the county or local Assisted Outpatient Treatment Program. The county or local program is responsible for ensuring the quality of benefits offered, case management services, and other administrative duties.

New York's Mental Hygiene Law, Section 9.60, is the statutory framework for the Assisted Outpatient Treatment program. The Mental Hygiene Law delineates the criteria for a person to be the subject of an Assisted Outpatient Treatment Order as follows: The subject must be at least 18 years of age and suffering from a mental illness, he or she must be unlikely to survive safely in the community without supervision, based on a clinical determination and a history of lack of compliance with treatment for mental



Carolyn R. Wolf, Esq

illness that has; (i) at least twice within the last 36 months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a correctional facility, or; (ii) resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last 48 months. In addition, the subject, as a result of his or her mental illness, must be unlikely to voluntarily participate in the recommended treatment plan and in view of the patient's treatment history and current behavior, the patient must be in need of Assisted Outpatient Treatment in order to prevent a relapse or deterioration that would be likely to result in serious harm to the patient or others. Lastly, the subject must likely benefit from Assisted Outpatient Treatment.

New York's Mental Hygiene Law, Section 9.60 also lists the individuals who can petition for a court order for Assisted Outpatient Treatment as follows: (i) Any person at least 18 years of age with whom the subject of the petition resides; (ii) the parent, spouse, sibling at least 18 years of age, or child at least 18 years of age; (iii) the director of a hospital in which the subject of the petition is hospitalized; (iv) the director of any public or charitable organization, agency or home providing mental health services to the subject of the petition in whose institution the subject of the petition resides; (v) a qualified psychiatrist who is either supervising the treatment of or treating the subject of the petition for a mental illness; (vi) the director of community services, or his or her designee, or the social services official, as defined in the social services law, of the city or county in which the subject of the petition is present or reasonably believed to be present; or (vii) a parole officer or probation officer assigned to supervise the subject of the petition.

Once an Assisted Outpatient Treatment Order is granted many services are put in place with a treatment plan that is approved by the county's Assisted Outpatient Treatment Program. The individual is given intensive case management services (ICM), either with a case-manager or ACT team (Assertive Community Treatment team) that provides comprehensive assistance and supervision of all facets of treatment and daily living. Additional services include: alcohol and drug counseling, psychiatric treatment, therapy and medication management and distribution; and supportive housing is also provided, if necessary.

It must be noted that an Assisted Outpatient Treatment Order cannot mandate that the subject of the Order comply with the recommended treatment plan. In other words, the subject of the Order cannot be forced to attend psychiatric treatment or even take medication. However, the outpatient psychiatrist charged with providing treatment under an Assisted Outpatient Treatment Order can have the police bring an individual who is not complying with his/her treatment plan to the hospital for evaluation. This provision provides the teeth, so to speak, to Kendra's Law. The removal power allows trained professionals caring for the subject of an Assisted Outpatient Treatment Order to monitor that person's progress and hope-

fully maintain that person's, as well as the community's, safety during periods of non-compliance.

The Successes and Failures of Assisted Outpatient Treatment

The Office of Mental Health keeps rather extensive statistics regarding Assisted Outpatient Treatment. According to these statistics it appears that Assisted Outpatient treatment has been a substantial benefit both to the community at large and individuals subject to an Order. In 2004 there were over 10,000 referrals and/or investigations of potential individuals in need of Assisted Outpatient Treatment. Of those, over 4,000 Petitions were filed in court and nearly 3,800 of these Petitions were granted. After an initial six month period with an Assisted Outpatient Treatment Order, physically harmful acts to self or others were reduced by over half, drug and alcohol abuse fell nearly 50% and threats of physical harm to self or others fell just about 50%. Arrests and convictions for crimes fell nearly 85% and psychiatric hospitalizations fell 77%. Perhaps one of the most astounding statistics is the reduction of time spent in the hospital as a result of an Assisted Outpatient Treatment Order. On average,

see A Helping Hand on page 30

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

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Bard House Child Day Hospital Program At New York Presbyterian Hospital in Westchester Helps Kids Succeed

By Kathleen Clarkson, LCSW
Program Manager, The Bard House
Program of New York-Presbyterian
Westchester Division

Any child attending school faces challenges and obstacles as they work to learn to succeed – imagine the struggles a child with a serious emotional disturbance experiences. Mental illness can impact a child's ability to form attachments and social relationships, sustain attention and concentration, regulate emotions, and exercise judgment, among many other things. How is a child supposed to participate in a typical school setting with such difficulties? Many of these children are unable to attend school in their communities, as their behaviors are so disruptive that they cannot be safely maintained in a mainstream school setting. Children with a mental illness require an intensive level of support and clinical care, and are often at risk of being placed in residential programs.

Billy was first hospitalized on a psychiatric inpatient unit at the age of 6. Throughout his life he has been diagnosed with different psychiatric disorders, including Post Traumatic Stress Disorder, Oppositional Defiant Disorder, Attention Deficit Disorder, and a Mood Disorder. He has never been able to succeed in a mainstream school setting and has been difficult to manage at home. For three years he attended a five day residential program, going home to his mother on weekends, where he became increasingly difficult to manage due to his behavior problems. Billy was hospitalized twice more when he was 10 years old. The program recommended that Billy go to a full



seven day residential program where he would receive more intensive support. However, his mother very much wanted Billy to be able to live at home and attend school in the community. Eventually, Billy did return home to live with his mother and began attending the Bard House Child Day Hospital.

The Bard House Child Day Hospital program, on the grounds of New York Presbyterian Hospital, Payne Whitney Westchester, provides a combination of mental health and educational services to children aged 5-12 years. The program is designed to meet the particular needs of these fragile, vulnerable children, many of whom have had repeated inpatient hospitalizations on psychiatric units. The only such Hospital-based program for this age group in West-

chester, Bard House allows these children the opportunity to live at home and attend school, and feel some measure of success in their lives. The overall objective of the program is to help the children improve academic, social, and emotional functioning so that they can be more productive in their families, schools and communities.

Integrating the best clinical care and educational services to help school-age children with behavioral problems is a tradition at the Hospital dating back to 1969. That's when the first collaboration between the Hospital and White Plains School District began with a small group of children participating in an intensive day program while also receiving academic instruction. Over the years, that program has developed into the current

model, known as the Bard House Child Day Hospital. The program has been a unique joint effort between the hospital and the school district for many years, providing a much needed service to a great number of children, and their families, in our community.

Bard House is both a licensed day treatment program through the Office of Mental Health and a recognized public school in the White Plains school system. Mental health services are provided by a multi-disciplinary hospital staff, including licensed social workers, nurses, rehabilitation specialists, and an attending psychiatrist. As New York Presbyterian Hospital is a teaching hospital, a supervising psychologist and psychology externs are part of the clinical program. All teachers are certified to teach in Special Education and content areas. Educational services are provided in small classes and instruction is adapted to ensure student success. The education curriculum is approved by New York State and students participate in State Education Department Examinations. Each student receives educational instruction along with individual and group therapy, psychosocial rehabilitation and family services.

As for Billy, he has been attending Bard House since his last discharge from inpatient care last summer. Billy's behavior has improved significantly, and he is able to remain in his classroom, making academic gains. His mother has reported that she has also seen an improvement in his behavior and feels more hopeful about his future. Billy will tell you that he is proud of himself for his success. Bard House gives children like Billy a chance to experience that kind of success and feel positive about the future.

Telephonic Follow Up to a Psychiatric Emergency Room Visit: A Call Center Service Model

Gerald McCleery, PhD
Associate Executive Director
The Mental Health Association
of New York City

A 2008 report by the National Association of State Mental Health Program Directors argues that "...lapses in continuity of care, especially after discharge from emergency department and inpatient psychiatry units, contribute to significant suicide-related morbidity and mortality". The report recommends improving continuity of care following discharge. At least in the NYC area and probably elsewhere, many psychiatric facilities already have in place a follow up system for people discharged from inpatient units to verify that initial post-discharge outpatient appointments are kept (personal communication, 2008). What is not well established is a service follow up model applied to people who visit a psychiatric emergency room with suicidal ideation but who are not

admitted to inpatient care. There is some research evidence to suggest that, for people with suicidal ideation, telephonic follow up with to the point that they have connected with an appropriate treatment resource (rather than simply being referred to such a resource), is an appropriate, cost-effective service model that can increase the probability that the person remains safe and will eventually begin or continue treatment. When combined with development of a "safe plan," such a call-out follow up service may be an important potential suicide prevention service model for higher risk individuals.

The published research data on the effectiveness of telephone follow up as a suicide prevention strategy is limited but promising. Vaiva et al conducted a study in France to determine the effects over one year of contacting patients by telephone one month or three months after being discharged from an emergency department following suicidal behavior, compared with usual treatment. The authors conclude that: "Contacting people

by telephone one month after being discharged from an emergency department ... may help reduce the number of re-attempted suicides over one year."

There is also evidence that development of a "safe plan" with people at risk may be a useful component of such a telephonic follow up model. A "safe plan" is different from a "no suicide contract." The former is logically more sound than a simple "no suicide contract", adding as it does the extra dimension of providing specific contingency methods and steps for the individual to use to help cope with suicidal thoughts and feelings. An evaluation of the Lifeline Australia program found that telephonic follow up with suicidal callers to the helpline, coupled with development of a safe plan resulted in a reduction in the frequency and strength of suicidal thoughts and self reports of marked improvement in coping ability. The safe plan now in use by LifeNet, the MHA of NYC's behavioral health crisis and information and referral call center, is based on the ASIST model of suicide in-

tervention, developed by Living Works. In general terms, such a safe plan is a collaborative undertaking between the client and the provider and consists of:

- Agreement to keep safe
- Safe or no use of drugs or alcohol
- Establishing a specific list of safety contacts
- Linking the individual to additional supportive resources
- Identifying and supporting specific past survival skills
- Working with the client to disable any current suicidal plans

We believe that the model lends itself to evaluation, is relatively inexpensive to establish and operate, and if implemented, can be an important step toward addressing the finding in the NASMHPD report regarding the lack of continuity of care and suicide-related morbidity and mortality following discharge from emergency departments.

Care Coordination Takes an Innovative Approach to Case Management At the Mental Health Association of Westchester

**Ruthanne Abramovich, MA,
Associate Executive Director
and Annette Peters, LCSW,
Care Coordination Program Director
The Mental Health Association
of Westchester (MHA)**

A 62-year-old woman named “Mary” from White Plains, New York has been diagnosed with a serious mental illness. During her lifetime, Mary had experienced a 20-year incarceration and multiple psychiatric hospitalizations. She was referred to The Mental Health Association of Westchester’s (MHA) Care Coordination Program in July 2008 after a long-term state psychiatric hospitalization. When Mary first met with the Care Coordinator, it was explained to her that Care Coordination is an Intensive Case Management and Peer Support program that differs from traditional services by employing a Person-Centered Planning approach in an Integrated System of Care.

Mary wasn’t quite sure what that meant but she heard that someone was willing to help her and she knew that she was going to need a different kind of help than she had in the past. Mary explained to the Care Coordinator that her greatest concern was making sure that she was able to abide by the conditions of her parole so that she never had to spend another day in jail. Mary also stated that her overall goal was to be able to live a healthy and happy life in the community. Right away she and the Care Coordinator started to map out small, easy to reach steps that would allow her to do this. They started to identify people and supports both from her life and from the mental health/criminal justice system that could support her in reaching her goals.

Mary has described Care Coordination as “a blessing in my life.” Within the first few months of discharge, Mary encountered some challenges such as establishing the correct amount of Social Security benefits, finding appropriate transportation to her mandated appointments, and advocating for herself at her Treatment Apartment. Together, Mary and her Care Coordinator addressed those concerns to a satisfactory end. Mary has found her Care Coordinator to be “supportive, hard working and honest,” which has been a comfort when various problems arise.

Right now, Mary’s daily schedule consists of going to her treatment program, seeing her parole officer and attending meetings with staff at her Treatment Apartment. With the support of her Care Coordinator, Mary has begun to involve herself in more activities and has expressed an interest in taking up former hobbies such as knitting. Her Care Coordinator is helping her find places in her community where she can knit, meet and socialize with others so that her days are not only spent attending treatment related activities but are filled with the types of activities that will further her personal goals and interests. Mary looks forward

to one day being in an apartment of her own, and living a full, productive life in the community.

Mary and her Care Coordinator believe this can and will happen. It has moved from a dream to an attainable goal. The person-centered approach being utilized puts the focus on Mary’s unique needs and treats her as a person with choices to exercise. It preserves Mary’s dignity by inviting her to play a leadership role in a collaborative planning process, and provides her with services and supports based upon her dreams, interests, preferences and strengths. The Care Coordination model differs greatly from previous individualized planning processes that traditionally focused on keeping individuals diagnosed with serious mental illnesses “stable” by matching them with the services that “the system” was set up to offer. This approach looks beyond assessing an individual’s symptoms and basing outcomes on reducing hospitalizations and increasing medication compliance, and looks to what the person truly desires as a human being, not restricting them to what the program or service can offer.

The Person-Centered approach creates a team of people who know and care about the individual, who come together to develop and share a dream for the person’s future, and who work together to organize and provide the supports necessary to make that dream a reality. This network might include relatives and friends, recovery mentors, clergy, landlords and service providers. This coordinated network also includes providers from across service systems so that the broadest possible array of resources can be brought into play as needed. This approach is what helped “Lila,” another participant of the Care Coordination program, to secure her own apartment through MHA’s Shelter Plus Care program.

Lila had been saying for some time that she wanted to live on her own but her treatment team opposed this and would not recommend her for independent living. The treatment team was worried that Lila, who had been recently released from jail and had experienced an extremely traumatic event, was ill prepared to live on her own and they worried about her safety. Lila and her Care Coordinator planned for the next treatment team meeting and Lila was able to articulate how she would care for herself. She answered her treatment team’s concerns and discussed the supports that she and the Care Coordinator were putting into place so that she could accomplish this goal. It took some persuading, but the team finally agreed to support Lila’s dream. Lila has now lived independently for 8 months; she is completing a substance abuse treatment program, preparing for a GED program and looking forward to starting computer classes. Lila credits her team for believing in her—even before she did—as the main reason she has been so successful.

A unique aspect of the Care Coordination program is that there are funds avail-

able called Self-Determination dollars that can be accessed by participants to further their stated goals. Some common uses for Self-Determination dollars are to pay for alternative therapies not covered by insurance, college courses, community workshops, tutors or clothing to wear on an interview or for a job. “Thomas,” a 21-year-old participant of Care Coordination was able to utilize these specialized funds to deal with an ongoing and troubling issue that had prevented him from taking public transportation. Thomas, who was very motivated to get his GED, admitted to his Care Coordinator that his biggest barrier to accomplishing this goal was his anxiety while he rode the bus to and from school. After discussing various ways that he might reduce his anxiety, it was discovered that listening to music distracted him enough so that he could not only get on the bus but also stay on it until he got to school. It was decided that he would use self-determination funds to purchase an iPod that he uses daily so that he can regularly attend school.

The Care Coordination program is targeted to serve adults diagnosed with Serious Mental Illness with a high need for clinical and support services. A typical candidate for the Care Coordination approach would be a person with some combination of the following circumstances:

- frequent crises;
- a history of repeated hospitalization or incarceration;
- absence of a constructive social or family network;
- unstable housing;
- a lack of daily structure;
- difficulties engaging in treatment, taking prescribed medications or self-monitoring; and/or
- those who have been in-patient for lengthy periods in state hospitals.

Care Coordination may prove to be a viable solution when traditional systems of support have proven inadequate to achieve treatment and rehabilitation goals. For instance, in places where the approach has already been tried, mental health professionals have been pleased to discover that the participants who had in the past been viewed as “non-compliant” became much more motivated to work toward their recovery, once they were offered opportunities to exercise more control

see Care Coordination on page 30

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Where Do We Go From Here? Follow-Up Care from Psychiatric Hospitalization

By Richard E. Beauvais, PhD
Co-founder, Wellspring Foundation

Psychediatric hospitalization is a disruptive event for any individual, especially for a child and family. However brief the hospital stay – and stays are very brief these days – the person, the child, and the family has to cope with medications, restoring relationships, making an awkward and difficult return to school or employment, and finding a way to resume meaningful activities and interests. No transition can be seamless; no after-care easy.

If the person, particularly an adolescent or a young adult, suffers from depression and has resorted to the negative coping skills of drug abuse and self-harm that often accompany it, recovery can be complicated and unstable. Family relationships have usually become strained, often explosive, and the need for further hospitalization is ever-present. Younger children may continue to be out-of-control, unable to be safely contained within the home or school setting. These are complex, multi-faceted problems, which outpatient treatment, however “intensive,” is often inadequate to address.

Families usually don’t consider residential treatment as a viable option. While parents may desperately need res-



Richard E. Beauvais, PhD

pite for themselves, they also know they need more than a holding tank for their child, and a holding tank, regrettably, is all that some residential facilities have to offer. Containment has benefits, no doubt. It can relieve parents from having to forcibly restrain their out-of-control child and can save the adolescent and young adult, temporarily at least, from further substance abuse, self-injury and

even suicide. But the containing situation has to offer families more than mere control of their child. It must provide a “womb,” a container for healing that can provide the real work of transition.

What is that “real” work? Family therapy is its cornerstone, much as parents might like to avoid facing this unpleasant truth. The myth that the child can be “fixed” outside of the family system has been debunked long ago. Although the child may be the identified “patient,” it’s the family system that usually needs “fixing.” Parents may have done the best they can with what they know, but what they know is what they’ve learned consciously and unconsciously from their own parents, and problems are handed down through generations. Foster and adoptive parents may conveniently blame the child’s unknown parents who came before them, but this simply dodges acceptance of their own parental responsibilities.

If residential treatment is to provide a viable transition, the whole family needs to be actively involved. Family therapy must be regular and intensive if relationships are to be restored or, in some cases, newly developed. The capacity for honest emotional communication must be opened to establish heart-to-heart connections. New parenting skills have to be learned and practiced both in the therapeutic milieu and on weekend visits home, as soon

as it is safe for the child to venture home. These visits cannot be little vacations from treatment where parents and kids tiptoe around each other, not wanting to rock the boat. They have to extend the work already begun in family sessions with clear tasks set forth for the parents and the child, not the least of which is to learn how to play and have fun together, because families in trouble have usually lost that gift. The successes and the problems that arise need to be processed in family sessions following the visit. Only when this work has been honestly undertaken and parenting and communication skills have been developed and practiced is the child ready to return home to parents who are actually prepared to receive him.

Substance abuse, self-harm and suicidality complicate the family process, because visits home must be safe and closely monitored by the parents. Containment and random drug testing maintain sobriety within the residential setting, and slips on home visits need to be processed as learning opportunities and indicators of readiness for discharge. Both the adolescent, young adult and parents are involved in psycho-education about drugs and drug abuse. AA meetings for substance abusers are attended while in

see *Follow-up Care on page 34*

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The Arc of Eating Disorders: Co-Morbid Diagnoses Contained Within

By Judy Scheel, PhD, LCSW
Grand Rounds at Four Winds Hospital

Eating disorders (Anorexia Nervosa, Bulimia, Binge Eating Disorder) are considered "umbrella disorders." Typically, an eating disorder is part of a larger diagnostic picture. There is almost always a co-morbid diagnosis—depression, anxiety or personality disorder in addition to familial issues and interpersonal conflicts. Sexual or physical trauma, Obsessive Compulsive Disorder or substance use can also accompany an eating disorder. Sometimes the eating disorder is the primary diagnosis; sometimes it is secondary or the consequence of another primary diagnosis like depression. The co-morbid diagnosis likely existed prior to the onset of the eating disorder, though may remain latent until the eating disorder emerges. However, co-morbidity can occur as an outgrowth of the eating disorder and can show improvement with reduction in eating disorder symptoms like weight restoration. Because eating disorders are intertwined within the greater constellation of psychological and psychiatric issues eating disorders cannot or should not be treated as separate and apart from other mental health issues.

- The most common secondary Axis I (mood disorder) diagnosis with eating disorders is Depression
- Higher rates of Dysthymia among adolescents than other co-morbid diagnoses
- Frequency of Personality Disorders (enduring patterns of maladaptive behaviors & personality traits i.e. Borderline Personality Disorder) varies from 27%-77% in eating disorder population
- Personality disorders typically precede the development of an eating disorder
- Mood Disorders with eating disorders remit more frequently than personality disorders with eating disorders



Judy Scheel, PhD, LCSW

- Anxiety states more pervasive and unremitting – lower recovery rates
- Males with Bulimia at higher risk for mood and substance use disorders
- Males with Anorexia Nervosa at higher risk for Schizophrenia
- Obsessive Compulsive Disorder pre-dates eating disorder & ED develops at a younger age
- Eating disorders and substance abuse disorders associated with the highest mortality risk across all mental disorders
- Greater prevalence of sexual abuse with Bulimia and alcohol abuse
- Greater risk for other self-destructive acts like cutting among individuals with substance abuse disorders and eating disorder

The percentage of individuals with eating disorders and substance abuse disorder are high; some studies reporting up to 55% of individuals with Bulimia and 23% of those with Anorexia have concurrent substance abuse with alcohol and stimulants being the most commonly abused. A recent New York Times article

reported on alcohol abuse and eating disorders, indicating that alcohol is the only "food" of choice among a select group of those diagnosed with Anorexia. Bulimia and alcohol abuse is associated with a higher incidence of Borderline Personality Disorder, a diagnosis that precedes the substance abuse and eating disorder. Borderline Personality Disorder as well as alcohol abuse is associated with disinhibition and impulsivity, two personality traits relatively common among individuals with Bulimia.

The causes of eating disorders are complex and varied. Research in eating disorders remains inconclusive, at best, regarding definitive claims to causation. Genetic research studies are increasing, however, the data remains weak and inconsistent. It cannot definitively be stated that eating disorders are genetic disorders. The Academy for Eating Disorders (aedweb.org) states: "Recently there has been considerable interest in both genetic and biological factors which may contribute to the onset of eating disorders. For both anorexia nervosa and bulimia nervosa, behavioral genetic studies using twin designs have indicated that there is a substantial genetic effect for the liability for each of these disorders. Researchers are now examining genetic influences by searching for genes, and some gene candidates have been found to be associated with anorexia nervosa and bulimia nervosa, although this research remains relatively inconclusive in terms of genetic effects. There are also numerous studies indicating that certain brain chemicals, such as serotonin, may be abnormal in eating disordered individuals."

Focusing exclusively on genetics as causation is inappropriate, at best. The belief that eating disorders are strictly a genetic or biological disorder reinforces for patients and their families that the eating disorder is running on its own track and has little or nothing to do with the individual's psychological and relational experiences that may have contributed significantly to the eating disorder. Professionals who treat eating disorders need to remain committed to understanding and staying abreast of all the research regarding eating disorders. Caution must remain, however, regarding those seeking to re-

duce causation to primarily genetic factors. There are too many variables that coalesce to create an eating disorder. Solid treatment includes utilizing an experienced team of professionals providing psychotherapy, medical and psychiatric care and nutritional counseling.

Eating disorder sufferers share common traits, like tendency toward people pleasing, perfectionism, and have high self-expectation. Some of these traits are consistent with the eating disorder diagnosis, however, can also be associated with a co-morbid diagnosis like Obsessive Compulsive Personality Disorder and Dependent Personality Disorder.

Eating Disorder treatment varies and needs to be consistent and appropriate with the specifics of the eating disorder diagnosis – including severity of condition and symptoms, length of time of illness, willingness and commitment to recovery. For those who provide eating disorder treatment or those with a loved one who is suffering with an eating disorder, treatment options can be confusing and often driven by insurance limitations and restrictions, particularly when it relates to seeking inpatient care. When a patient has a concurrent substance abuse diagnosis, treatment for the eating disorder may vary from how the substance abuse disorder is treated. Some eating disorder treatment, particularly when the eating disorder is in conjunction with a substance use disorder, may promote a 12-step approach to obtaining sobriety and maintaining recovery. Many times, however, eating disorder treatment may not be consistent with a 12-step approach. Often, eating disorder treatment reflects a combination approach utilizing insight, family systems and/or cognitive/behavioral treatment (CBT). A treatment model, such as 12-step, can be difficult to utilize exclusively in treating eating disorder patients because not only is food not an option to avoid (as is necessary and possible with alcohol and drugs), but also so much of what needs to be changed in the thinking of eating disorder sufferers is the perfectionism and all or nothing thinking that laid the ground work for the disorder. A 12-step model emphasizes behavioral changes and often

see Eating Disorders on page 20

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SPECIAL EVENT

Friday • April 24, 2009 • 9:30 – 11:30 am

Are Psychiatric Medicines Over-Prescribed to Children?

Kevin T. Kalikow, MD, Child and Adolescent Psychiatrist, Private Practice, Mt. Kisco, NY; Author, "Your Child in the Balance: An Insider's Guide for Parents to the Psychiatric Medicine Dilemma"; Assistant Clinical Professor in Child Psychiatry, NY Medical College

Dr. Kalikow will examine every parent's fear that psychiatric medicines are over-prescribed and ways parents and professionals can decide whether each prescription is appropriate.

At the conclusion of this program, participants will better understand:

- How to evaluate the risks and benefits of psychiatric medicines.
- How to use the risk/benefit ratio to decide if a prescription is appropriate.

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

Applications pending for 2.0 CME Credits and *2.0 OASAS CASAC/ CPP/CPS clock hours

Book Sale & Signing

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

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Register online at www.fourwindshospital.com

MAY 2009

GRAND ROUNDS

Friday • May 1, 2009 • 9:30 – 11:00 am

Advances in DBT with Multi-Problem Adolescents

Alec L. Miller, PsyD, Co-Founder, Cognitive & Behavioral Consultants of Westchester, LLP; Professor of Clinical Psychiatry and Behavioral Sciences, Chief, Child and Adolescent Psychology, Montefiore Medical Center/Albert Einstein College of Medicine

Dialectical Behavior Therapy is an evidence-based treatment that has been adapted for multi-problem, difficult-to-treat adolescents.

At the conclusion of this program, participants will be able to discuss:

- The bases of DBT and the populations for which it is effective.
- The structure, goals, and stages of DBT treatment.
- How the diagnosis of Borderline Personality Disorder is reframed in DBT in order to use it as a psycho-educational tool and to organize the treatment goals.
- The modes, the functions and the typical treatment agreements made in DBT.

Fee: \$15.00 payable to Four Winds Hospital

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Book Sale & Signing

SPECIAL TRAINING

Thursday • May 7, 2009

9:30 am – 12:00 pm

Child Abuse Identification and Reporting



Valerie Saltz, LCSW, Four Winds Hospital

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

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

* This training is provided under New York State Office of Alcoholism and Substance Abuse Services (OASAS) Education and Training Provider Certification Number 0815. Training under a New York State OASAS Provider Certification is acceptable for meeting all or part of the CASAC/ CPP/CPS education and training requirements.

Community and Professional Education Programs

MAY 2009

GRAND ROUNDS

Friday, May 29, 2009 • 9:30 – 11:00 am

“Carefrontation” with Co-Occurring Disorders

Harris B. Stratyner, PhD, CASAC, Vice President and New York Regional Director, Caron Treatment Center; Clinical Associate Professor of Psychiatry, Mt. Sinai School of Medicine; Vice Chairman, National Council on Alcoholism and Drug Dependence

Dr. Stratyner developed the technique “Carefrontation,” which combines the latest motivational engagement techniques in an environment of respect and dignity to stress individual responsibility to deal with one's addiction and or mental health condition.

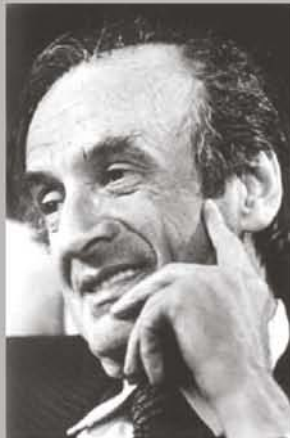
This program will enable participants to:

- Understand the fundamental concepts of the “Carefrontation” model of treatment.
- Identify and describe a myriad of mental health and treatment issues, which interfere with recovery.
- Describe dual diagnosis treatment considerations.

Fee: \$15.00 payable to Four Winds Hospital

Applications pending for 1.5 CME Credits and *1.5 OASAS CASAC/ CPP/ CPS clock hours

Save the Date
An Evening with Professor Elie Wiesel
 to benefit the
Four Winds Foundation
Thursday, May 14, 2009
 at Purchase College, Purchase, NY
Information to follow



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

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

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



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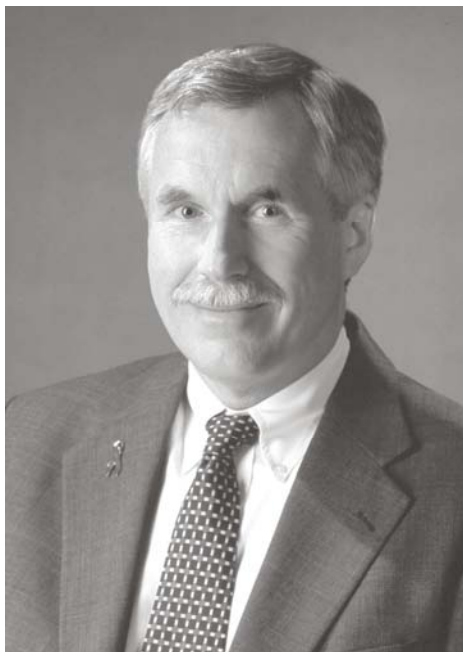
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Mental Illness Presents Challenges to Individuals, Families and Communities

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

Mental illness presents great challenges for individuals, families and communities. From stress disorders and depression among an over-stressed military, to incidents of school violence, to the \$193 billion in wages lost annually in the United States because of mental illness, mental health issues affect us all. But despite this significance—and the fact that mental illness is a major driver of school failure, health care costs and suicide—many are not aware of its impact until mental health problems strike to home.

How are we doing in New York State on these challenges? We are a leader! From services to children to treatment for state prison inmates, we have approaches that are the envy of other states. Under Governor David Paterson's leadership, the Office of Mental Health is partnering with other agencies, such as collaboration with the Office of Alcoholism and Substance



Michael F. Hogan, PhD

Abuse to better address the needs of those with both mental health and substance abuse issues.

It is a sad irony that even though mental health issues are so prevalent and their effects so far-reaching, at the national level mental health care is often an afterthought. Too many health settings don't screen for or treat mental illnesses, and many insurance plans don't fully cover mental health care. In too many schools, emotional disturbance is a neglected driver of drop-outs and failure. And as a result of this neglect, mental illness disability is the nation's largest and costliest category of disability payments.

This historic pattern of neglect is especially significant and especially troubling in health care. Mental illness is unique among all major categories of illness in that we must maintain a separate, government run, illness-specific "mental health system" instead of providing early care within mainstream health care programs, covered like care for other illnesses by mainstream health insurance.

The good news is that the times are changing. In 1999, the first Surgeon General's report on Mental Health was issued, concluding that "there is no overall health without good mental health." In 2002-

2003, I was privileged to chair the first President's mental health commission since the Carter administration, recommending sweeping changes in mental health care—such as earlier detection and family-centered care for children, which are now being pioneered in New York.

These signs of national attention follow what people with mental illness are teaching us. With early identification, appropriate treatment and suitable supports, people with mental illnesses can live full, productive and meaningful lives in their communities.

Now, the U.S. Congress is in the final stages of considering legislation that would put care for brain disorders on a par with care for other illnesses within health care plans. Through the enactment of "Timothy's Law," New York State has already taken this important step. In 2002, President Bush called for such legislation nationally. Congress must enact it and the President must sign it this year. Equal medical care for the brain is common sense, and is long overdue. As a nation, we should expect no less.



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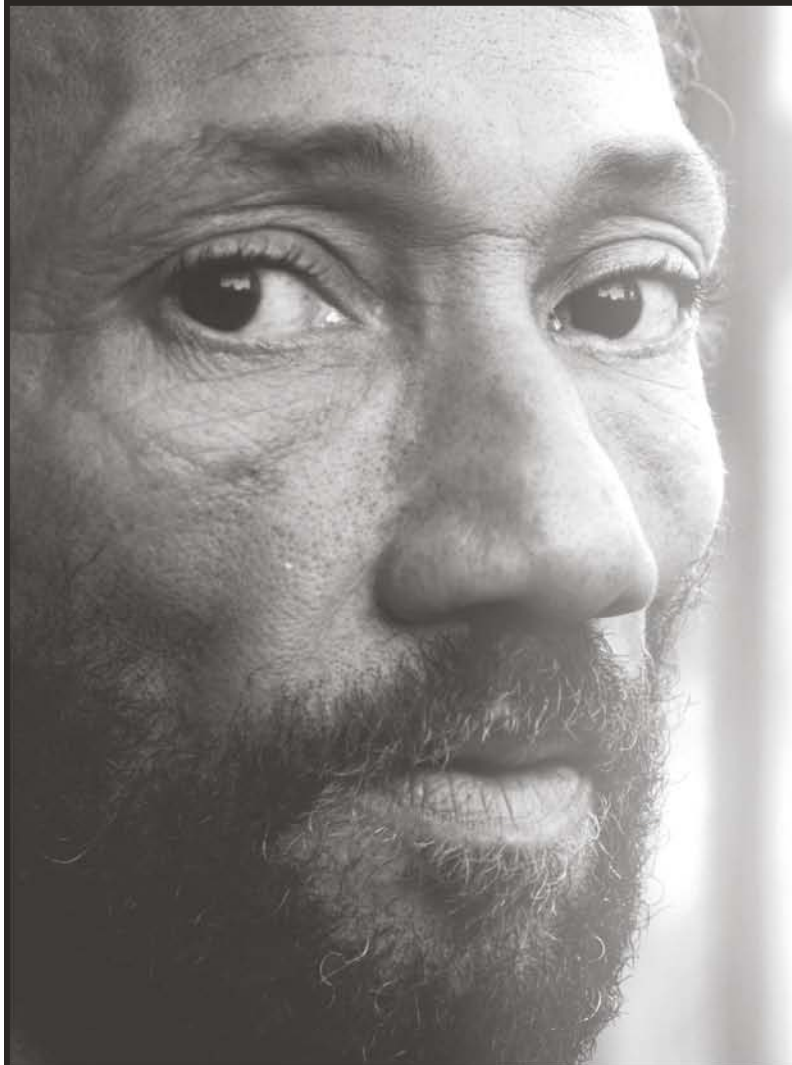
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Eating Disorders from page 17

encourages abstinence of certain food groups, i.e. sugar and white flour. While this treatment approach is effective for some patients, it can also reinforce all or nothing thinking around food for many sufferers – that is, that some food is bad. The goal of eating disorder treatment is generally to help patients integrate all foods into their diet, thereby removing the negative stigma associated with eating foods that are enjoyable but not necessarily nutritional i.e. deserts. Food is pleasurable. There are no good versus bad foods. For many eating disorder sufferers, the absence of pleasure and the presence of self-criticism, perfectionism and rigid self-control dictates life. Depriving oneself of pleasurable foods is a psychological metaphor for these harsh self-imposed expectations.

Taking responsibility for one's eating disorder so that lasting recovery may occur is the goal of treatment, regardless of the approach one employs to get healthy. It is important, in the end, however, that the type of treatment is appropriate and acceptable to the sufferer and or the family. Different approaches work for different people and sometimes it takes a few types of treatment or therapists before someone is ready to settle in and begin the serious work of recovery. Complicating the picture is often the co-morbid diagnosis, which runs parallel to the eating disorder, and the eating disorder is also a vehicle to express and concretize the co-morbid diagnosis. It is important to remember that an eating disorder is rarely the only diagnosis present and that understanding and treating the conditions that are co-occurring are essential. Although there are similarities in behaviors and personality traits of eating disorder sufferers, the eating disorder and co-morbid diagnoses need to be fully understood and treated as they are unique to each sufferer based on her/his own genetic (nature) and experiential/environmental factors (nurture).



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- Decrease symptoms & improving functional ability
- Improve knowledge base about medications, illness, coping & staying well
- Improve medication compliance
- Access community services

The Big Picture

Visiting Nurse Services in Westchester (VNSW) believes in a holistic, broad approach to the treatment of mental illness, addressing the "whole person's" life circumstances and environment. VNSW fields nurses with advanced psychiatric training, and in some cases, advanced degrees in related fields. The staff provides home visits for assessment, evaluation and development of a treatment plan with interventions related to mental health issues in conjunction with medical/surgical needs. This program meets the total health care requirements of individuals utilizing a case management approach led by a psychiatric nurse specialist. Adjunct services complementing the mental health component include psychiatric social workers, home health aides, medical/surgical nurses and relevant rehabilitation therapies.

The program serves the elderly, adults, adolescents and children.

To receive further information or make a patient referral, contact:

Lisa Sioufas, LCSW-R, ACSW • Mental Health Program Manager
(914) 682-1480, Extension 648 • e-mail: MentalHealth@vns.org



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VNSW Mental Health Home Care Program: Transitioning Back Home Following Hospitalization

Staff Writer
Mental Health News

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

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

There are several important aspects of the discharge plan. It is essential that clients return to adequate housing. Depending on the needs of individual clients, this may require extensive planning so that the individual can return to some level of supervised housing. Medical care is another area that requires appropriate planning. To help ensure proper follow-up, it



Back Row (L to R): Judith Bogart, Juan Antonio, Lisa Sioufas, Annie Balzer, Pat LaMorte, Hot Zef, Penny Parham, Hugh McKenzie, Carol Griffiths, Imelda Walsh. Front Row (L to R): Louise Borg, Margaret Burns, Miriam Cruz-Soto, Roberta Roberts. Not pictured: Pam Putnam, Carlos Monserrate, Rosamund Duarte-Bovell, Edward Lewis.

is beneficial that the patient have medical and psychiatric appointments set up prior to, and for a date shortly following, discharge. This will help establish a routine with providers in the community and prevent a delay in further follow-up care and medication refills. There is a significant rate of co-morbidities for psychiatric patients and it is imperative that their medical needs, as well as their psychiatric needs, are addressed.

Often patients are discharged home without a proper psychiatric referral, so a treating psychiatrist is needed in the community to prevent further psychiatric hospitalizations. In addition to an appointment with a psychiatrist, the need for outpatient mental health services relevant to the patient diagnosis should be considered. Frequently, patients benefit from continuing day treatment programs and case management services.

Supportive services are an essential component of the discharge plan. All appropriate community resources should be set up while the patient is in the hospital. Personal care aide services through the

Department of Social Services should be in place to begin immediately following discharge so as to avoid a delay in service and ensure that the client has the proper support in the home to assist with activities of daily living.

Medication compliance is a concern for many psychiatric patients. Often individuals are discharged with prescriptions that the patients are left to fill themselves. By contrast, knowing for certain that hospital patients being discharged actually have their medications goes a long way toward minimizing non-compliance. The social worker in the hospital should also work with the patient to clarify how the patient will pay for and obtain needed medication. For example; does the patient need to be connected with a pharmacy that delivers, does he/she need assistance calling in refills, does the individual need assistance managing funds and allocating needed funds towards medication and/or medical supplies? The social worker in the hospital must also explore transportation options available to clients; if they do not have transportation to medical ap-

pointments and referrals in the community, compliance will be difficult if not impossible.

Visiting Nurse Services in Westchester's unique Mental Health Program is frequently part of the discharge plan for psychiatric patients from both medical and psychiatric hospitals. VNSW's mental health team is the link between the patient and his/her providers in the community. The agency ensures comprehensive psychiatric and medical care, and their nurses meet the clients at their homes immediately following discharge.

VNSW reviews the discharge plan with the patient and assists in setting up a schedule of visits with its nurses in conjunction with the client's medical and psychiatric appointments. If the client attends a continuing day treatment program, the agency arranges its visits so that the patient can attend all necessary programs. The VNSW teams review all medications prescribed upon discharge and, where needed, sets up medication pre-fill sets and locked medication boxes. The mental health nurse also can monitor medication renewals and assist with obtaining prescription renewals, while monitoring symptoms, mood, medication compliance and safety as appropriate, and acting as educators and advocates for their patients.

In addition to nursing care, VNSW provides a full range of rehabilitative therapies, social work and home health aide services; psychiatric patients receive comprehensive care from a coordinated team of health care professionals versed in, and sensitive to, their complete history and needs, providing a complete package of essential multidisciplinary services to help them, following a hospital discharge, to attain and maintain optimal health and functioning in their communities.

With its dedicated Mental Health Home Care Program, Visiting Nurse Services in Westchester is achieving this objective, emphasizing treatment of the whole person with the agency's core multidisciplinary approach. For details, visit www.vns.org, call (914) 682-1480 Ext. 648 or e-mail MentalHealth@vns.org.

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AAS Guidelines Help Identify Risk of Suicide for Inpatient and Residential Patients

By The American Association of Suicidology (AAS)

These recommendations are for consideration prior to pass, trial leave or discharge and are appropriate for inpatient psychiatric units in general hospitals, psychiatric hospitals, and residential treatment centers. These recommendations are not comprehensive treatment guidelines regarding suicidal persons and are not a substitute for the clinical decisions that arise from the treatment relationship. Research to support these recommendations is not conclusive. However, based on the literature that does exist, and in the collective clinical experience of the authors and the American Association of Suicidology, these recommendations represent current best practices. They are subject to change as additional research is published and new knowledge gained. For a review of the evidence, and for more comprehensive recommendations, the reader is invited to consult the American Psychiatric Association's *Practice Guideline for the Assessment and Treatment of Patients 11th Suicidal Behavior* (American Psychiatric Association, 2003).

Trial leaves, passes and discharges are transitions that necessarily result in a reduction in the level of monitoring of patients known to be at elevated risk for suicidal behaviors. Frequently, some or many clinical or environmental risk factors remain to at least some degree. Vulnerability to suicide may persist, and may be exacerbated while the individual is on pass or leave, or after discharge from an inpatient or residential setting. While the use of trial leaves and passes have declined significantly because of changes in the system of financing for inpatient care, they still warrant selective use but with an understanding that they require a careful balancing of risks and benefits. For patients at significant risk of suicide, risk may also be exacerbated during the period following discharge from an inpatient setting. That risk is most elevated in the month following discharge with about half of all post discharge suicides occurring in the week following discharge



(Appleby et al., 1999; Ho, 2003). It is also clear that patients do not always accurately self-report suicidal ideation to mental health professionals, increasing the importance of communication and coordination between families and the treatment team (Busch et al., 2003). To minimize suicide risk during these periods of transition, the American Association of Suicidology issues the following recommendations.

Recommendations:

- 1) Treatment providers should reevaluate suicide risk prior to approving a pass or discharge.
- 2) The decision to grant a pass or discharge should include a risk-benefit analysis to support the clinical decision. This decision should be based, at minimum, on a consideration of the following: response to treatment, external support(s), current mental status, presence of current suicidal ideation, availability of means to suicide (including firearms), patient's adherence to treatment, and history of impulsivity and of past suicide attempts. The assessment should also include a review of the crisis that precipitated the admission, and whether or not the precipitating crisis has abated or been resolved, and

whether or not any new potential precipitants have arisen during hospitalization. The crisis precipitating admission may have been resolved but profound distress may be arising for additional reasons.

- 3) The simple denial of suicidal ideation is insufficient evidence to determine an absence of suicide risk. One recent study of 76 suicides that occurred during inpatient hospitalization or immediately after discharge reported that 78% of the patients had denied suicidal ideation when last assessed (Busch et al., 2003).

- 4) Reliance on so-called "no-suicide" contracts should not be considered, by itself, to be a sufficient intervention upon which to make a pass or discharge recommendation. According to the Minnesota Office of the Ombudsman (2002), such contracts were in place for almost every suicide that occurred in an inpatient, acute care facility. Other studies have also found that significant number of those who made suicide attempts or died by suicide had such contracts in place at the time of their suicidal act (APA, 2003).

- 5) The availability of the family and other sources of support should be assessed, as well as their willingness and ability to provide such support.

- 6) A family session should routinely be recommended.

- 7) Both the patient and the family or significant others should be given instruction regarding suicide and its associated risk, including, but not limited to the following: warning signs of suicide, the increased risk for suicide during pass or following discharge; the need for medication and other treatment adherence; explanation of how psychiatric symptoms may impair judgment; explanation of the need for the patient to avoid use of intoxicants and how intoxicants increase risk; the need for the removal of the means for suicide, and the particular risk associated with firearms.

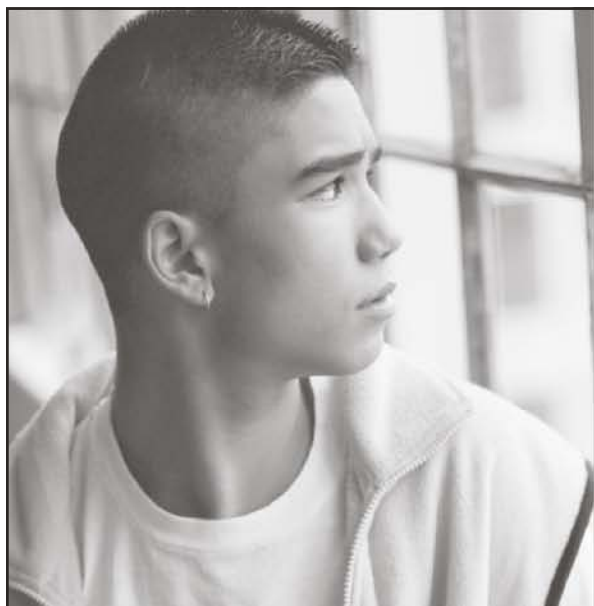
- 8) The patient and family or significant others should be given explicit instructions on how to access the treating physician or therapist regarding questions, observations or concerns, and should be given information regarding how to access treating clinicians after office hours and any limitations on their availability. Emergency phone numbers that are available 24 hours a day, 7 days a week, such as psychiatric emergency services, and crisis lines should also be given.

- 9) If family members or significant others are asked to assist in the outpatient monitoring of risk, specific instructions should be given, including action steps to be taken in the event of felt concern or the development of a crisis. Consideration should be given to providing these in writing, as oral instructions may be difficult to recall accurately in the midst of a crisis.

- 10) Where permitted by law, and with the patient's written permission, the patient's family members or significant others should be alerted to the patient's history of suicidal thinking, feeling, behavior, and non-fatal suicide attempts.

- 11) Every effort should be made to assure that the clinicians with responsibility for treating the patient following discharge

see *Suicide Risk* on page 32



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It Takes A Village

By Laurie M. Reisman, LCSW
Parent Advocate

My philosophy as a clinical social worker has always been that families with children suffering from mental health problems need the appropriate skills, tools, and services to effectively help their child. These families often encounter deficit based delivery systems and somehow get stuck. I never understood why. Then my daughter, Alana, started me on a journey I never expected to take.

It began in 2004. Alana, then 6 years old, began having what we thought were night terrors. It made sense until they started happening during the day. She became combative, mutilating herself and anyone who got in her way. Seizures were diagnosed and then quickly dismissed as we made our way to our first psychiatric admission.

Since that first admission, Alana has been in over 12 placements, including psychiatric hospitalizations and sub-acute stays. It is only now that I really understand what the parents I worked with were going through. I understand what it is like to be blamed for my child's behavior because she doesn't fit neatly into a diagnostic category. I understand what it is like to watch your child end up in a restraint when all you want to do is hold her. I understand what is like to feel like you are living in a fishbowl as everyone judges your every interaction. I finally understand the toll mental illness takes on a family.

Instead of giving up, I decided to share our story and view this journey as an opportunity to grow as a professional and a parent and pass along what we have learned along the way.

Families need to understand our behavioral health system. The child's parents are in charge of treatment. They need to know how outpatient therapy and other treatment modalities differ, what the admission criteria are, and how to access them. I would urge parents to familiarize themselves with their insurance benefits and to know how and when to seek help from their state health care advocate.

Make it your business to research your child's diagnosis. Get together with other parents to advocate for extra support, for improved DSM diagnoses, for accommodations needed at school, and for specific protocols in treatment facilities. Parents who choose to advocate can increase the availability of mental health resources. Get involved! Find other parents in the same situation! Encourage your family therapist to start a parent support group. There really is power in numbers.

All parents need to be able to advocate on behalf of their children. It's important to compile a complete history of your child's illness, medications and hospital admissions. This document should combine medical, family, and educational information. This narrative should be kept up-to-date and used to educate any new provider who may be unfamiliar with the case. This summary can help bring providers together as a cohesive outpatient treatment team so if the child goes to the hospital, everyone agrees about the interventions that are needed and the discharge criteria. I found that doing this was invaluable to my child's treatment and my own sanity.

When a child is in acute distress and the family has knocked on many doors seeking help, they may be grappling with many feelings including helplessness and fear. Even when there's no solution in sight, professionals must listen to accounts of the nightmare and grief of losing the dream of a "perfect child."

Every professional can and should help parents make time to care for themselves. Siblings, who often feel upstaged by the ill child's symptoms may also need coping strategies that let them adapt without losing their childhood or their sense of self.

Alana and I continue on our journey, and it's not an easy road. What we have learned is to listen to each other and to remember that we are in charge of the illness and the treatment, even when it doesn't feel like it. We have also learned that there is a whole village of people behind us who can help. Parenting a child with mental health challenges has taught me that it takes a "village to raise a child." I encourage you all to be part of someone's village.

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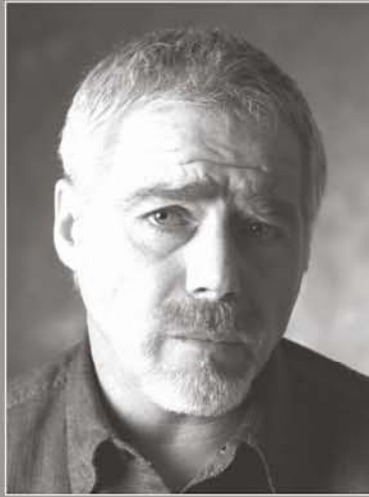
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After the Hospital The Real Treatment Begins

By Steven Shainmark, MD
Clinical Chief, Evaluation and
Referral Service and Outpatient
Mental Health Service
St. Vincent's Hospital Westchester

It is often in the period following an inpatient psychiatric hospitalization that the "real treatment" begins. After stabilizing the most severe symptoms that compromise a patient's functioning, the patient and his or her therapist must then collaborate on the next steps that will help to make the patient's goals and objectives into practical realities. Depending on the severity of the illness, many treatment choices are available.

A partial hospital program offers a high level of supervision for individuals who need more intensive services following an inpatient stay. Patients attend a partial program five days a week for five to six hours, receiving individual and group therapy and medication management. A patient usually attends a partial hospital program before transitioning to a lower level of outpatient care. Some illnesses are disabling enough in severity to require ongoing case management. Programs such as supportive and intensive case management or intensive psychiatric rehabilitation treatment provide essential support to patients with more severe mental illnesses.

Following an inpatient rehabilitation hospitalization for chemical dependency, outpatient options include intensive day/evening treatment programs, which are offered three to five days a week, and a variety of outpatient services that address aftercare and relapse prevention. For those who are being treated for co-occurring mental illness and chemical dependency, an ambulatory rehabilitation program may be appropriate. The dual focus of such programs offers therapy, medication management and development of skills for a sober life. An important



Steven Shainmark, MD

component of these programs is the opportunity to meet others in early recovery.

Group therapy is a significant aspect of outpatient treatment. Some groups focus on a particular therapeutic technique, such as cognitive behavioral therapy, while others deal with a specific life or problem issue. Regardless of the specific topic, group therapy provides an excellent opportunity to exchange ideas and problem-solving techniques with others who are facing the same concerns.

In deciding which outpatient program to choose, the two main considerations should be preventing a reoccurrence of the acute episode that resulted in hospitalization and finding a program that will help the patient return to his or her normal function as soon as possible.

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

Recovery from page 7

overwhelming symptoms and a slowly diminishing connection to, and control over, one's world. It is critical that a person's sense of control over his life is restored before he leaves the hospital. This is where discharge planning, as collaboration between an individual and hospital staff, can serve as a restorative process for the consumer. It is a process within which an individual should be encouraged to express preferences, deliberate options, question recommendations and make important aftercare choices.

In speaking with a number of members of Services for the UnderServed's (SUS) Brooklyn Clubhouse, who were referred from inpatient hospital units, many were able to recollect how they felt on those first days that they "reported" to the Clubhouse. Overwhelmingly, the common experience was one of fear.

They said that they were "not in good shape", that they felt "lost". The staff described them as "distant, isolated and mistrustful". In response, staff "takes it very slow" offering these new members the opportunity to participate in their choice of the various activities the Clubhouse offers. A senior Clubhouse member is assigned to "stay close by" and orient the new member to what is going on at any given moment, and how he/she could get involved. "We try to find out what they like. We know that there is a lot more to this person than may be apparent initially." The emphasis is on allowing the new member to "see the clubhouse as a place that they will be respected and feel safe."

The referral process is another bottleneck in the system. Hospital staff is under intense pressure to discharge patients as

see Recovery on page 33

Budget Proposal from page 9

We last encountered a similar threat to the mental health system when we raised concerns about the potential impact on mental health services of the "Commission on Health Care Facilities in the 21st Century", known as the "Berger Commission" in 2006. Fiscal data presented at that time made the point that Article 28 facilities accounted for an enormous percentage of mental health service in the state. For example, 48% of funds expended for inpatient care and 40% for outpatient care was provided through Article 28 facilities (See the NYSPA Report, *Mental Health News* Spring, 2006 V. 8, No. 2, available in the back issues section of the *Mental Health News* website: www.mhnews.org). We want to make sure that legislators are

aware of this pressing concern when they consider changes to the Medicaid reimbursement scheme this year.

Our aim is to reduce the undue influence of drug companies, protect the doctor-patient relationship from further bureaucratic intrusions, protect patients from inappropriate medication "switches" by their PBMs, and assure adequate access to the public mental health system for persons with serious mental illness.

Barry B. Perlman, MD is the Chairman of the Committee on Legislation of the American Psychiatric Association, and Immediate Past President of the New York State Psychiatric Association. Seth Stein, Esq., is the Executive Director & General Counsel of the New York State Psychiatric Association.

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NIMH, Departments of Defense and Veterans Affairs Join Forces on PTSD Research

**By Thomas R. Insel, MD, Director
and Farris K. Tuma, ScD, MHS
Chief of the Traumatic Stress Disorders
Research Program, National Institute
of Mental Health**

NIMH supports a wide-ranging program of research on PTSD, aimed at helping people and communities cope with the effects of traumatic events and preventing lasting mental health consequences. Although the institute's research encompasses different populations and types of trauma, one area of renewed focus is the psychological cost of war.

With a rapidly growing need in recent years for mental health care of military personnel generated by sustained conflicts in Iraq and Afghanistan, the Institute is working with the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to identify research priorities and potential areas of collaboration, and to support high quality research by investigators within and outside of the military. The insights gained from research on the mental health consequences of war will reach beyond the military. They will contribute to our understanding of risk and resilience in responses to all types of trauma and how to care better for those exposed to traumatic events.



Thomas R. Insel, MD

The psychological reactions of individuals to trauma are varied and complex. Most people recover, but a significant minority experience severe stress-related symptoms for long periods. Depression, panic disorder, generalized anxiety disorder, and substance abuse, as well as PTSD, are among the



Farris K. Tuma, ScD, MHS

spectrum of reactions to trauma. Approximately 3.6 percent of American adults age 18 and older—about 7.7 million American adults—have PTSD in a given year; over a lifetime, nearly 7 percent of American adults develop PTSD. PTSD can develop at any age, including childhood.

NIMH War-Related Research Past and Present

The need to understand the effects of war-related trauma in particular was one of the major catalysts for the creation of NIMH more than 60 years ago. Recognition of the psychological consequences of trauma during World War II stimulated interest in research and helped reshape systems of mental health care within the military, a change that subsequently influenced community health care. In helping these soldiers, both overseas and upon their return home, clinicians gained insights into treatment needs, systems, and resources for anyone who needed mental health care.

The wars in Afghanistan and Iraq have generated an urgent need for research on the risk and resilience factors for and treatment of PTSD and accompanying conditions. Since March 2003, about 1.6 million U.S. troops have been deployed to both countries (<http://www.rand.org/pubs/monographs/MG720/>). Moreover, screening of combat veterans on their return home and six months later found that 20.3 percent of active and 42.4 percent of soldiers in the reserves required mental health treatment (Milliken, Auchterlonie, and Hoge, 2007).

see PTSD Research on page 33



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New York City Program Helps Individuals Suffering From Borderline Personality Disorder Prepare for Employment

By Beth Elliott, PhD
and Devin Macnow
The Connections Place

With the national economy faltering and the unemployment rolls rising every month, it's tough for Americans not to become depressed and worried about their financial stability and economic future. However, those individuals who suffer from borderline personality disorder (BPD) may find themselves particularly demoralized by the current economic climate compared to most segments of the U.S. population.

Though individual therapy is the path that many people with BPD choose to follow, there is a program in New York City that specifically focuses on helping to boost the morale and confidence of those with BPD wishing to reenter the workforce. This program is called The Connections Place (TCP), and is a job preparedness program uniquely developed for individuals who are suffering from BPD, or who have features of BPD. TCP teaches skills to overcome emotional issues related to working, as well as skills to improve vocational readiness for employment.

TCP was co-founded in 2006 by Beth Elliott, Ph.D., and Dale Terilli. "Many people with BPD who are not working find themselves demoralized, lacking structure and direction in their lives" says Elliott, Director of TCP, "and the longer that they remain off the vocational track, the harder it is for them to get back on. TCP provides a place where people with BPD can begin to overcome these emotional and vocational obstacles, and prepare to return to the workforce, ultimately leading the life that they want to live."

Dale Terilli, Program Director, is a veteran of the mental health community having spent most of her career in outpatient mental health services at New York Presbyterian Hospital, Westchester, and Mt. Sinai Hospital, New York City. She heads up a team consisting of vocational

coaches, and runs the day-to-day operations of TCP. According to Terilli, one of the main aims of TCP is to give its clients hope. Hope not only for their future, but hope that there can be recovery from BPD. She stresses that a major function of TCP is to bridge the gap between therapy and a fuller life.

The TCP program is the first of its kind in the U.S., according to the co-founders of TCP, as it is a job preparedness program specifically targeted to individuals with BPD. Some skills taught to overcome emotional barriers to working include increasing motivation to change, dealing with the stresses of the job application process, and handling interpersonal conflicts. Many of these skills are similar to those utilized in dialectical behavior therapy (DBT), a therapy that has been very effective with individuals suffering from BPD.

Vocational skills taught at TCP focus on interviewing, conducting job searches, writing resumes and cover letters, and finding meaningful work. Elements of the "choose-get-keep" approach to employment are used in this program, especially those that emphasize the importance of clients deciding what sort of work they would like to do based on their personal values. TCP also monitors the economy and helps identify many fields for clients that offer the most promising areas of employment in this difficult job market.

Since opening in December 2006 TCP has had over 75 clients. Many clients have moved on to jobs (paid and volunteer), or to school. Clients found work in copy-editing, legal services, marketing, public relations and pet care; others obtained work in settings including a bookstore, bakery, and hotel; while others have entered training programs, colleges, and started coursework for graduate school. In general, clients who have not started working have succeeded in taking some step toward working, such as writing their first resume (or improving their current resume), applying to jobs,

see Employment on page 32

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Care Coordination from page 14

over their treatment plan and make informed decisions.

Eligible enrollees work with either a MHA or Westchester Department of Community Mental Health (DCMH) Care Coordinator and a Recovery Mentor from the Empowerment Center in New Rochelle, NY, thus ensuring access to Intensive Case Management and Peer Support services that address the individual's specific needs, as defined by the individual. Care Coordinators and Mentors operate as a team with 24-hour access serving a total of 48 participants and delivering a minimum of 4 face-to-face visits per month per participant and making the following services available:

- Work with enrollees to develop individualized Wellness Recovery Action Plans.
- Work with providers to arrange admission into desired or needed services.
- Coordinate mental health, chemical dependence, medical, legal, housing and needed support services.
- Provide guidance and access to self-determination and service dollars.
- Provide ongoing case management services.
- Assess the appropriateness of treatment/services and review plans every 6 months.

Although the principles and values of Person-Centered Planning are not new, the adult mental health service system remains fragmented. Adults diagnosed with serious mental illnesses still have high unemployment rates and are faced with a lack of affordable and appropriate housing options. Too many individuals with serious mental illnesses still reside in shelters or adult homes that are not environments with a recovery-based culture. MHA believes that the Care Coordination project can initiate system change because the model has been effective when implemented. The well-established Western Care Coordination Project (WCCP) has reported for its participants a 59% reduction in emergency visits, a 62% decrease in days in hospital, and a 44% increase in gainful activities such as school, volunteering, or employment. MHA and its partners, DCMH and The Empowerment Center, are extremely optimistic that the Westchester County Care Coordination program will yield positive outcomes for people participating in the program. Additionally, MHA has found that this innovative program has led to a transformation of philosophy and practice throughout the agency so that services are recovery-oriented and person-centered.

For more information about Care Coordination or MHA's Recovery Oriented Rehabilitation and Treatment Programs, please contact Ruthanne Abramovich, Assistant Executive Director, at 914-345-5900 x299 or visit our website at www.mhawestchester.org.

A Helping Hand from page 11

Assisted Outpatient Treatment patients spent 50 days in the hospital during the six month period prior to an Order being granted. Compare that with 22 hospital days while the Order was in effect and only 13 days during the six month period following the completion of the Assisted Outpatient Treatment Order. The foregoing statistics makes it difficult to argue with the overall effectiveness of Kendra's Law. The Law has reduced acts of violence in the community to others as well as self injurious behavior and has significantly tightened the revolving door of hospitalizations that so many psychiatric patients struggle with.

However, despite the glowing statistical evidence of Kendra's Law success, there remain complaints and difficulties with the Law. Naturally, many individuals subject to an Assisted Outpatient Treatment Order lament the restriction of freedom that is attendant with an Assisted Outpatient Treatment Order. One is required to comply with the recommended treatment plan in order to avoid hospitalization, which often times means numerous meetings per week with treatment team members. While some find the structure of the program to be beneficial others find it smothering and have difficulties complying with such a strict regiment.

Moreover, one of the largest difficulties with Assisted Outpatient Treatment is a lack of resources. While this is generally a problem common to all government programs it is particular onerous in the realm of Assisted Outpatient Treatment. For patients that have a prior history of

non-compliance with treatment, inpatient treating psychiatrists will often apply for an Assisted Outpatient Treatment Order. While this is wise clinical practice, the lack of resources often leads to increased hospital stays for individuals waiting for an Assisted Outpatient Treatment Order to be granted. The problem lies with county Mental Health programs that run the Assisted Outpatient Treatment programs that lack adequate resources to timely provide the services that an inpatient psychiatrist thinks are necessary. For instance, it often takes weeks if not months for Intensive Case Managers or ACT teams to be provided. While waiting for these services to be put into place, many inpatient treating psychiatrists, and rightfully so based upon the prior conduct and non-compliance of Assisted Outpatient Treatment candidates, do not feel comfortable discharging the patient until an Order is in place. Accordingly, individuals who are otherwise psychiatrically stable enough to leave the hospital often spend unnecessary time as an inpatient, waiting for county mental health offices to scramble for scarce resources.

Conclusion

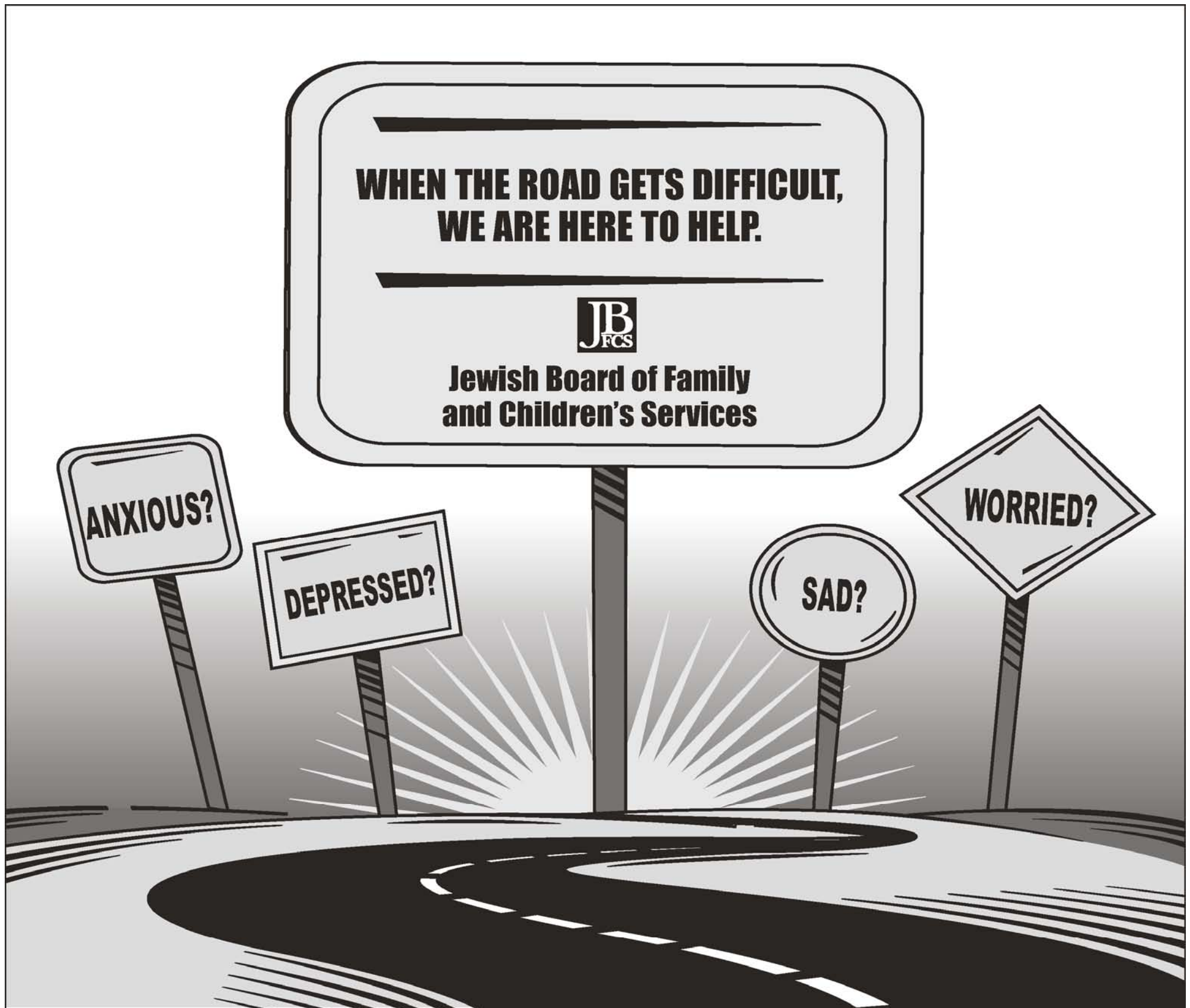
In all, Assisted Outpatient Treatment has been of great benefit to those that suffer from mental illness and the community they reside in. The numbers are simply hard to argue with. Less time in the hospital and fewer incidences of violence and arrests are clearly a benefit to everyone. While problems do exist, when looking at the program as a whole the positives clearly outweigh any downsides.



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Discharge Planning from page 1

symptomatic relapse and readmission. Other stressors may have to do with lack of adherence to treatment regimens, family conflict, economic and entitlement stressors, legal entanglements, etc. Each of these should be evaluated in the context of the discharge planning process. Once an optimal plan has been thought through, it then remains to be determined the availability of the preferred services. Ultimately, discharge plans represent a compromise between what might be best and what is currently accessible in the area.

Perhaps a composite clinical vignette will help to illuminate the discharge planning process. Mr. M was admitted to the hospital under an involuntary status. He had been brought to the emergency department by the local police. He came to their attention when he was reported to have been wandering into traffic. When questioned he evidenced disorganization, belligerence and paranoia. A drug screen was positive for cocaine and he had an elevated blood alcohol level. Once settled on the inpatient unit, additional history was obtained from Mr. M and his family. He had a history of several prior admissions along with problematic adherence to his aftercare plans over the past several years. Recently he had stopped taking his medications and attending his clinic appointments. He had let his Medicaid lapse. In order to design an appropriate discharge plan for Mr. M, the treatment team will need to integrate the information presented. Reactivating his Medicaid will be a necessary first step. Once that is done the team can consider which level of treatment and case management will best provide the needed support and structure for their client. For example, the clinical team may decide that, given the history of multiple admissions as well as non-compliance with treatment, intensive case management (ICM) would help Mr. M access and stay with a partial hospital program which includes a "double trouble" track for persons suffering with a mental illness and substance use disorder. ICM services would also help him main-

tain his "room," keep appointments, and remain current with his entitlements. They may also suggest the use of a long acting injectible antipsychotic medication. Given his history, however, the clinical team has decided to refer him to the highest level of treatment – an Assertive Community Treatment (ACT) team. An ACT Team is a mobile treatment team that goes to the consumer instead of the consumer coming to an agency for treatment appointments. As an ACT Team had not yet been tried with this individual, and since ACT is considered to be the least restrictive treatment to keep this individual safely in the community, AOT will not be pursued. AOT would be considered in the future if the present plan was unsuccessful in helping Mr. M remain in the community and begin to move forward with his recovery plan.

Persons without insurance may have a more difficult road to travel despite the extensive access provided for them in programs licensed by the state. It is important for the treatment team to be aware of their uninsured status early in the course of treatment. With that information in hand, affordable medications can be prescribed during the admission. For example, atypical antipsychotic medications may cost hundreds of dollars per month and be unaffordable. However, efficacious alternatives exist. Typical antipsychotics, several classes of antidepressants and mood stabilizers can be purchased at minimal cost at pharmacies at such stores as Walmart, Target, Stop and Shop, and others. There the medications on their formularies can be purchased for \$4 per month or \$10 for 3 months supply.

Barry B. Perlman, MD, is the Director of the Department of Psychiatry at Saint Joseph's Medical Center in Yonkers, New York. He is the Immediate Past President of the New York State Psychiatric Association. John Turtz, PhD, is Program Coordinator – Mental Health at the Westchester County Department of Community Mental Health, located in White Plains, New York.

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Employment from page 29

and/or obtaining interviews. Furthermore, most clients have reported improvements in their lives such as decreased isolation, increased structure, greater social contacts, and feelings of increased productivity.

Overall, there appears to be a great need for vocational programs for individuals with BPD. Research indicates that more than 50% of these individuals have serious problems with employment. In addition, a recent NIH study found that the lifetime prevalence of BPD in the US population is 5.9%. Thus, there are a great number of individuals with BPD who need help dealing with obstacles related to working. The

TCP program is a beginning step towards providing vocational services for individuals suffering from BPD – services which are even more important during difficult financial times.

Clinicians and individuals suffering from BPD interested in learning more about TCP may visit the TCP website at www.theconnectionsplace.org, and contact the center at 212-362-5545 or at contact@theconnectionsplace.org. To view a presentation on TCP by Dale Terilli, Program Director, go to http://web4.streamhoster.com/video4nea/Yale08/TCP-Terilli_files/fdeflt.htm. TCP is operated under the auspices of the National Education Alliance for Borderline Personality Disorder (www.neabpd.org).

Levels of Outpatient Psychiatric Treatment

- Assertive Community Treatment (ACT) – ACT services consist of a multidisciplinary mobile treatment team that provides comprehensive services including psychiatric, psychosocial rehabilitation, case management and support services. The ACT Team meets the consumer in the community as opposed to the consumer coming to an agency for services.
- Partial Hospitalization – This is an intensive and structured day program for consumers that need further stabilization following a period of inpatient hospitalization. It is time-limited (usually under 6 weeks) and followed by a referral to a lower level of treatment.
- Continuing Day Treatment (CDT) - CDT programs provide day programming up to 5 days per week usually for individuals with serious mental illness. The consumer is offered a number of groups each day, as well as individual therapy and medication evaluation. Some day programs include groups that address both mental health and chemical dependency issues as part of their programming.
- Clinic – Clinics provide various services, including but not limited to medication evaluation, individual therapy, and group therapy. Frequency and duration of appointments are individualized.

Levels of Housing

- Supervised Community Residence – This is a home that provides congregate living, rehabilitation services, 3 meals per day, and 24 hour supervision.
- Supervised MICA Community Residence – This is a home that provides congregate living and specialized services for those individuals with mental health and chemical dependency issues.
- Treatment Apartment Programs – This is an apartment program shared by a small number of residents. Staff visits occur on an as needed basis. Rehabilitation services are provided.
- Supported Apartment – This is an apartment for a single individual. Support services are provided as needed.
- Supported Single room Occupancy (SRO) – This is a home where each individual has his or her own private room, but shares other living space. Staff support services are available on site.
- Shelter Plus Care – This is analogous to a Supported Apartment, but for individuals that are currently homeless.

Levels of Case Management Services

- Both ICM and SCM services are available to assist consumers that have difficulty connecting with treatment. Participants often have multiple hospitalizations and/or inconsistent participation in outpatient services. Some also want assistance with vocational goals, use of leisure time or other issues in order to further their recovery.
- Intensive Case Manager (ICM) – Sees consumers a minimum of 4 times per month
- Supportive Case Manager (SCM) – Sees consumers a minimum of 2 times per month.

Suicide Risk from page 24

receive a copy of the patient's discharge summary.

12) The patient should have an outpatient follow up appointment scheduled before discharge.

13) Prescription of psychiatric medications at pass and discharge transitions should be undertaken with consideration

of the potential for overdose.

14) All clinical and residential staff should have training in the assessment and management of suicidal risk, and the identification and promotion of protective factors.

The American Association of Suicidology does not regard the previous recommendations as invariant standards of care, but rather as evolving best practices. They may not be feasible for every patient in every setting.

PTSD Research from page 28

The conflicts now underway have features that distinguish them from previous wars with several additional stressors for combatants:

- The overseas force includes an all volunteer army along with substantial numbers of reserve and National Guard personnel.
- Multiple tours of duty are common.
- More wounded survive with injuries that would have been fatal in previous wars.

The ubiquity of improvised explosive devices adds to the chaos of the war zone, and is a contributor to a high rate of traumatic brain injury.

NIMH, DoD, and the VA are collaboratively addressing a broad array of issues related to PTSD, among them how gender, race, and other socioeconomic factors influence the development of trauma spectrum disorders; standards for clinical trials in PTSD; prevention of posttraumatic stress adjustment problems in emergency responders and military and law enforcement personnel; and best practices for early interventions after mass trauma.

NIMH has joined DoD and the VA in planning pre- and post-deployment assessment studies of PTSD and the genetics of PTSD. In recent years, NIMH has issued several requests for applications (RFA) inviting researchers to apply for grant funding for PTSD-related research. DoD and the VA joined NIMH in an RFA in 2006, for example, focused on intervention and practice research for combat related mental disorders. Another joint NIMH-VA RFA sought teams of investigators to conduct studies to develop PTSD assessment tools.

Suicide in the military and among veterans is also a concern. Under a recently signed memorandum of agreement with the U.S. Army, NIMH will conduct a multi-

-year research study that will evaluate the risk and protective factors that are associated with suicide. This NIMH-DoD collaboration promises to be the largest study ever conducted of the risk and resilience factors for suicide. The study, modeled on the Framingham study for heart disease, will include active-duty forces, the National Guard and Army Reserve, and veterans. The goal is to provide information the Department of Defense can use to develop strategies to promote resilience and prevent suicides.

Research Efforts in Military Populations

NIMH funds a variety of studies on PTSD in military personnel examining the epidemiology, natural history, and risk factors for PTSD, and new approaches to prevention and treatment. The following are some examples:

- Investigators are looking at the factors associated with mental health problems following deployment in reservists and National Guard personnel. Knowledge of how such features of military life as length of time in service, unit cohesion, training, rank, and separation from family influence post-combat concerns will help guide training and development of interventions.
- Several studies seek to identify the risk factors for PTSD and to track the course of development of symptoms. One study is looking for genes that may contribute to negative interpersonal behavior in intimate relationships, including verbal hostility and physical aggression. In another study, veterans use personal digital assistants to record daily assessments of life stresses and any PTSD symptoms in an effort to gather a picture of how PTSD emerges and either resolves or becomes chronic.
- Research suggests that only a minority of the Afghanistan and Iraq war veter-

ans who screen positive for mental disorders seek mental health care. The stigma associated with seeking care is among the reasons for not seeking help; others include the accessibility and perceived effectiveness of mental health care (Hoge, Castro, Messer, McGurk, Cotting, and Koffman, 2004). If shown effective, Internet-based approaches would provide easy accessibility and privacy for veterans hesitant about seeking formal treatment. Complementary research is aimed at identifying the beliefs that determine whether veterans seek treatment, and developing ways to overcome biases that discourage treatment-seeking.

- PTSD and accompanying depression can complicate a veteran's resumption of relationships with spouse and children. Spouses are at elevated risk of psychological distress, marital difficulties, and intimate partner violence. Studies are aimed at developing ways to help returning veterans and their spouses handle the transition between deployment and return. One study focuses directly on developing an Internet-based intervention to help spouses understand and cope with PTSD in their returning partners.

Research in military personnel has begun to demonstrate the effectiveness of new treatment approaches for PTSD. Early data from an NIMH-sponsored double-blind study of 24 war veterans showed a marked reduction in acoustic startle—the reflex response to sudden loud sounds—in those treated with virtual reality exposure therapy combined with either d-cycloserine, an antibiotic that has been shown to facilitate the extinction of fear memories; pill placebo; or the anxiety medication alprazolam (Xanax). The study is continuing to examine the effectiveness of d-cycloserine. Another pilot study showed that an Internet-based, self-managed cognitive behavioral therapy can help reduce symptoms of PTSD and de-

pression, with effects that last after treatment has ended.

Brain Stress Mechanisms

NIMH-supported research is investigating the spectrum of factors that may influence the risk of developing PTSD and those that promote resilience. These include the genetic background and past experiences of the individual; the nature, intensity, and duration of trauma; social support; and the availability of timely, effective treatment. Among the central targets of recent research are the brain's stress circuitry and the role of genetic factors in resilience and vulnerability. A better understanding of the neurochemistry of fear reactions is helping researchers develop medications to help treat PTSD.

Although the nature and pattern of stresses experienced by someone in war may differ in important ways from, for example, those encountered by a hurricane survivor, the brain mechanisms that underlie PTSD in both are the same. Research on genetic factors in military and non-military populations can inform treatment in both. A recent NIMH-supported study reported that a traumatic event is much more likely to result in PTSD in adults who had experienced past traumatic child abuse and also had certain variations in a specific stress-related gene. Each factor alone—child abuse or genetic factor—was not enough to raise risk, but the combination raised it substantially.

It is hoped that PTSD research can help military personnel continue in their military careers or return to civilian life without being hampered by the psychological consequences of their experience in war. That alone makes the need for these efforts compelling. In addition, what we learn from research on the effects of war on mental health in military personnel will help in designing interventions for others exposed to trauma of all types. It is especially important to develop effective, accessible ways to help individuals early and prevent deepening, long-term difficulties with post-traumatic stress.

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Recovery from page 27

soon as possible; this results in referrals to outpatient services that are often based more on administrative needs than consumer preferences. Individuals are often not aware of their options after being discharged from a hospital. The key here is in being given “choices” and “respecting” those choices.

We should consider bringing peers to the inpatient setting to help consumers make educated choices regarding their discharge. Peers can also be involved in the implementation of advance directives. Advance directives (AD) allow an individual to decide in advance how they would like the team to work (and even designate other people to make decisions) when they are unable to do so. Informing the consumer about AD should be part of every outpatient treatment program. Once the person has an AD in place the inpatient team will use that document as a roadmap for treatment and discharge planning.

After a stay on an inpatient unit an individual just needs time and a place to restore their bearing, to reconstitute in order to meet the demands of the community. The transition from inpatient to outpatient is often too abrupt and while all the aftercare referrals might be in place, an individual may need support and assistance to cross over successfully. The SUS Clubhouse is structured to do just that. The belief is that an individual must be offered many ways to take charge of his own recovery. Medication is a part of that recovery, but so are relationships and meaningful activity. As a Clubhouse member you are expected to train, work and ultimately teach others.

Crises are often opportunities to make life changes but if the person believes that their problems are only related to medications, they will not be open to change. They might even become more confused, frustrated, and defiant toward a system they see as imposing its will on them. To help prevent this from happen-

ing, we can try to return as much control as possible to the consumer during an inpatient stay. By sharing power and accountability with consumers, we will improve communication and ultimately start to restore trust in the system. Utilizing a person-centered model we will increase the capacity to make appropriate referrals for outpatient services upon discharge from the hospital and improve the engagement process of the person with available services.

The overall quality of outpatient psychiatric services is sound, but by definition it focuses on treatment. A large percentage of the people referred for outpatient treatment do not return to that site after one visit. One of the main reasons this occurs is that consumers feel they do not get what they need.

A comprehensive discharge plan should include rehabilitation services.

Symptom stability alone is not a goal but more often than not a result of other complementary interventions. By waiting

for someone to be symptom free or stable we lose the opportunity to connect a person to the services that would assist in their recovery. When an individual can address their service needs, they will also have better chance to control their symptoms.

After several months of Clubhouse membership at SUS, one member, who had spent several months at a state psychiatric center, stated, “I belong here, and what I do while I’m here matters to me and the people who are also members here.” It is that simple and not at all different from what most people want out of life, to feel valuable and valued.

Pablo Sadler MD, is the Mental Health Medical Director Bureau of Mental Health, at the New York City Department of Health & Mental Hygiene (NYCDOHMH). Yves J Ades PhD, is Senior Vice President, at Services for the Underserved. Robert Goldblatt, LCSW is Director of Rehabilitation Programs, Bureau of Mental Health, at NYCDOHMH.

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Follow-up Care from page 15

residence and on home visits, so that commitment to sobriety and support can be established prior to transition.

Positive peer relationships are a crucial need for adolescents and young adults, who often use drugs and drinking as ways to belong. Children, adolescents and adults that need residential care often have poor social skills and lack the ability to form meaningful friendships. Interpersonal skill training is, therefore, a necessary component of the transition process. Clients need to learn how to assert themselves appropriately, ask for what they need, deal with limit-setting and confrontation, and develop the capacity for honest dialogue and conflict resolution.

All that are enrolled in residential treatment need to learn *how to work on themselves*. They have often heard this phrase and can parrot it back, but haven't a clue what it means. To be prepared for transition and after-care, they need to develop healthy coping skills in place of negative ones. They need to experience therapy, not as something "done to them," but something that works for them and in them to improve their lives. Perhaps the most crucial dimension of therapy involves emotional expressive work to become aware of feelings and learning how to explore and express them appropriately in relationships. It is this positive experience of therapy that can help an adolescent or a young adult to be active agents in their outpatient treatment, which depends so much on what they bring to it.

Because mental illness and behavioral problems interfere with concentration and study, academics suffer accordingly. Children, adolescents and adults have often fallen behind or have dropped out of school. School within the residential setting has several tasks. Small classes, personal attention, support for different learning styles, help with learning disabilities, and appreciation of different gifts are all aspects of academic work that help to diminish shame and build self-confidence that makes return to main-

stream education possible.

Good psychiatry and a competent nursing staff are important elements of residential treatment that support stabilization and transition. If the residential program provides containment and quality medical support, medications that were initiated in brief hospital stays can be monitored over time, changed, or stopped altogether to determine what works or doesn't and what is essential or unnecessary. In outpatient treatment, by contrast, medication adjustment is more risky and not as easily undertaken.

What outpatient treatment can address only piecemeal, residential treatment can address simultaneously and in process, but only if the program is consciously designed to do so through a multi-modal approach. Transition from psychiatric hospitalization to after-care can be approached gradually, step by step, and is less precipitous. Readiness for transition can be monitored by how the child and the family actually function in response to the challenges they face. It supports a kind of transition that diminishes the threat of recidivism and repeated hospitalizations and protects against the shame attached to them.

What I am presenting in terms of transition and after-care needs is an actual description of residential treatment at Wellspring, a multi-service mental health agency in Bethlehem, Connecticut. Wellspring has residential programs for young children, adolescent girls and young adults that are specifically designed for transition from psychiatric hospitalization. Each program is situated in a spacious country home with barns for animals. Each is surrounded by woods and fields, a flowing stream or a nearby pond. Each program is small, intimate, homelike and personal – the opposite of an impersonal institutionalized setting. Families are included in the treatment according to the specific needs of the residential population. Children need to have their parents very present, so parents are brought into the residential for meals and play and bedtime activities. Adolescents don't

need their parents hovering over them, but want them actively involved in weekly family sessions, parent support and multi-family groups. Young adults need their parents to be available for family sessions but want them to be supportive of their efforts at independence.

In the children's residential program, parents are encouraged to share meals, play with their children, read to them and put them to bed. During this time, they are coached by the staff in high structure, high nurture parenting skills that are particularly focused on developing bonding and attachment. These coaches attend family sessions with a clinician to share their observations and reflections as part of the process. They also become home coaches and support persons for the family as part of after-care and transition.

In the Adolescent program, weekly family sessions are an admission requirement, along with attendance at parent support group and multi-family group every other weekend, which coincide with parent visits or visits at home. The program is multi-faceted with a substance abuse track, emotional expressive groups, and interactive groups to develop interpersonal skills. Special mind-body groups address body image and eating disorder issues. Animals care, animal assisted therapy, adventure, and horticulture offer a wide range of life experiences that are both instructive and challenging, designed to develop confidence and responsibility. There is considerable emphasis on creative self-expression through art, pottery, sand tray therapy, and theater as aspects of a multi-faceted learning experience that touches mind, heart, body and spirit.

Adolescents and children attend the Arch Bridge School, a certified special education school on the grounds. Young adults at Angelus House take college courses while in residence, preparing to return to college when they leave. They also obtain part-time jobs in the area from employers known and trusted by the staff to provide a meaningful work experience and honest feedback. Animal care, work therapy and adventure programming are

staples of the program that help restore functioning, self-confidence and responsibility. In contrast to the children's and adolescent programs which restore families and return kids home, Angelus House provides a series of step downs that involve work outside and school as part of a gradual process of transition to independent living.

Each of these three residential programs provide an intensive, multi-modal process that prepares the individual – child, adolescent or adult – for transition back to normal life, whether that life is centered in one's family or in one's own apartment. The transition from the residential presents many of the same challenges as transition from the hospital. But much more is now in place that makes this transition more advanced and secure. Primary relationships are usually improved, capacity for healthy peer relationships is more developed, substance abuse is under control, and attachment and bonding for young children is more developed. Residents have had practice making the right choices, and have learned from their experience making wrong choices. If they have slipped, they have learned to re-group, take stock and continue on their way. The elements of successful transition have already occurred in calibrated steps, and the major building blocks are more or less in place. They are prepared academically for return to school and are better prepared to develop new friendships. While residential treatment is not the same as real life, because stability in a supportive structure was provided, there are ways life has been more real in the residential, because relationships built from the experience of shared work and self-disclosure are often more intimate and authentic. Parents have had an opportunity to do their own work, and they are typically grateful for what they have learned, though all will say it hasn't been easy. Transition home or to independent living presents many of the same problems in different form, but the problems are experienced differently from this angle than before.

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