

MENTAL HEALTH NEWS™

YOUR TRUSTED SOURCE OF INFORMATION, EDUCATION, ADVOCACY AND RESOURCES
SUMMER 2003 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 5 NO. 3

Employment for People With Mental Illness

Ira H. Minot, Founder & Publisher
Mental Health News

While conflicts test our nation in distant lands, the struggles of people with mental illness continue here at home. The injustices of stigma against people with mental illness continue to surface within the social fabric and the workplace in communities throughout the nation.

For people with mental illness, the struggle and challenges often imposed

by their illness require the same understanding and accommodations accorded any other form of disability.

When the barriers to employment are lifted for people with mental illness, a broad and just vision to accept the good and the ability of all men and women are valued. This, in turn, may have far-reaching effects in lessening peoples' fear of a disabled population, which is at the root of all stigma.

Many employers have embraced this vision and have taken a leadership role in employing people with mental illness.

However, much remains to be done in education and legislation to turn the tide.

Those with a serious mental illness face the greatest barriers to employment and the highest degree of stigmatization in the workplace. The unemployment rate for this population is reported to be as high as 70-90%. The majority of people with a mental illness want to work, and recent surveys report that approximately 70% of those with significant psychiatric problems rank work as an important goal for themselves. (Source: Matrix Research Institute, 1995.)

Mental Health News takes pride in bringing the efforts of the mental health community to enhance opportunities in employment for people with mental illness--and to encourage and support more and more employers to provide meaningful job opportunities for consumers.

We hope that this issue of Mental Health News helps to advance your understanding of this vital topic and further encourages leaders in the business community to become involved.

Please see our table of contents for the complete story.

The Effect of War on Our Mental Health

By Robert Abramovitz, M.D.
Chief Psychiatrist and Director, JBFCS
Center for Trauma Program Innovation

These are extraordinary times filled with threats that evoke fear, uncertainty and anxiety. How does one go about daily life while simultaneously balancing being on alert with the need to keep from over-reacting? As mental health professionals, the message we should convey is that people can learn "how to function effectively in spite of being afraid." We are not telling people "don't be afraid."

In these uncertain times, each of us needs to work to promote resiliency and adaptive coping strategies. Part of this effort involves integrating the useful knowledge we now have about how the brain processes threats,¹ how going into survival mode affects thinking and behavior,² and how the use of expanded concepts of safety can promote adaptive coping.

Coping With Fear and Anxiety is a guide that was developed at the Jewish Board of Family and Children's Services Center for Traumatic Program Innovation. This guide is designed primarily to assist mental health professionals help clients and the general public by converting conceptual frameworks into useful psycho-educational and coping skills training. Many other professionals may also find it useful.

We wish to thank *Mental Health News* for bringing *Coping With Fear and Anxiety* to its readership.



Although the guide was intended for the clinician, we feel that consumers' families and the general public will also gain a great deal from reading it.

Everyone can benefit by a better understanding of ways to identify and express troubling feelings that they may be experiencing. Should these feelings become too severe, we would urge you to seek the help of a qualified mental health professional in your community, many of which are featured in *Mental Health News*.

What is The Fear Response

Fear is an innate, primal emotional reaction that involves a feeling of alarm or dread invoked by some specific object or situation that signals danger.³ Fear serves a useful function by mobilizing us to respond to a threat. Manageable levels of both fear and anxiety can facilitate adaptive functioning. However, if the intensity is too great, maladaptive responses cause freezing, withdrawal, disorganization, confusion and helplessness.

Acts of terrorism are designed to cause such intense fear in order to interfere with effective action even in the absence of an actual attack. They also disrupt normal trusting bonds, which further erodes one's sense of security and safety. Anxiety is defined as an unpleasant state of tension associated with a more generalized, long-term anticipation that something unpleasant may happen.⁴ Freud defined signal anxiety as the fear that arises from the anticipation of a perceived threat of danger. Fear can also have an adaptive function in that foreseeing the possibility of danger allows one to prepare to avoid or prevent the dangerous situation.

Understanding how our fear reactions are triggered and how they change our thinking and behavior can be useful for everyone but especially anxious, fearful people. This knowledge can help contain maladaptive reactions that perpetuate the fear.

see *The Effect* on page 22

Also Inside This Issue Of Mental Health News - Timothy's Law Campaign: Spearheads Parity Battle in New York State
- Shocking Trend: Parents Giving Up Custody to Get Child MH Services

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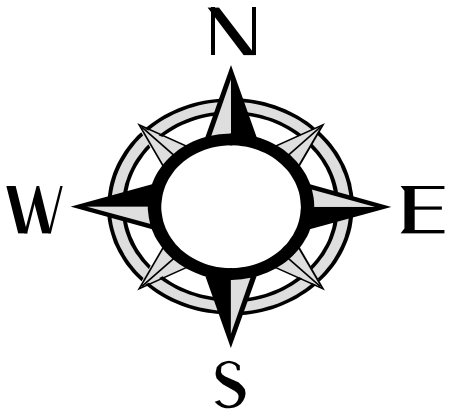
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The Publisher's Desk

The Currents



Of Our Times

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

For almost everyone afflicted by a mental illness or connected in other ways to the mental health community, our present day universe often defies logic and understanding. It's as if we are riding in an H. G. Wells time-machine that can't make up its mind in which direction we are going—to a much desired utopian future or back to our shadowed past. This dichotomy is quite troubling and unfortunate.

The last twenty years have seen great advances in the science, medicine, public policy and relative acceptance of the disease model of mental illness. However, the social and political environment surrounding mental illness continues to flip-flop, taking one step forward and then two steps back.

The articles and editorials in this issue of *Mental Health News* are a good example of the ebb and flow of the currents of our times. For example: in *Your Letters*, you have written to us about:

- people with mental illness continue to fall through the cracks,
- the business community needs to consider hiring people with mental illness,

- people are still struggling in silence because of the stigma against mental illness and
- the consumer movement is marred by an atmosphere of non-inclusiveness and an unclear agenda.

In our *NewsDesk*, a disturbing report by the federal government indicates that parents are giving up custody of their children in order to get them the care they need to battle serious emotional disturbances.

Next, we are elated to learn that Clifford Levy of the NY Times (so admired for his hard hitting reporting of critical mental health issues) has just won the Pulitzer Prize. But we are saddened, that Levy's exposé has not yet resulted in major changes for people with mental illnesses who live in adult homes or nursing homes.

We learn that the President is proposing Medicaid reform which would put millions of Americans with mental illnesses at risk, by allowing states to reduce eligibility and benefits to Medicaid recipients; which is predicted to increase homelessness, institutionalization and criminalization, which will result from more people being untreated for mental illnesses. And this, at a time when New York's mental health system takes additional steps to tie mental health services to Medicaid funding in order to fill skyrocketing budget gaps.

We are encouraged by the much fought-for *Medicaid buy-in* program, due to begin this summer, but wonder if it will be the answer to why 85% of people with mental illness do not hold jobs. Hopefully, with Medicaid buy-in more will want to return to work without the fear of losing their health coverage.

The compelling story of Timothy O'Clair and the parents whose courage to fight for our cause is *Timothy's Law Campaign* and may well be the story of the year. But alas, it's a happy and sad story again, indeed. The happy part is that our community is rallying with mo-



Ira Minot

mentum to reduce insurance discrimination against treating people with mental illness. The pitifully sad part is that a beautiful child named Timothy took his life while battling a mental illness, and that he was not afforded adequate insurance coverage that would have probably saved his life.

The stories are many and the problems deep, as we read about them in every issue of *Mental Health News*. From inadequate housing, to budgetary cut-backs, to battles over the right of people to receive proper medications when they may be the cutting edge they need to recover.

Yes, the currents of our times run in many directions and when you're caught in them, it may seem like we're swimmers caught in a deadly rip-tide. There has always been one constant at work throughout the history of the mental health community: *the people*. The people I refer to are those who care, support and fight for the rights of people with mental illness. This constant, is the life-preserver that wraps around us, giving us buoyancy and safety in difficult times.

We are not living in a perfect time or with a perfect mental health system or national agenda. But we have *our people*. People who represent our most precious organizations such as the ones who united to support Timothy's Law and the ad campaign in this issue of *Mental Health News*. They include:

Coalition of Voluntary Mental Health Agencies, Center for Urban Community Services, Association for Community Living, New York Presbyterian Hospital, New York State Psychiatric Association, Ellis Hospital, Law & Public Policy Consulting, Samaritans Suicide Prevention Center, Mental Health Association of Westchester, Mental Health Association of NYC, Mental Health Association in New York State, National Alliance for the Mentally Ill in New York State, Schuyler Center for Analysis and Advocacy, NASW - NYS Chapter, Mental Health News, and National Alliance for the Mentally Ill of New York City.

There are many, many more vital mental health organizations that represent the true spirit of our community in all parts of the nation. They are the fabric of our landscape. They are hard at work year in and year out to provide treatment, housing, employment, research and vital advocacy efforts on behalf of the system as a whole and on behalf of the individual consumer and their families.

Thanks to you, *Mental Health News* has become a vital forum for ideas and a catalyst for change. We are proud of our role and will continue to devote ourselves to represent the best that our community has to offer.

This current issue of *Mental Health News* is devoted to Employment; the one previous to this one was about housing—two vital issues that affect the daily lives of people with mental illness.

In upcoming issues, *Mental Health News* will again focus on more clinical topics, including: Understanding and Treating Adolescent Depression, The Crisis of Suicide in America, Eating Disorders: The Conflict Within, and Understanding and Treating Sleep Disorders.

Thank you for your continued readership, participation and support, which reaffirms our commitment to this vital educational mission.

Have A Great Summer!
Ira H. Minot

Your Letters to Mental Health News

Fix Our Mental Health System

I wish to thank Mental Health News for its efforts to present a balanced picture on Housing for persons disabled by mental illness. While a number of viewpoints were presented, I am not certain the real picture came across.

To stay in reasonable physical condition and also to practice what I preach to the folks with mental disability that I work with, I often take a long walk in the late evening. I walk downtown NYC on Broadway and return on Columbus Avenue. Almost every night on these cold winter evenings I pass folks who seem homeless. Some search in trash, appear poorly dressed for the weather, and some seem confused. I try to help when I can with a little cash or advice to get someplace warm.

Last week, I saw a man in his 30's lying on the street on 72nd Street. It was much below freezing, and his coat was open. Few of those rushing by seemed to notice him. We've gotten used to the homeless.

What happened on 72nd street is happening across our country. Most people do not care what happens to people with mental illness. Psychiatric hospitals are no solution. People should be free to be homeless.

The Governor has a plan. In five or ten years everything will be ok. The government is appropriating a few bucks to build more residences and shelters. In the meantime, the young chap on 72nd street will be dead. Dead of exposure,

as many of the homeless died this bitter winter

The President's Commission Interim Report is a fine document. It tells us that half of all persons in our great country with mental illness receive no treatment. The report states that one result of our fragmented system is that 30,000 persons with mental illness kill themselves each year and that these are preventable deaths.

And if you believe data collected by the US Dept of Justice, we learn that 300,000 persons with mental illness are now incarcerated in our jails and prisons—a number higher than the total number of incarcerated persons with mental illness in all the other countries in the world! Prior to 1956, we had only 6000 persons with mental illness incarcerated. The big jump in numbers in our jails came after 1980 when our president kept his pledge to "Get the government off the backs of the people" and closed our 700 Community Mental Health Centers.

Incarceration is risky for people with mental illness. Many leave incarceration with diseases like HIV, TB and hepatitis. To make matters worse, in most states they lose all Federal benefits like Medicaid and Medicare and must re-apply. Not only are folks with mental illness dying prematurely when they are homeless, even when domiciled in NYC (C. Levy, 2003) their

see Fix on page 10

Employing Consumers

Both my husband and I have hired a large number of employees over the years—he in his New York business, and I in my Connecticut based real estate complex. We have both had the experience of working successfully with employees who have psychiatric conditions.

People from all walks of life, education and social strata may become ill with some form of mental illness at some point in their life. All employers need to recognize that sooner or later, they are likely to encounter someone who has such a diagnosis and that eliminating them from the pool of likely candidates solely on this basis also means they are limiting the range of potential for finding employees who have the skills for becoming successful employees. As a practicing psychologist, and as someone who has encountered mental illness with a family member, I can say that I understand much about the fears and myths that employers may have in regard to working with people who have psychiatric conditions.

Employers may fear that such people will demonstrate emotional fragility or instability in work habits and work relationships. I know what I find necessary in hiring such an employee, and it is not very different than what an employer would look for in any employee. Of course, you are never guaranteed that a so-called "normal" employee won't show emotional fragility

or instability in work habits and work relationships.

On the other hand, if someone with a mental illness has had the benefit of training and preparation for working in competitive employment, he may be more reliable than someone who, because he was never diagnosed, didn't have that preparation. So, one thing I would check on is his background, just as you would for any other employee.

Secondly, I would want to know that he is taking care of himself medically; being open to understanding what the illness is and what the employee needs to maintain stability is likely to forestall any misunderstanding later—which makes me wonder how often employers show interest in the physical health of other employees. Being interested in the general health of your employees would go a long way, not only to having productive employees, but also to enhancing relationships with them if you are indicating you care about their health.

Thirdly, I would want to know what kind of support system the candidate has. Is there a caring family; does he/she have friendships and social relationships. Is there someone he can talk to when he is troubled. It is always a good idea that there be someone in the workplace he can talk to as well. Once again, how is this different from what any other employee needs?

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Let's Not Suffer in Silence

My car read the outside temperature as a cold 20 degrees. It was a late winter's day as I began my drive home from work. The sun was setting. The ducts of the car pumped out a steady stream of warm air over my skin. From the outside I looked like any other commuter. On the inside nothing could be farther from the truth.

In the last months, my mind had been held captive to an insidious depression that refused to go away. Everything looked bleak; nothing provided me with any relief. I didn't understand what had taken over. In fact, I had a lot to be happy about. My family loved me and was healthy. I was receiving some of the best medical treatment from a kind and very skilled doctor. He was desperately trying to find a medication that worked, one that would stop the pain and misery. Thoughts of harming myself had started to fly in and out of my mind again and had become more pronounced.

I knew that I should have been more forthcoming with my doctor. I thought I could handle the situation. I had handled almost everything else that life presented

until this mysterious illness arrived. I was wrong. My mind had taken a terribly wrong turn. I was feeling hopeless and lost. I resigned myself to the fact that this was how I was going to live the rest of my life.

That day I reached down to use my cell phone to check to see if I had any messages. I remember dreading that would only bring me more bad news. But I did it anyway, and I was right. Two more deals were starting to unravel. My hands began to shake. My mind began to race from one thought to another. I had to stop the pain.

Suffice it to say that later that evening, I came close to ending my life but stopped short through a miraculous intervention by somebody else. My behavior did land me in the hospital where I spent the next seven days.

My depression gradually lifted. Maybe I just felt relieved being in a safe place. Maybe the burden of my thoughts had lifted. Maybe it was simply the nature of my depression. It doesn't really matter.

see In Silence on page 19

"Peer Movement" Conundrum

When I first heard that there was a c/s/x (consumer/survivor/ex-patient) movement, I was eager to get involved and help promote what seemed like a good cause. Now I am having critical second thoughts.

In the late 1960's, when I personally experienced some difficulties trying to navigate the psychiatric system, there was nothing in the way of peer support or self-help groups for psychiatric patients. With societal stigma abound, I quickly learned to keep my situation private, which may be one reason I never knew about the peer movement that was growing around me. Once I did become aware, I learned as much as I could about self-help, peer support, consumer-run organizations and other c/s/x oriented groups and activities. I attended training in advocacy issues and went back to college to earn a degree in Community & Human Services to better serve this good cause.

Now, after several years of working in the field, the discouragement I used to feel in dealing with an impersonal mental health system, is more than out-

weighed by the frustrations I've encountered in dealing with my fellow c/s/x's in the peer movement and now call into question if our peer movement is honestly what it claims to be.

My observation is that our peer movement in NYS, isn't unified nor does it have clear and identifiable goals. Behind the scenes, it's everyone for themselves.

Some peers insist that the mental health system is completely wrong, period. Others think that any treatment is acceptable if a person chooses to participate. Some feel that medications are lifesavers, while a large contingent denounces psychotropic drugs and the manufacturers that promote them. Some stand up firmly against forced treatment, while others waver on this issue. These issues are just the tip of the iceberg.

Along with great disparity in the goals of c/s/x activists, there is an ever decreasing quantity of funds to maintain peer organizations, let alone to start new ones. The competition for available dollars is fierce, unrelenting and often

see Conundrum on page 10



Disturbing New Government Report: Parents Giving Up Custody of Children to Provide Them With Mental Health Services

Thousands are placed in child welfare, juvenile justice systems to obtain needed services

The Bazelon Center for Mental Health Law

Washington, DC April 21, 2003—Thousands of families have been forced to choose between obtaining needed mental health services and relinquishing custody of their children with mental or emotional disorders, according to a new government study scheduled to be released today.

The US General Accounting Office (GAO), Congress' investigative arm, documented at least 12,700 cases in fiscal year 2001 of children placed in child welfare and juvenile justice systems so they could access needed mental health services.

"Custody relinquishment is absolutely devastating to families," said Laurel Stine, director of federal relations at the Bazelon Center for Mental Health Law, a national non-profit organization that has worked for three years to end the dilemma that faces many parents who lack access to mental health services for their children. "Children with mental health needs face the added stress of being displaced and feeling abandoned. Meanwhile, parents have to give up their say about key aspects of their children's lives, like where or whether they go to church and how late they can stay up at night."

Custody relinquishment may be even more prevalent than the GAO's study suggests. Data on the practice are not generally tracked and officials in 32 states—including the five with the highest child populations—did not respond to the agency's request for data on custody relinquishment.

"This may be the tip of a much larger iceberg," said Stine. "Families across America are being ripped apart because

they can't find the help their children with mental and emotional disorders need."

Approximately 3,700 children were placed in child welfare systems, according to the report. The GAO estimated that another 9,000 were "placed" in the juvenile justice system by police who had detained children—sometimes at parents' request—for delinquent behaviors that stemmed from or were related to their mental or emotional disorders.

The GAO identified several factors that influence parents' decisions to relinquish custody:

- Gaps in and limits on mental health coverage—Some mental illnesses are not covered and families often face limits on the intensity or duration of care that private insurers will pay for. Medicaid, the main public funder of child mental health services, covers a limited number of children who could benefit from mental health services. Both public systems and private insurers often fail to cover the intensive community-based services that could reduce the need for more expensive residential treatment.

- Limited child mental health resources—Parents may be encouraged to take drastic measures to make their children a priority for scarce mental health resources.

- Lack of coordination—Eligibility requirements for services often differ from agency to agency, making it difficult for children to obtain coordinated care. According to the GAO, some service providers and officials have also "misunderstood the role of their own and other agencies" and have given parents incomplete or inaccurate information, creating service gaps for children with mental health needs.

Thirteen states—Colorado, Connecticut, Idaho, Indiana, Iowa, Maine, Massachusetts, Minnesota, North Dakota, Oregon, Rhode Island, Vermont and Wisconsin—have passed laws that prohibit child welfare from requiring custody relinquishment in order for parents to obtain mental health care for their children. But such laws do nothing to improve access.

"Just banning the practice closes one door to services without opening another," said Stine. "States certainly must act, but a more coordinated effort with the federal government is needed."

Many barriers to accessing care can be removed at the federal level, according to the Bazelon Center. The group also believes that more can be done to give states and communities the incentive to develop and implement the kinds of services that can keep children out of crisis and with their families.

"In the private sector, families need parity in insurance coverage for mental health services, so children aren't denied access to needed services because of stigma and discrimination," continued Stine. "In the public sector, states and the federal government need to expand Medicaid eligibility to cover more children."

The Family Opportunity Act, which has been reintroduced in Congress again this year, would reduce the need for custody relinquishment by expanding access to Medicaid-financed mental health services for more children. Despite broad bipartisan support for the bill, Congress adjourned last year without passing the bill.

"The congressional logjam shouldn't stymie efforts to enact legislation to deal with this problem," said Stine. "Custody relinquishment is not a partisan issue."

Senator Susan Collins (R-ME) and Representatives Patrick Kennedy (D-RI) and Pete Stark (D-CA) requested the GAO report. In response to the GAO's findings, the lawmakers plan to introduce a proposal to improve state systems of care for children with mental or emotional disorders.

"Families have faced the terrible choice between retaining custody and obtaining needed mental health services for far too long," said Stine. "Congress can and should act this year to end this horrible practice."

The Bazelon Center for Mental Health Law is the nation's leading advocate for the rights of children and adults with mental disabilities. The Bazelon Center authored *Relinquishing Custody: The Tragic Result of Failure to Meet Children's Mental Health Needs*.

NYAPRS Note

This Bazelon report gives powerful testimony as to why New York must approve Timothy's Law this session.

Having such legislation on the books would have saved Timothy O'Clair's parents from having to surrender his custody to get him the mental health care he needed and, ultimately, couldn't get enough of in time to prevent his tragic loss.

Without passage of decent mental health parity legislation, too many more such tragedies will follow, both in New York and nationally. (see pages 28 & 29)

Levy Awarded Pulitzer for Adult Home Exposé

NYAPRS E-News

Heartfelt congratulations to Cliff Levy for his much deserved acknowledgment by the Pulitzer Board of his outstanding coverage of New York's adult home crisis.

Levy was granted the award for a distinguished example of investigative reporting by an individual or team, presented as a single article or series. His vivid, brilliantly written series, "Broken Homes," that ex-

posed the abuse of mentally ill adults in state-regulated homes prompted the award.

Clifford J. Levy became a special projects reporter on the metropolitan desk of The New York Times in 2000. He previously served as chief of the Albany bureau of The Times and as a political reporter, City Hall correspondent and Newark correspondent.

He joined The Times in 1990 as a news assistant and was promoted to reporter in 1992.



Clifford J. Levy

Before coming to The Times, Levy was a reporter for the New York bureau of United Press International for a year.

Born in New Rochelle, N.Y., Levy graduated from Princeton University in 1989 with a degree in public policy and international affairs.

Mr. Levy received the 1998 George Polk Award for local reporting for his articles in The Times on the campaign finance practices of prominent state officials in New York.



Medicaid Reform Proposal Threatens Public Mental Health

Bazelon Center for Mental Health Law

The Bazelon Center for Mental Health Law today condemned President Bush's Medicaid reform proposal as a threat to the public's access to needed mental health services. The statement below was released at a recent national news conference on the proposal held in Washington, DC.

Statement of Laurel Stine, Director of Federal Relations at the Bazelon Center for Mental Health Law

We are troubled by the crisis facing state Medicaid programs across the country but have grave concerns about the Administration's proposed policy to drastically change the program.

It not only states they are feeling the pinch but also the nation's poor, many of whom rely on Medicaid to access needed mental health services. The President's proposal would put at great risk the safety net that millions of Americans with mental illnesses count on—a pro-

tection that is all the more important in these hard economic times.

Currently, Medicaid pays for about half of all community mental health care furnished through state public mental health systems. By allowing states to reduce eligibility and benefits to Medicaid recipients, the Administration's proposal risks the increased homelessness, institutionalization and criminalization that can result from untreated mental illnesses.

Significant reductions in Medicaid-funded services would prove disastrous for people prioritized by public mental health systems—low-income Americans with the most serious mental disorders, like schizophrenia, manic depression, depression, attention deficit disorder and autism. Such cuts would exacerbate the current crisis in public mental health systems by reducing systems' capacity to serve some of America's most vulnerable populations.

Adults and children with mental disabilities would be hit particularly hard if states opt for the Administration's proposed reductions in benefits for people



Laurel Stine

covered under Medicaid's optional eligibility categories.

Included in this group are children from families whose incomes are just over the poverty line but who are either

uninsured or have insurance that has extremely limited mental health coverage. Children with severe mental disorders, a group that represents 7-11 percent of all children in the country, according to the Surgeon General—must have access to in-home services, day treatment and other intensive community services not covered by private insurance, as well as to medications and therapy.

Across the country, children's mental health needs are often left unmet. The Administration's proposal would exacerbate the problem by further reducing coverage of services for children with mental disabilities.

Adults who have high medical costs can also be covered under Medicaid's optional eligibility criteria. Inclusion in this category allows Medicaid to cover services for people with schizophrenia whose incomes are too high to otherwise be Medicaid-eligible but who would be unable to afford essential mental health care they need to continue their lives in the community.

see Medicaid Reform on page 19

House Legislation Protects SSI and SSDI

NAMI E-News

On April 2, the House of Representatives passed the Social Security Protection Act, H.R. 743, by a vote of 396 to 28. This bipartisan bill would make important improvements in the representative payee program for beneficiaries of the Supplemental Security Income (SSI) program and the Title II (SSDI) disability programs. It would also require the Social Security Administration to issue written receipts and establish a centralized computer file for beneficiaries reports of earnings or changes in work status.

NAMI strongly supports this legislation as an important step to restore integrity of the Representative Payee program and to protect the interests of SSI and SSDI beneficiaries with severe mental illnesses who receive their cash benefits through rep payees. This legislation grew out of several high profile cases in which institutional representative payees were found to have illegally diverted cash benefits from SSI recipients. In these cases, beneficiaries were prevented from recovering back benefits that were they never received.

This is the third time the House has passed this legislation since 2000. Each time, the legislation has stalled in the Senate, or been derailed by extraneous provisions. NAMI also strongly supports the provisions in HR 743 that would

require Social Security to establish a system to issue written receipts for earnings reports submitted by SSDI beneficiaries and a computerized system for tracking earnings.

Over the years, SSDI beneficiaries have grown enormously frustrated in their efforts to accurately assess whether earnings from part-time work in a given month exceed the Substantial Gainful Activity (SGA) limit.

Because Social Security is way behind in tracking earnings, beneficiaries can, through no fault of their own, go above limits in the program and be forced to pay back overpayments of benefits. Issuance of receipts from Social Security for submitted earnings reports will help provide a more accurate written record of earnings and help beneficiaries track their earnings. Likewise, a computerized tracking system at Social Security will help SSDI beneficiaries track earnings and use of "trial work period" months.

Background on HR 743

Approximately 8 million SSI and SSDI beneficiaries have representative payees, often family members or friends, who receive the benefits on behalf of the beneficiaries and have a responsibility to manage the benefits on behalf of these beneficiaries. HR 743 includes provisions to strengthen SSA's ability to address abuses by representative payees. The provisions would:

- Require non-governmental fee-for-services organizational representative payees to be bonded and licensed under state or local law.

- Provide that when an organization has been found to misuse an individual's benefits, the organization would not qualify for the fee.

- Allow SSA to re-issue benefits to beneficiaries whose funds had been misused.

- Allow SSA to treat misused benefits as "overpayments" to the representative payee or thereby triggering SSA's authority to recover the money through tax refund offsets, referral to collection agencies, notifying credit bureaus, and offset of any future federal benefits/payments.

- Require monitoring of representative payees, including monitoring of organizations over a certain size and government agencies serving as representative payees.

- Require representative payees who are delinquent in filing annual accounting reports to receive the individual's benefits in person at a local office.

- Disqualify as representative payees people convicted of offenses and imprisoned more than a year, and people fleeing prosecution, custody, or confinement for a felony.

HR 743 would also make improvements to the attorney fee payment system to help individuals with disabilities

gain access to representation by:

- Extending the voluntary attorneys fee payment system to SSI claims.

- Imposing a \$75 cap (indexed for inflation) on the current 6.3% assessment on approved attorney fees for Social Security and SSI claimants.

The legislation would also further protect Social Security programs and individuals by:

- Requiring the Social Security Administration (SSA) to help people avoid overpayments by issuing receipts to beneficiaries who report changes in earnings or work status and by implementing a centralized computer file to maintain records of beneficiaries reports.

- Clarifying civil monetary penalty authority so that sanctions may be imposed against people who withhold material facts in order to obtain or increase benefits.

- Denying Social Security benefits to people fleeing prosecution, custody, or confinement for a felony, as well as probation/parole violators.

- Requiring the Commissioner to publish regulations that allow a waiver, where good cause exists, of the non-payment of benefits to fugitive felons and those in violation of parole or probation.

- Requiring individuals who provide Social Security-related services for a fee

see House Legislation on page 19

The New York State Office of Mental Health Working to Increase Supported Employment Opportunities

By James L. Stone, Commissioner
NYS Office of Mental Health



James L. Stone

For most people, having an interesting and challenging job is central to a meaningful and fulfilling life. For individuals with mental illness, however, access to employment has historically been very limited. Employment is ranked number one among goals expressed by consumers, yet only one out of five individuals with serious mental illness who want to work are actually employed.

I am pleased to say that times are changing. Supported employment provides opportunities for people with severe mental illness to work in competitive, real-world settings by offering on-site and as-needed support services which are designed to help individuals perform their jobs. We know that with

rapid job placement and ongoing supports, we can achieve employment rates up to 40 percent. We also expect that the new Medicaid buy-in initiative will enable more individuals to enter the workforce by giving them the opportunity to purchase needed health insurance coverage at affordable rates.

Supported employment not only gives people a chance to exercise their choices for different job roles and settings, but it also gives them the chance to experience a real-world work environment. Supports can include job coaches, specialized job training, and help with managing symptoms in the job setting. Another important feature of supported employment is equitable compensation: wages and benefits are the same as other workers in similar jobs.

A large body of evidence has found that supported employment produces a number of positive outcomes. Studies have shown that providing individualized support services in competitive employment settings can help achieve job retention, improvements in quality of life and self-sufficiency, and lessen dependence on entitlements. Competitive employment has also been found to reduce the stigma associated with mental illness.

Supported employment is an established evidence-based practice, and is one part of OMH's quality campaign to improve outcomes for and promote the recovery of individuals with mental illness. OMH has undertaken a number of initiatives designed to increase supported employment opportunities.

We are working to raise awareness through collaborations with local governments on targeted employment initiatives. Local innovative programs have led to positive outcomes for more than

3,000 individuals, and have achieved wages and hours that are superior to those found in national studies.

We have developed the Work Exchange, a technical assistance center for supported employment established under the auspices of the New York Coalition of Voluntary Mental Health Agencies, Inc. Available to more than 100 agencies across the State, the Work Exchange is a program that operates a web-based employment information and referral database designed to facilitate the integration of clinical and employment services. It provides technical assistance to providers wishing to incorporate the best practices in this area into their existing programs, and also offers formal staff development opportunities using the nation's premier authorities on supported work and other work issues.

OMH is implementing Assertive Community Treatment (ACT) across the state, with the teams serving as a platform for the delivery of evidence-based practices - including supported employment. ACT teams include an employment specialist, and training for ACT teams which focuses on supported employment is also currently underway.

OMH has recently completed and is evaluating a demonstration project which used performance-based contracting for supported employment services. Part of an award-winning national project to create results-based financing, this program uses the principles and practices of the evidence base in supported employment. Providers are compensated for achieving specific, progressive milestones in the employment placement process, and the further the client gets toward achieving his or her placement goal, the more money the provider receives. It's an entirely out-

comes-based system of payment and so far it is producing some really impressive results. We hope to incorporate some the findings from this project into future employment programs.

We have also strengthened our collaborative efforts with Vocational and Educational Services for Individuals with Disabilities (VESID), and together we are supporting providers and sharing our outcome data.

One of our joint projects is the New York State Interagency Supported Employment Reports (NYISER). OMH and VESID, as well as the Office of Mental Retardation and Developmental Disabilities and the Commission for the Blind and Visually Handicapped, are gathering detailed feedback and employment information through these reports.

Approximately three-quarters of OMH's vocational providers are now completing and submitting the NYISER forms, which provide us with data on client outcomes such as the numbers of individuals who are working, where they are employed, how much money they are earning, and their length of time on the job. This information is helping planners at all involved agencies to identify areas in need of improvement. It is my goal for all OMH providers to be on board by the end of calendar 2003.

In summary, it is OMH's goal to help individuals get the jobs they want, in a reasonably short period of time, and then to provide the supports needed to help them succeed in their chosen workplace. I look forward to working with provider agencies, other State agencies, recipients and other stakeholders to make that goal a reality for all.

Work Programs in Westchester DCMH Helps You Get To Know What's Out There

Staff Writer
Mental Health News

The Commissioner of the Westchester County Department of Community Mental Health, Jennifer Schaffer, Ph.D., recently addressed the Mental Hygiene Area Councils in the County. In her introduction she informed the councils that she is committed to providing a system of care in this county that supports the recovery of all individuals who have mental illness. One important aspect of the recovery process is work. County Executive Andy Spano said, "Work has been such an integral part of my life that I know how important it's been in contributing towards my feeling of self-fulfillment and personal integrity." Westchester County therefore will continue to provide supports to many work efforts to

help individuals to achieve their personal goals.

Currently, the County receives a little over two million dollars specifically for vocational programs from the New York State Office of Mental Health. These funds are distributed to various hospitals and agencies to provide the financial support for their vocational programs. The Guidance Center, New York Presbyterian, and St. Vincent's provide IPRT's. These programs provide initial training in managing life issues and also help consumers begin to discover their vocational interests. Careers, the Guidance Center, Human Development Services, Jawonio, the Mental Health Association, and Search for Change provide assisted competitive employment, which allows individuals to have job coaches and other supports onsite as they begin employment. The Volunteer Center of the United Way provides internships, which allows

individuals the opportunity to explore new careers while being supported. And the internship simultaneously helps to fill in gaps on resumes prior to applying for competitive employment positions. Human Development Services and The Guidance Center also have funds available to help individuals with educational goals they may wish to pursue.

The office of Vocational and Educational Services for Individuals with Disabilities, VESID, is a completely separate funding source but offers individuals with mental illness many resources for vocational assessment, training, and job placement as well. Some individuals prefer to stay with the agencies they are more familiar with in the mental health system such as the programs listed above while others pursue these goals with VESID. Each individual can make a choice as to which program will meet his or her needs the best.

If you or anyone you may know is interested in returning to work or has interest in beginning to work on job skills, they should discuss this interest with their treatment provider, case manager, primary therapist or contact a drop in center.

Since there is no one central point of intake for work opportunities in the County, you must explore the various options out there with your treatment provider. Once you begin to become familiar with the different agencies and the different programs offered you will better be able to decide where you would like to start based on your own goals and needs.

Sue Erway, M.P.A. Program Director, Westchester County Department of Community Mental Health, is also available to assist if you have questions regarding the current system or if you need help accessing a program. She can be reached at 914-995-6073.

Conundrum from page 6

brings out the worst agendas within the peer movement. Alliances and factions work to thwart the plans, sometime the very existence, of groups whose goals they disagree with. Maneuvering and back room discussions are the politics which can pull funding from one peer-run program only to show up later as the funding source for a competitive peer program. Radical or anti-system viewpoints are snubbed and dismissed as irrelevant by other peer leaders who disagree with them, along with unprofessional ethics that further marginalize those individuals deemed as problematic.

It has been my observation that a number of peer leaders at the top of the peer movement have employed various means to disparage or even shut out rival or rising leaders. Their agenda is not inclusive and is highly sensitive to any dissent.

Ironically, in a movement meant to embrace other peers, a veil of stigma exists within the peer community itself, exhibited in the movements tendency to relegate "lower functioning," mental health consumers to the sidelines—while the political savvy, better posi-

tioned stars run the show. In many ways the "peer" label will always keep c/s/x's separate and seated at the kids table.

Thankfully, the NYS Office of Mental Health supports self-help and peer support as important components in recovery, and many professionals do respect the concept, especially those who have a person-centered orientation. However, there are many who look upon the "peer movement" as an amusing exercise in letting the inmates feel like they're running the asylum.

After several years working with peer activists all over the state, I can understand that viewpoint, but I am not at all amused. With respect to the hundreds of well meaning men and women who are trying to address life-affecting problems for consumers of mental health services such as forced treatment, therapeutic choices, fair accommodations and so on, I have serious questions about the effectiveness and the very purpose of this so-called peer movement. What I've witnessed among the peer leadership are far too many people trying to hold on to positions of power and far too few who know what it means to truly serve and to help empower other people.

Gene Ira Katz

Fix from page 6

average life expectancy is 58 years. Why so few years? Life expectancy like infant mortality is one of our best measures of the quality of health care.

It is time we required facilities which provide housing for persons with mental illness to make public resident life expectancy data.

Almost half of persons with mental illness have co-occurring disorders. Sure, substance abuse but also hepatitis, obesity and diabetes. Sernyak and Rosenheck (April, American Journal of Psychiatry, 2002) studied 38,000 veterans with a diagnosis of schizophrenia and found that many had diabetes. Some 24% of those being treated with the newer antipsychotic medication also had a diagnosis of diabetes. Diabe-

tes is a tough disease to cope with and is a major cause of blindness.

The President's Commission Interim Report needs to be read. There are bright spots. We have many fine professionals and advocates working in our field. We have many fine facilities working hard to provide a decent level of treatment care and rehabilitation.

But despite the bright spots, we should not delude ourselves. The report is a wake-up call. If you want to understand something about the quality of care provided, simply examine life expectancy for persons with mental illness.

America needs to catch up and fix our health and mental health care system.

Martin Gittelman, Editor,
International Journal of Mental Health

New York-Presbyterian Psychiatry Opens Premier Inpatient Services

Staff Writer
Mental Health News

Building on its long tradition of providing the finest psychiatric care to the community, New York-Presbyterian Psychiatry has established two inpatient services for patients desiring a level of individual amenities, comfort, and privacy beyond that available in the typical hospital setting.

The Haven at Westchester, located on the serene wooded grounds of the Westchester Division of New York Presbyterian Hospital, and the Columbia Neuropsychiatry Service on the luxurious McKeen Pavilion at Columbia Presbyterian Medical Center of New York-Presbyterian Hospital, offer outstanding evaluation and treatment for adults seeking discreet care for psychiatric disorders, including dual diagnosis. Each program ensures accessibility to the full spectrum of expert psychiatric and medical subspecialties available at New York-Presbyterian Hospital.

The Haven at Westchester

The Haven at Westchester offers a premier secure inpatient facility for adults 18 years of age and older in need of psychiatric treatment for all major diagnostic categories, including affective, psychotic, dual diagnosis and personality disorders. Program goals include the rapid stabilization of acute symptoms, identification of stressors that interfere with optimal functioning at home and in the workplace, and creation of an effective aftercare plan for the patient.

A multidisciplinary team providing intensive psychotherapy and pharmacological treatment is led by Raj Velamoor, MD, BS, Unit Chief of the Haven and Assistant Professor at the Weill Medical College of Cornell University. George Alexopoulos, Professor of Psychiatry and Director of the Weill Cornell Institute of Geriatric Psychiatry, is the Unit Director. Weill Cornell faculty with international reputations for expertise in a wide array of psychiatric subspecialties provide consultations to patients at The Haven.

Patients are treated in a deluxe setting that includes concierge services and a variety of amenities tailored to individual needs. The Haven at Westchester occupies an elegant space, re-designed and newly furnished, with

private bedrooms and baths for the comfort of patients.

**The Columbia
Neuropsychiatry Service**

The Columbia Neuropsychiatry Service can be especially helpful for individuals whose illnesses have been refractory to standard treatments, or who pose diagnostic dilemmas requiring the expertise of a tertiary care medical center. Each patient receives individualized attention from world-renowned faculty, who consult in diagnosis and provide psychopharmacology and psychotherapeutic approaches as appropriate. Experts in internal medicine, neurology, radiology and all other clinical specialties are available as needed. Jeffrey Pines, MD and Carolyn Douglas, MD co-direct the program and personally care for every patient. Both are Associate Clinical Professors of Psychiatry at Columbia University College of Physicians & Surgeons.

All patients at the Neuropsychiatry Service receive a thorough, structured diagnostic and cognitive assessment by a neuropsychologist, and, where appropriate, a substance abuse assessment by a clinical psychologist with expertise in addiction treatment. Treatments include intensive psychotherapy using individual, group, family and cognitive modalities. Substance abuse detoxification, treatment and referral for aftercare rehabilitation are provided for patients requiring these services.

The Columbia Neuropsychiatry Service offers two treatment settings. Selection of the appropriate setting depends upon the patient's clinical suitability for an open or a locked unit. The least restrictive environment is always preferred. Patients may be admitted to either the open, medical surgical unit on the McKeen Pavilion or to the newly renovated locked Garden Unit on the same floor of the Milstein Hospital Building. Some patients admitted to the Garden Unit for reasons of clinical necessity may transfer to the McKeen Pavilion as their conditions stabilize.

Further information on these two programs is available on the web at www.nypppsychiatry.org. For additional questions or to make a referral, please call The Haven at Westchester at (888) 694-5700, or The Columbia Neuropsychiatry Service at (212) 305-2599.

Mental Health Association of Rockland County



"Working For The Community's Mental Health"

845-639-7400

20 Squadron Boulevard . New City . NY
visit us at: www.mhrockland.org

New York-Presbyterian Psychiatry



New York Weill Cornell Medical Center



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The Westchester Division

Columbia Weill Cornell Psychiatry of New York-Presbyterian Hospital provides a full continuum of expert diagnosis and treatment services for adults, adolescents and children with psychiatric, behavioral and emotional problems.

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

The psychiatric services of New York-Presbyterian Hospital are ranked among the nation's best by *U.S. News & World Report*®.

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

Columbia Psychiatry (212) 305-6001

Weill Cornell Psychiatry (888) 694-5700

www.nyppsy psychiatry.org

New York-Presbyterian
The University Hospitals of Columbia and Cornell

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Local Businesses Hire Employees With Disabilities

Staff Writer
Mental Health News

Several area businesses, in Westchester, have learned the value of hiring dependable, part-time employees while keeping the lid on expenses. They hire people with disabilities to get the job done.

For the Guidance Center, a leading mental health provider in Westchester County, Zanaro's Restaurant, Weber Studios, and Stop and Shop seek out clients of The Guidance Center's Vocational Services Program.

When Zanaro's restaurant was opening in New Roc City, New Rochelle this past April, Ed Lachterman, executive general manager, called the Job Placement and Retention Program at The Guidance Center. Job developer Waliyyah Salaam-Hussain and job coach Lori Jarhoud-Saleh helped him find four employees to provide cleaning and maintenance services and package leftover food for his customers.

"These employees want to work, and they work very hard," said Mr. Lachterman. "They take pride in their work and make sure that they arrive on time. One of them even leaves his home at 5:15 in the morning to arrive here by 7:45 and begin his day. They are good people."

The Guidance Center's Supported Employment Job Placement and Retention Program helps individuals with disabilities to negotiate the road to competitive employment. Services include coaching on resume preparation and interview skills, job placement, and follow-along job coaching.

Judith Weber, owner of Weber Studios, a ceramics studio in New Rochelle, is not new to hiring people with disabilities. She hired a Guidance Center client five years ago who has been working for her ever since. Recently, she hired two more employees through the program.

"The job coach really understands my employment needs," remarked Ms. Weber. "To me, hiring employees through The Guidance Center's vocational program is an affordable way to get part-time help on a flexible schedule. It also gives someone with a disability the opportunity to work and grow into a job."

Guidance Center vocational services clients are also employed by a number of Stop and Shop supermarkets including the stores in New Roc City and Palmer Avenue in New Rochelle, Westchester Avenue in White

Plains and Weaver Street in Mamaroneck. Stop and Shop encourages its store managers to hire from within the community as a way of providing jobs for local residents and maintaining a positive public image. Guidance Center clients experience the same application and interview process as do all other job applicants and have been hired to fill a number of positions at the stores.

"Hiring employees who have disabilities is a new experience for me because the supermarket chain I previously worked at did not have the same policy about hiring people with disabilities as Stop and Shop," said Antoine Gomes, manager of the Stop and Shop store in new Roc City. "But I have five employees who came from The Guidance Center program and I can't even tell they have a disability. Lori is very caring and comes in regularly to check on the workers and it's working out very well for the store."

Chris McGovern, manager of the Weaver Street Stop and Shop in Mamaroneck, is satisfied not only with the job performance of his three Guidance Center hires but also noted the cost benefits that the store has realized by hiring these individuals.

"The turnover rate of these associates is much lower than that of the average employee," he said. "From a business standpoint we save money on the cost of rehiring and retraining associates, which is a plus for the store."

That thought was echoed by Greg Feerick, customer service manager at the Westchester Avenue Stop and Shop in White Plains where three other Guidance Center clients work. He also praised the productivity of the workers. "We're getting good people who show up each and every day for work," said Mr. Feerick. "And they give one-hundred percent to the job."

The Guidance Center, Inc. is one of Westchester's leading health and human services agencies. For six decades, residents of Westchester have turned to The Guidance Center for assistance in dealing with daily life stresses related to early childhood development, academic/work performance, antisocial behaviors, domestic violence, depression, substance abuse, crisis intervention and other mental health issues. The center serves the community from 14 locations in Westchester County including Mount Vernon, New Rochelle, Mamaroneck, Port Chester, Purchase, and Mount Kisco.



Pictured from left to right: Front Row: Ed Lachterman, Executive General Manager; Edward Prieto, Kitchen Manager. Back Row: John Amicucci, vocational program participant; Joseph Ruggiero, Restaurant Supervisor; Nana Yao, Assistant General Manager; Isaac Gannie, vocational program participant; Yoshi Hirata, vocational program participant and Lerian T. Maxwell III, vocational program participant.

The Guidance Center Offers Unique Vocational Training Opportunity

ARTWORKS is a socially-responsible retail store located in Mamaroneck, managed and staffed by adults with special needs, selling fine crafts and art by people with special needs.

ARTWORKS is currently seeking individuals with disabilities interested in obtaining vocational training in graphic arts, computerized design, and sales and management skills, as well as artists with special needs who wish to sell their art and crafts on consignment.

Contact Cristina Boardman for details.

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The Guidance Center is a health and human services organization that provides services to individuals with disabilities. Artworks is a Guidance Center vocational program.



NAMI Corner

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

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



J. David Seay, J.D.

One of the themes of this issue of *Mental Health News* is employment for persons with mental illness. NAMI-New York State has long championed employment training and supported employment programs for our loved ones and others who suffer from a mental illness. Work can be a powerful therapeutic component for a person's treatment for and recovery from mental illness, especially given the newer medications that allow persons with mental illness to function as a contributing members of their communities.

Yet 85% of persons with mental illness do not hold jobs. However, with training and supported employment, many more can work and be the productive members of society they want to be. The new "Medicaid buy-in," which was to have gone into effect in April and is now delayed until the summer, should allow such persons to be able to work without losing their health coverage. This year, NAMI-New York State has called for an additional 1,500 supported employment slots in the budget, at an additional estimated cost of only \$3.4 million.

Other issues of immediate concern to NAMI-New York State include restoration of the proposed cuts to the Office of Mental Health's research budget. These cuts – nearly 23% of the total research budget – would result in the closing of the world-renowned Nathan Kline Institute for Psychiatric Research in Rockland County and very serious damage to the Psychiatric Institute in Manhattan. Research is indeed

our hope for the future and we believe that the state's budget should not be balanced by selling off our future.

Also of major continuing concern to NAMI and its members is the availability of housing for persons with a serious mental illness. We applaud the Office of Mental Health and the Department of Health for providing additional funds in this year's budget proposal to help fix the adult home problem by making more housing and other vital services available. We also salute OMH for proposing a budget that has virtually no cuts in basic community programs and services – no small feat in a year with a projected budget deficit of nearly \$12 Billion. But the problem with the need for housing is so large that many good deeds are still not sufficient to make safe, adequate and affordable housing with support services available to all New Yorkers who need them.

NAMI-NYS also is fighting hard to secure passage of "Timothy's Law," which would provide for mental health parity by requiring insurance companies, HMOs and other health plans to cover mental illness the same as other illnesses. The bill is named after young Timothy O'Clair of Schenectady, New York, who tragically committed suicide two years ago at the age of 12 after his parents' limited mental health insurance benefits ran out. We are pleased that Senator Thomas W. Libous has introduced Timothy's Law in the New York State Senate with no less than 31 other majority members as co-sponsors, and that Assemblymen Tonko, Rivera and others will be doing the same in the Assembly. We are particularly grateful for and wish to publicly thank Senator Libous and his co-sponsors for their support of this much-needed and long overdue legislation. NAMI has been fighting for such a law for at least fifteen years and we are hopeful that 2003 may be the year for parity and for Timothy's Law.

We are also calling for serious, fair and balanced long-term planning for mental health housing and services in New York State. We want to support and work with OMH in this year's planning process, as required by section 5.07 of the Mental Hygiene Law, to make sure that needs are properly assessed, existing system capacity is evaluated and a real long-term, rational plan is hammered out that seeks to meet unmet needs in an effective and efficient manner. NAMI-NYS opposes four bills that have been introduced in the Assembly that would have the effect of blocking access to electro-

convulsive therapy (ECT) for those few people for whom there is no other effective treatment. As refined and administered today, ECT bears little resemblance to the electric shock treatments of 20 or even 10 years ago, and are endorsed by all credible scientific organizations as safe and effective including the state and national psychiatric associations, medical associations, US Surgeon General and the National Institute of Mental Health. At the same time we fully support the safeguards to patient rights in existing law, and concur with the New York State Commission on Quality of Care for the Mentally Disabled and its recent study of ECT in New York that found safeguards to be adequate and that the procedure is not being abused, misused or over-used. We feel that medicine should be practiced by doctors and not the legislature.

NAMI-New York State's 2003 Annual Meeting and Educational Conference will be held September 19-21, 2003, at the Four Points Sheraton Rochester Hotel in Rochester, New York. As NAMI-NYS finally grows up and turns 21, we will have a stellar cast of speakers, workshops, networking opportunities and other events. The Keynote Speaker will be Dr. Michael F. Hogan, Chairman of the President's New Freedom Commission on Mental Health. OMH Commissioner James L. Stone will also speak, as will researchers and clinicians from the University of Rochester and elsewhere. Rochester is especially beautiful that time of year and we encourage early registration to what will be a sell-out conference. A brochure will be going out soon and interested people can call us at (800) 950-FACT toll-free in New York or at (518) 462-2000 to request a brochure or for more information.

The national NAMI convention will be held in Minneapolis this year from June 28 through July 1st. With a theme of "Partnerships for Recovery: Confronting the Mental Health Crisis in our Communities," this ever-expanding national event also is not to be missed. More information about it can be found at the NAMI website www.nami.org.

On February 10th NAMI-NYS held an Affiliate Leaders' Day which featured hands-on infrastructure-building workshops on such topics as legal issues, including incorporation and related matters, local fund raising, effective communications and outreach and working better with the county mental health systems. More than 70 NAMI leaders from around the state attended

what is intended to be the first in a series of such workshops to support our 58 affiliates around the state.

The next day, on February 11, 2003, NAMI-NYS held its annual Legislative Breakfast and Conference in the Legislative Office Building in Albany. Addressing a crowd of well over 200 NAMI members and friends from across New York were NYS Comptroller Alan Hevesi, Assemblymen Peter Rivera, Richard Gottfried, Jeffrion Aubry and Harvey Weisenberg and Senators Thomas W. Libous, Velmanette Montgomery and James Brennan. Also speaking were Office of Mental Health Commissioner James L. Stone, Andrew Sperling of National NAMI, NAMI-NYS Board President Michael Silverberg and members of the NAMI-NYS Government Affairs Committee.

In all of these efforts, NAMI-New York State continues to press its mission of *support, education and advocacy* for all New Yorkers with mental illness and their families.

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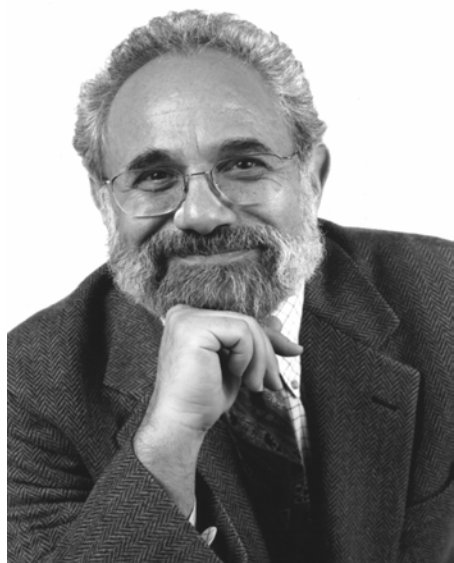
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POINT OF VIEW

By Michael B. Friedman, CSW



Michael B. Friedman

Don't Restrict Access to Psychiatric Medications

Psychiatric medications are not the only critical component of recovery from serious mental illnesses or serious emotional disturbances, and for some people they are not a critical element at all; but, for most people with severe and prolonged mental health illnesses, they are certainly one of the three or four necessary conditions for living a satisfying life in the community. Sadly, access to psychiatric medications for people who rely on Medicaid is now under attack in several states around the country, including New

York State. Sadly, too, the attack on access to medications has not risen to the top of the agendas of many mental health advocates. Of course, we have many fires to fight so as to be able to continue to provide people with the mental health services they need to lead decent lives in the community. But isn't it obvious that if the people for whom we are fighting do not get access to the medications that work for them, little else we do will matter very much?

It is easy enough to understand why state governments, which are experiencing rapid growth of Medicaid expenditures, want to limit access to medications. The cost of pharmaceuticals (although a relatively small proportion of overall Medicaid spending) is the fastest growing element of Medicaid cost. By creating "preferred drug lists" which favor the use of one or two drugs from the same drug class, they are able to negotiate volume discounts and other financial benefits, thus reducing the overall cost of drugs.

It is important, of course, to find ways to reduce spending in these economically trying times—so long as it can be done without depriving people of the services that are critical to their well-being. The question is whether drug costs can be reduced without depriving people of access to the medications they need.

It seems clear to me that the creation of a preferred drug list which restricts access to certain medications prescribed by a physician invites disaster—even if a procedure is created to appeal and to get exceptions made.

Appeals processes are often difficult,

arbitrary, and time-consuming—designed in fact to discourage appeals even when they are medically appropriate. People on Medicaid should be able to get the medications their physicians believe are most appropriate without running a bureaucratic obstacle course. It makes no sense to require a physician to prescribe a medication he or she believes will be ineffective just because it is on a state's preferred list. A physician's judgment about what is likely to be the most effective drug should be questioned only if there is good reason to believe that the physician is making an error in medical judgment. In such a case it should be up to the state to appeal to the physician to use a more appropriate drug rather than to force a physician to appeal an arbitrary list.

It is critical to be clear that there are sound clinical reasons for a physician to choose one drug rather than another, even if they are drugs from the same family including: history of response to medications, avoiding the risk of precipitating a crisis by changing medication, combinations of symptoms and side-effects.

For people with severe mental illnesses, it is also important to prescribe medications which patients will agree to take. Lack of willingness to take psychiatric medications (usually referred to as lack of "compliance") is the source of a great many relapses as well as periods of very low quality of life for people with severe and recurrent mental illnesses. Physicians must have the freedom to prescribe medications that the patients will agree to take

Finally, it is important to keep in

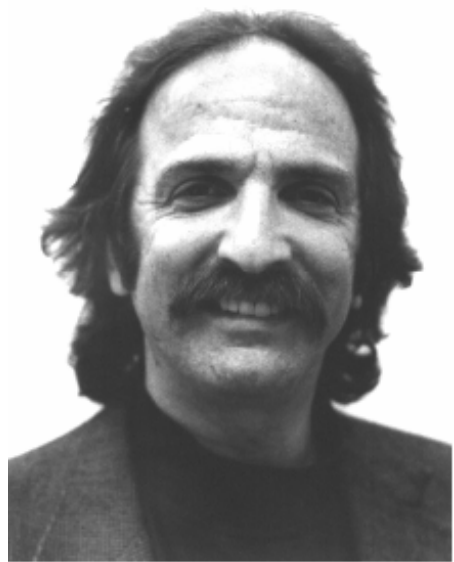
mind that very rapid progress is now being made regarding psychiatric medications. New drugs, generally with fewer side-effects, are introduced frequently. In theory the state's preferred list could be updated every time a new drug is introduced. But given the nature of bureaucracy and the goal to save money by negotiating quantity discounts, how likely is it that the new drugs will get on the preferred list rapidly? Those of us who have been advocates for high quality care for people with serious mental illnesses remember all too well the battle we had to wage in New York State a few years ago to get chlozapine approved for Medicaid payment—even though it was a drug—albeit an expensive drug—with clear benefits over other medications. As the experience with chlozapine makes clear, states are likely put the need to hold down costs ahead of the needs of people with serious mental illnesses.

For all of these reasons, I oppose the establishment of "preferred drug lists," have made it a top priority for my mental health advocacy, and hope that more and more advocates will make it a top priority too. As I said at the beginning, if people with serious mental illnesses do not get access to the medications that work for them, little else will matter.

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

THE NYAPRS ADVOCACY WATCH

By Harvey Rosenthal
Executive Director, NYAPRS
New York Association of
Psychiatric Rehabilitation Services



Harvey Rosenthal

Governor's Medicaid Buy-In Implementation Plan

Enrollment into Landmark Work Incentive Program to Begin on July 1, 2003

No Premiums Until April 2004

At a recent Capitol meeting of groups called to provide outreach, education and client representation in support of the implementation of the Medicaid Buy-In, Governor Pataki's Buy-In implementation plans were announced as follows:

- Education and outreach to New Yorkers with disabilities and the various provider and governmental groups that serve or support them will be quickly developed and available by mid-Spring to support the Medicaid Buy-In program's implementation date of July 1, 2003 (see below for more details)

- New Yorkers with disabilities will be

able to go to their local County Social Services offices on July 1 and apply for the Medicaid Buy-In.

- In recognition of staffing shortages and workload issues at many Local Departments of Social Services, local DSS offices will be playing a more limited role during the first 9-12 months of the program's 'interim' implementation (July 1, 2003 to April 1, 2004). During that period, local social services staff will be responsible for taking applications and, upon ensuring that each application has been completely filled out and that the necessary supporting documentation has been attached, send it on to the State Department of Health's Bureau of Medicaid Eligibility Operations.

- Interagency state staff comprised largely of DOH, OMH and OMRDD personnel will then, during this 'interim' period of July 1, 2003 and April 2004, process each application for the Buy-In.

- Applications must demonstrate the

applicant has both a job and a verifiable disability (SSI and SSDI status will be adequate, VA or Workers Compensation disability status will require more documentation). State staff will then make a disability determination, issue a letter verifying the applicant's acceptance or denial into the Medicaid Buy-In program and then enter eligible individuals' information into the appropriate state and local databases.

- This process will typically take 45 days for most applications, up to 90 for those needing additional corroboration.

- Applicants who are successfully enrolled into the Medicaid Buy-In program can expect that Medicaid will cover their medical expenses retroactively back to the date of their application.

- Due to delays in the establishment of an automated premium collection and tracking system, the Governor has

see Buy-In on page 21

The MHA Connection



Mental Health Association in New York State, Inc.
 194 Washington Avenue, Suite 415, Albany, NY 12210
 Phone: (518) 434-0439 Fax: (518) 427-8676 www.mhanys.org

By Joseph A. Glazer
 President & CEO, MHANYS



Joseph A. Glazer

NIMBY vs. NOMBY

Any time an organization tries to site a new program, particularly residential, for people living with mental illnesses, NIMBY (Not In My Back Yard) rears its head. People from throughout the community, usually lacking sufficient understanding of the program, understanding of those to be served or other attributes of the planned service will rally against the proposed site, making the argument that they don't want it in their community. Largely founded in misguided fear and ignorance, NIMBY has untracked many a worthy program or residence.

NOMBY is a much lesser known phenomenon. An acronym for Not Out of My Back Yard, NOMBY is a similar, albeit more educated and compassionate response to proposed dismantling of services or facilities. This year, as in 2001, Governor Pataki has proposed the closure of state run psychiatric centers around our state. And in the communities that fear new and greater gaps in the mental health services available, NOMBY is the first and most visceral reaction.

The demarcation line in the MHA movement around proposed closures is best explained in terms of NOMBY. Virtually all of our MHAs, as well as MHANYS, believe that the size of the infrastructure of the state run psychiatric

hospital system exceeds the demand and required capacity. Downsizing is warranted, and utilizing the funds saved to improve (dare we even say develop) the system of community-based care is universally supported. Where we divide is the question of which community is going to lose their facility.

Over the years, the role of psychiatric hospitals has evolved. Although the residential buildings remain large, each facility actually serves many times more people on an outpatient basis than inpatient. They have become the core of intensive mental health services for their communities, as well as their large catchment areas. Communities fear that the closing of the facility will lead to a drop in access to inpatient beds, outpatient services, and continuity of care. And, in the absence of a plan, history continually bears out those fears as justified.

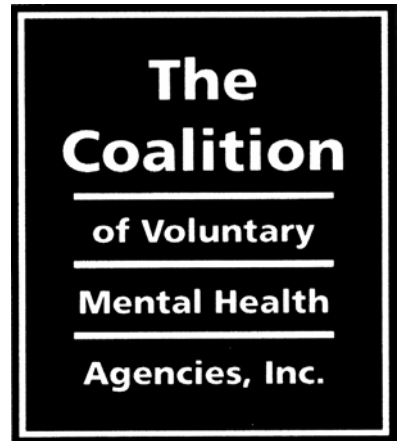
First and foremost, it is important to note that Deinstitutionalization, long a rallying cry for mental health advocates, has never included a plan. That, at least in part explains how the same percentage of the population that occupied state hospitals in the 1950s is numerically equivalent to the percentage living with mental illnesses caught in the criminal justice system today - 0.3%.

More recently, we need look no further than the closing of Gowanda psychiatric center a decade ago. Today, people in that community will tell you that the county jail is the largest psychiatric hospital in the county, there are substantial gaps in housing and services, and that Buffalo is too far for many people to go to see, and advocate for, their loved ones who are hospitalized with critical mental health care needs.

Understanding NOMBY is what has brought MHANYS to its position regarding the proposed closures Governor Pataki has put forward. We agree that the infrastructure is too large, and that services can be provided more effectively and cooperatively in the community. But we cannot support closures in the absence of an overarching plan, for what happened in Gowanda will happen elsewhere unless the planning and systems change is completed.

Children's Mental Health Week is nearing. What are you doing to help raise awareness to the importance of this issue? See the Children's Mental Health Toolkit which can be viewed on line at www.MHANYS.org. Make things happen in your home town. May 4th - 10th is Children's Mental Health Week. □

The Coalition Report



New and Old Amsterdam: An Exchange of Working Ideas

By Alysia Pascaris, Director
 New York Work Exchange

There is a common saying in Amsterdam: God created the world, but the Dutch made the Netherlands. Carved out of swamp and marshland, with few natural resources and a barely navigable port, this part of the world rose to greatness out of the sheer determination of its people to engage in a constant and collective battle with the sea. Since the 14th century a vast system of dams, dykes and canals has added 10 percent to the country's land mass and made it possible for people to safely live and flourish below sea level. To hold back the sea, and then to harness its power, takes planning, endurance and teamwork. It is no surprise then that the Dutch routinely rank among the most productive workers in the world. Curiously, this intense work ethic exists alongside a strong commitment to volunteerism as an alternative to paid employment, a robust social and health safety net including universal health care that makes it possible to live above the poverty line without working, and a minimum of five weeks paid vacation per year.

How we work, and how we understand the role of work in our lives, varies from place to place. The Dutch do not necessarily do work better, but they do work differently. Their experiences might help us understand better our own hidden assumptions about the way we work, the way we use work to give meaning to our lives, and the way we build work environments to promote health and well-being. This is as true for people with psychiatric disabilities as it is for the population as a whole.

The system of vocational rehabilitation programs that exists to help consumers with psychiatric disabilities in the Netherlands is relatively new. It was not until the mid-eighties that the Dutch government launched a policy of deinstitutionalization and started developing a system of community-based care. As in the US, two government agencies, health and employment, are typically involved in assisting the return to work of individuals with psychiatric disabilities. Generally, it is the health system that has responded to consumers' vocational needs creating options similar to those found in New York State. Consumers pursue vocational goals in sheltered workshops, pre-vocational and transitional employment programs, day

activity centers that offer social support and volunteer work experiences, and a small selection of supported employment services primarily designed for individuals with mental retardation and developmental disabilities. Sheltered workshops differ in the Netherlands in that workers are paid a competitive wage for their efforts. Nevertheless, they remain segregated settings that offer little encouragement and opportunity for participants to move on to regular employment environments. Transitional employment and the volunteer work-ordered day is an option only for consumers living in Amsterdam, home to the only Clubhouse in the Netherlands.

Although the US and Dutch mental health systems and their underlying principles appear quite similar on the surface, important differences exist. The Dutch do not necessarily equate 'good' work and a dedicated worker with long workdays, the accumulation of overtime, and substantial pay. Within the community mental sector, this issue for people with psychiatric disabilities may be less about 'real work' for 'real pay', and more about participation in meaningful activity, whether paid or unpaid. Within the Dutch Clubhouse for example, transitional employment is viewed as volunteer work; participants are paid a small and non-competitive wage through the Clubhouse provider, not directly by the employer. The Dutch seem less ashamed of not working, or of not working for pay, than Americans.

But the landscape is changing in the Netherlands. The economic recession felt worldwide is both altering the role government plays in aiding those most in need and influencing the options available to potential workers with psychiatric disabilities. The government has adopted a policy to privatize the delivery of employment services mandated to help all unemployed persons including people with psychiatric disabilities. A belief exists among some officials that organizations operating for profit will be more inclined to reach their objectives, to find more jobs for more people, and most important, to reduce the number of recipients receiving social assistance. The concerns among advocates for the disabled sound all too familiar: the practices of these privatized services may 'cream' among their clients, place people in jobs that may not serve their best interests, and neglect to assist those most in need, especially people with psychiatric disabilities. Consumers contemplating work for competitive wages face the

see Amsterdam on page 21

the NARSAD report

The National Alliance for Research on Schizophrenia and Depression

By Constance Lieber, President
NARSAD



Constance Lieber

Earlier this year, the National Alliance for Research on Schizophrenia and Depression (NARSAD) was faced with a dilemma. We had received a record number of outstanding grant proposals from researchers at leading medical centers and universities worldwide. The quandary was how to fund all the researchers whose proposals showed such promise and innovation. Ultimately, NARSAD's Board of Directors decided we could not turn our backs on a single young investigator deserving of a research grant.

In February, NARSAD awarded new grants to 190 researchers around the

world, with total funding for 2003 projected at a solid \$16.8 million. The latest round of awards included a record 175 Young Investigator grants of up to \$60,000 each to provide early career support to scientists, and 15 Distinguished Investigator grants of \$100,000 each to provide continued support to established researchers. These are impressive numbers, and even more so when you add the 164 Young Investigators and 40 Independent Investigators who will be receiving second-year grants in 2003. NARSAD is providing funding for studies on depression, schizophrenia, anxiety disorders, bipolar illness, post-traumatic stress disorder and other brain-based illnesses.

Since 1987, NARSAD has been awarding grants for the most promising psychiatric research based on the recommendations of our Scientific Review Council. By the end of 2003, NARSAD will have awarded \$144.5 million in grants to more than 1,600 scientists at 212 research centers worldwide. These numbers are a testimonial to the extraordinary growth NARSAD has experienced since 1987, when the organization distributed grants to just 10 researchers totaling \$250,000.

NARSAD's Scientific Review Council is composed of 75 scientists and academic leaders in all phases of neurobiological and psychiatric research. This distinguished group of volunteer reviewers screens hundreds of applications each

year to find the most promising research proposals. NARSAD expects grant recipients to play key roles in discovering the causes, new treatments and eventual cures for mental illness.

Young investigator awards give many scientists the career boost they need to get their research off the ground. Countless young investigators have parlayed their NARSAD awards and subsequent research findings into multi-million dollar grants from the National Institutes of Health. Many researchers credit NARSAD with having given them their start.

Distinguished investigators funded by NARSAD have made momentous discoveries. Two such scientists, Dr. Eric Kandel and Dr. Paul Greengard, won the Nobel Prize in Medicine in 2000 for research elucidating the mechanism by which brain cells communicate with each other. Both Dr. Kandel and Dr. Greengard had received Distinguished Investigator grants, and they currently serve on NARSAD's Scientific Council.

Recent advances in research tools are aiding investigators in their quest for better treatments and cures, and top scientists predict major discoveries in years to come. Advanced brain imaging, the unraveling of the human genome, and new cellular and molecular biology techniques will enable researchers to make breakthroughs that will benefit countless patients and their families facing mental illness.

I have been gratified, recently, by the efforts of several families challenged by a psychiatric illness, who realize that research represents our best hope in conquering the devastating brain disorders.

One extraordinary gesture came from a childhood friend of a young man with schizophrenia who committed suicide 15 years ago. She wrote to everyone who knew him on the occasion of what would have been his 40th birthday, urging them to make a donation to NARSAD in his memory. The response was overwhelming.

Just recently, a successful young woman whose sister was diagnosed with schizophrenia organized a major fundraising dinner in Manhattan. She and her friends persuaded 200 people to attend. They raised not only money for NARSAD... but awareness of the terrible toll of brain disorders and the importance of research.

Another family in Boston is now working to spread the word in their town. They have also generously offered to underwrite an upcoming NARSAD Scientific Symposium.

The devotion of so many families who have become involved in NARSAD's mission, along with the tireless efforts of researchers, gives me much hope for the future. For more information about NARSAD, please call us at 800-829-8289, or visit www.narsad.org.

NARSAD RESEARCH

National Alliance for Research on Schizophrenia and Depression

A Unique Partnership of Scientists and Volunteers To Conquer Mental Illness

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- **Since 1987, NARSAD has funded 1,695 researchers at 212 universities and medical research centers in 20 countries.**
- **Three NARSAD-funded scientists are Nobel Prize Winners.**
- **Grants are awarded by our 75-member all-volunteer Scientific Council which includes three Nobel Prize Winners, four former directors as well as the present director of the NIMH.**
- **Contributions to support NARSAD's programs go 100% to Research.**
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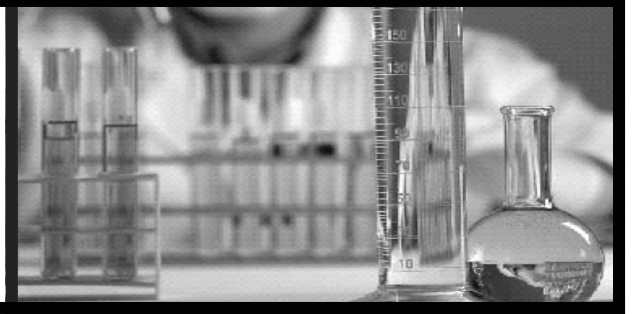
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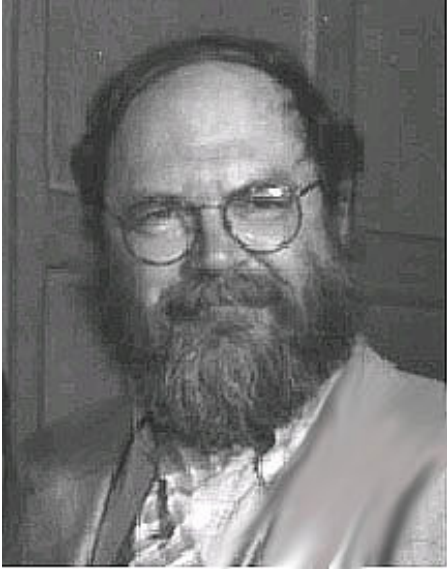
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WORKING WITH MEDICATIONS

What is a chemical imbalance?



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



Dr. Richard H. McCarthy

People suffering from mental illnesses or brain disorders are frequently told that they suffer from a chemical imbalance in the brain. What does that mean? In order to understand what a chemical imbalance is, it is necessary to have some general idea of how the brain works.

The brain is the organ in the body that is responsible for thoughts, feelings, and control of virtually everything that we do. The brain is organized into clusters of cells, each located in different areas of the brain. Each cluster is responsible for different functions. So, for example, the ability to produce speech occurs in one part of the brain and the ability to understand speech takes place in another part of the brain. In order for our speech to be reasonable what we say must be related to what we hear. Therefore, these two parts of the brain must be able to communicate with each other. If this communication between the parts of the brain is interfered with, there would be a significant impairment in our ability to make both understand and make ourselves understood. Nerve cells perform this task of linking different parts of the brain together by a process known as neural transmission. One way to understand the brain depends on where prob-

lems are taking place. Another way of understanding the brain is to understand how these parts of the brain are communicating with each other. One kind of chemical imbalance will have something to do with the balance between actions that are taking place in different parts of the brain. Another kind of imbalance will have something to do with how nerve cells carry messages. In order to understand either of these we have to understand how nerve cells work.

Nerve cells move information from one place to another. Each cell is made up of many, highly specialized parts, but to simplify things, we will look at only four: a part that receives information; a cell body where cell metabolism takes place; an "axon" that moves the message over great distances; and a transmitting end, the part of the cell that passes information on to the next cell. In general, information moves only one way: from the receiving end, through the length of the cell body and axon to the transmitting end. Neural transmission, i.e., nerve cell communication, is an "electrochemical" event. This means that nerve cells transmit information by means of a series of both electrical and chemical changes. The "electro-" refers to how information moves across the cell. We can observe this small electrical charge that nerve cells create when they carry messages when we do an EEG (electroencephalograph). Many of the medications that are used to treat seizures and bipolar disorder influence this "electro" part of the electrochemical event. So, medications such as valproate (Depakote) or carbamazepine (Tegretol) modify the movement of messages across the length and breadth of the nerve cell. We believe that these medications do this by stabilizing the cell membrane which then blocks the electrical passage of information and thereby slows down neural transmission. The "-chemical" part refers to how messages move from one cell to the next.

When two nerve cells meet they do not touch but are separated by a small space called the synapse. Most psychiatric medications work by modifying what goes on in the synapse. This is

the place where we presently can best find and influence the chemical imbalances associated with mental illnesses. Obviously, the synapse, the space where nerve cells meet will be a very important space to understand.

The synapse consists of an incoming nerve cell, (the presynaptic nerve cell), a small fluid filled space across which chemicals will drift, (the synaptic cleft), and an outgoing nerve cell (the postsynaptic cell) that receives the message and carries it forward to the next cell. The chemicals released by the incoming, transmitting, presynaptic cell are called neurotransmitters. These message carrying chemicals, the neurotransmitters, drift across the synaptic cleft and attach to special parts of the receiving, postsynaptic cell, called receptors. When enough of the receptors are stimulated, the postsynaptic cell "fires" and carries the message forward. When we speak of a chemical imbalance we are talking about an imbalance in the chemicals that carry messages between cells such that they do not perform their message carrying function properly. There are several kinds of difficulties that could cause an imbalance.

The kind and amount of neurotransmitters that are released by the presynaptic cell can be out of kilter. Something can happen to the neurotransmitters as they drift across the synaptic cleft so that they no longer are effective. The neurotransmitters can interact with the receptor on the receiving, postsynaptic cell in a peculiar way such that the message is interfered with. There are many other types of problems that can influence this tightly controlled and delicately balanced system. This should not be surprising. The more delicate and complicated a system is, the more easily it is to disturb it. While the brain is well protected, by bone and special membranes, it is not invulnerable.

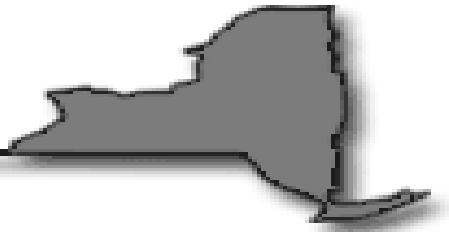
An example of the problems associated with correcting chemical imbalances may help. Dopamine is an important neurotransmitter that is used in many different cell clusters in the brain. Even though each cluster uses dopamine as its neurotransmitter to move, each

cluster is responsible for a different behavior. In the cluster known as the striatum, dopamine is involved in the control of movements, in the frontal lobes, dopamine plays a role in attention and concentration, and in the meso-limbic system dopamine plays a role in psychosis. Clearly, if there is an imbalance in dopamine there can be problems in any or all of these functions.

It would be simple if all of the problems were the same, that is, too little dopamine in each area. Then we could give medications that could only raise the level of dopamine everywhere. Unfortunately, this is not the case. Dopamine requirements and balance are different in different parts of the brain. Too little dopamine in the striatum causes the symptoms of Parkinson's disease but too much dopamine in the meso-limbic system we can cause psychosis. Physicians can help minimize the resultant movement problems of Parkinson's disease by giving a medication such as L-Dopa (sinemet) which will raise dopamine levels where ever dopamine is found, including in areas where it may be normal and where we do not want it raised. This may correct the movement problem of Parkinson's disease but cause psychosis. Similarly, we can treat the problem of psychosis by giving medications such as fluphenazine (prolixin). This will lower dopamine levels everywhere dopamine is found including areas where it is normal and where we do not want it lowered. This may help correct the problem of psychosis but can cause the person to have problems with the control movement. i.e., the symptoms of Parkinson's disease. When this happens we say that the person is having side effects.

Chemical imbalances are complex and their treatment is not without problems. In the future, a few things are likely to occur. We are likely to develop a better picture of how nerve cells communicate with each other and how different parts of the brain work. Moreover, it is likely that better medications will be developed to address the brain disorder problems that are caused by chemical imbalances and their treatment.

The NYSPA Report



By Seth P. Stein, Esq.
and Rachel A. Fernbach, Esq.

An Introduction To The New Federal Law On Medical Privacy

What is HIPAA?

HIPAA, which stands for the Health Insurance Portability and Accountability Act of 1996, is a new federal law that creates standards for the use and disclosure of personal health information that is maintained or transmitted by electronic means. In order to implement the new law, the federal government created standards and guidelines that applies to all health care providers who bill electronically or transmit health information electronically. These federal guidelines are known as the HIPAA Privacy Rule or simply, the Privacy Rule. The Privacy Rule went into effect on April 14, 2003.

Who must comply with the Privacy Rule?

Health care providers, including psychiatrists, psychologists and social workers who provide mental health treatment, will be subject to the rule if they engage in at least one standard electronic transaction. A standard transaction means the transmission of information between two parties to carry out financial or administrative activities related to health care, including health care claims, health care payment and remittance advice, coordination of benefits, health care claim status, enrollment and disenrollment in a health plan, eligibility for a health plan, health plan premium payments, referral

certification and authorization, first report of injury, and health claims attachments. If a provider engages in any standard transaction by electronic means, that provider is subject to HIPAA.

What is covered by the Privacy Rule?

The Privacy Rule applies to any individually identifiable health information transmitted or maintained in any form, referred to by the Rule as "protected health information" or "PHI." Information that has been de-identified is not subject to the Rule. De-identified information includes information that has been stripped of certain identifying information, such as name, dates, address, telephone number, social security number, among others.

What does the Privacy Rule require?

Patient Authorization: Under the Privacy Rule, providers must obtain written authorization from patients for all non-routine uses and disclosures of patient health information. A non-routine use or disclosure is a use or disclosure other than for treatment or payment purposes that is not otherwise permitted or required by law. For example, an authorization would be required in connection with a pre-employment medical exam or the release of information to a patient's attorney.

Notice of Privacy Practices: The Privacy Rule requires that all covered providers provide patients with a Notice of Privacy Practices, which is a document that sets forth the provider's policies and procedures with respect to the handling of confidential patient information and also informs patients of their individual rights with respect to their own health information. All new and existing patients should receive a copy of the No-

tice at their first office visit following the April 14 deadline. Providers are required to ask patients to sign a form indicating that they have received the Notice. However, patients may obtain treatment even if they do not sign the form. The provider must post the Notice in a prominent location in the provider's medical office and make a copy available to anyone who asks for it.

Individual Rights: Under the Privacy Rule, patients have certain rights with respect to the health information that is collected and maintained about them. This includes the right to:

- Request that the provider restrict certain uses and disclosures of health information.
- Request that the provider communicate with the patient by alternative means, such as making records available for pick-up, or mailing them to an alternative address, such as a P.O. Box.
- Request to review, or to receive a copy of, the health information about that is maintained in the provider's files and used to make decisions about the patient's treatment.
- Request that the provider amend the health information that is maintained in the provider's files.
- Request an accounting of certain disclosures of the patient's health information to third parties.

Safeguards for Information: The Privacy Rule requires that all covered providers implement appropriate technical, physical and administrative safeguards to ensure the privacy of personal health information. These guidelines will require providers to reassess the way they handle and maintain personal health in-

formation and to improve their practices where necessary. Providers are also required to limit the amount of personal health information they use or release to the minimum amount of information necessary to accomplish the task at hand.

What is the relationship between HIPAA and New York State law and practice?

New York State law has always required physicians and other health care providers to obtain patient consent before disclosing health information to any third parties for treatment and payment purposes, with some exceptions where disclosure is permitted or required by law. Under HIPAA, all state laws that provide greater privacy protection or afford greater rights to access to records remain and are not affected by HIPAA. Because New York State law provides greater privacy protections, the HIPAA Privacy Rule does not erode or in any way diminish the privacy rights that patients currently enjoy under New York law.

For further information about HIPAA and the Privacy Rule in general, visit the U.S. Department of HHS website at <http://www.hhs.gov/ocr/hipaa/>. For information about HIPAA and mental health care and services in New York State, visit the website of the New York State Office of Mental Health at <http://www.omh.state.ny.us/omhweb/hipaa/index.htm>.

Seth P. Stein is the Executive Director and General Counsel of the New York State Psychiatric Association and Senior Partner in the law firm of Stein & Schonfeld LLP, Garden City, NY. Rachel A. Fernbach is an associate at Stein & Schonfeld LLP.

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In Silence from page 6

Three years have passed since this incident. I take my life easier now. I also take my medication, exercise regularly, and try to keep life's stressors to a minimum. The three years have also taught me something else about depression. It carries with it a stigma with those who don't understand it.

Even the best-intentioned people will probably view you differently and may wonder just how to approach you. Others will just avoid you or the issue altogether. Only those that have the illness can really appreciate it and the power it can wield over your mind.

I have chosen to remain anonymous in this writing to underscore this stigma. Others have talked to me about the shame they feel or what it might do to their career. To all of those people I say you are not alone. To those that are reading this, I ask that you withhold judg-

ment on my decision for now.

Mental Health News gave me the opportunity to share my story and reach out to others who might also wish to remain anonymous. Depression does not pick and choose whom it might attack next. It is blind to age, race, occupation and creed. Corporate professionals are chosen to the same degree as others. In fact, given the stressors associated with corporate life one could make a case that it may take an even heavier toll. The triggers are definitely there.

If you would like to chat with me or join me in helping others in similar situations please write or E-mail Mental Health News, and they will forward your note to me. I promise to return any calls on a strictly confidential basis. I hope to establish some type of outreach program for those like me. I'm open to your ideas and I'm calling it "PRIVATE PARTNERS."

A Private Partner

Employing from page 6

I have found that an employee who meets these requirements and has demonstrated stability by the time he comes to me is as likely, and maybe more likely, to be a successful employee than one who hasn't met these requirements, regardless of whether or not he has a psychiatric diagnosis.

Dr. Laura Lustig, President
The New Learning Therapy Center

Medicaid Reform from page 8

Reducing coverage for these optional populations to a package similar to private insurance appears to be the Administration's preferred option. But this approach would deny adults and children with mental disorders the critical intensive services that are only available through the public mental health system. The Bazelon Center believes that the Bush proposal is reckless and would needlessly put millions of Americans with mental health care needs at risk.

House Legislation from page 8

to explain in their solicitations that the SSA provides the services free of charge.

- Authorizing the Commissioner to refuse to recognize certain disqualified attorneys.
- Establishing penalties for impeding any SSA employee while acting in their official capacity.
- Expanding the current law prohibition on the use of Social Security or Medicare symbols, emblems, or references.
- Prohibiting individuals who fraudulently conceal work activity from being eligible for a trial work period.
- Allowing Federal courts to order a

person who breaks the law relating to Social Security or to the SSI program to make restitution to the trust funds or general fund as appropriate.

HR 743 would also improve work incentives for individuals with disabilities to return to work by:

- Clarifying some provisions of the Ticket to Work and Work Incentives Improvement Act of 1999, including beneficiary access to assistance from the Protection and Advocacy System for maintaining a job.
- Clarifying the Work Opportunity Tax Credit so that it is also available to employers who hire a beneficiary with disabilities who is referred from any employment network, not just the State rehabilitation agency.

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The Effects of War on Children

By Barbara Bernstein, Ph.D.
Director, Training and Education
MHA of Westchester

As the war in Iraq, now in its third week, dominates the media and our discussions, concern has turned to how this war affects children.

I asked friends, colleagues, and educators about children's reactions to the war in Iraq. I learned that children's responses range from appearing to be unaffected to expressing fear and even fascination. Some children feel protected by the distance between the United States and Iraq. Others are confused about where the war is being fought and whether it is far away and they are safe. For some in the greater New York City area, the war has rekindled the anxiety that followed September 11th. Anxiety has remained high for many who live near Indian Point. Bedtime rituals are drawn out as children do not want to be left alone. Other children, uncharacteristically ask to sleep with their parents. Perhaps surprisingly, teens no longer want to be at home without their parents. There is an urgent need to stay together and stay connected—children do not want to go to school, travel on vacation, or have their parents travel on business. There is a heightened sense of "something in the air."

Our children identify with the children they see on the news—those who have escaped to refugee camps, and those who are seen in rubble and debris. Some children identify with our soldiers: some boys, in particular, are excited about awesome weapons and their capabilities. Older youth recognize that they are not substantially younger than our soldiers and worry about a draft.

Children are inquisitive and actively work to make sense of their worlds. They accomplish this based on their own experiences and the lessons and values they have been taught. Children remind us that they are taught to resolve conflicts through non-violent means and ask how it is acceptable that adults and nations resort to "shocking and awe-

some" violence to resolve international conflict.

How can these examples of children's experiences guide us to help them through unsettling and unsettled times?

Children's comprehension of events and their worries vary with their ages, developmental stages, and personal history. Most of all, children want to know that they and their loved ones are safe. Older youth want to know that the world they will inherit will be stable and predictable. It is up to adults to reassure but in a realistic way. We need to be credible and willing to have difficult discussions. War and the world situation are on the minds of many youth even if they never raise the topics or express concern. It is up to adults to invite discussion. It may be most comfortable to ask what peers are feeling and saying and about what is being discussed in school, rather than directly about the child's feelings. As you listen carefully to what a child says and doesn't say, keep in mind his or her personal history—perhaps he or she has experienced trauma, the death of a loved one, or has a mental illness or physical illness that leaves that child more vulnerable than others. Children ask difficult questions and adults may not have all the answers. We don't have to, but we should acknowledge when we don't.

Children are reassured by routine and predictability, so maintain your child's usual routines as much as possible. Young children should not see televised images of war. Limit your older children's exposure to the news and watch it together. Discuss what you have seen, your child's and your own reactions. Use this opportunity to affirm your values and beliefs. Give children opportunities to release nervous energy in healthy ways such as physical activity. This is a particularly important time to help others. Whether writing to soldiers, sending care packages, or doing community service close to home, children benefit from contributing to others.

Having a sense of purpose and meaning to life beyond their own interests is essential for children.

From the time they are babies, child-

ren absorb the emotions of adults. It is essential that we not burden them with our worries. For their sake as well as our own, it is important that we take care of ourselves. For many, that means limiting exposure to the minute-by-minute, mile-by-mile coverage of the war, doing things that nurture us, spending time with loved ones, and avoiding substance use, excessive use of alcohol and dependence on food to relieve stress.

By the time this issue is released, I hope that the war will have ended. I

hope that families will be focused on summer vacation. Whatever the world situation is at that time, summer, when children are out of school, can be a time to focus on our families and on strengthening the bonds that sustain us.

Additional information about children's responses to war is available on many web sites including: The Mental Health Association of Westchester, Inc. www.mhawestchester.org, The National Mental Health Association at www.nmha.org, and at Mental Health News at www.mhnews.org.



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Buy-In from page 14

provided for a moratorium on premium payments until April 2004, when the system is expected to be operational.

- Local Social Service Departments will be taking over full responsibility for taking and processing applications and enrolling individuals into the Medicaid Buy-In program on April 2004. At that time, Buy-In enrollees earning between 150-250% of the Federal Poverty Level will be expected to begin paying premiums to retain their Medicaid.

More Details on New York's Medicaid Buy-In Program

- The Medicaid Buy-In program for Working People with Disabilities will make Medicaid coverage available to employed people with disabilities who are at least sixteen years of age but under the age of sixty five and whose income from work previously would have disqualified them from coverage.

- Once the program starts, individuals with net incomes up to 250% of the Federal Poverty Level can be eligible, meaning Medicaid will be available for working individuals with a gross income of \$46,170 for a household of one and

\$61,870 for a household of two. A premium (a payment back to the state to retain Medicaid coverage), based upon a percentage of earned and unearned income, may be required.

- To be eligible for the Basic Medicaid Buy-In program, a working individual between the ages of 16-64 must have a disability that meets the medical criteria for Supplemental Security Income (SSI) established by the federal Social Security Administration, but have too much income to qualify for SSI.

- Eligible individuals can have no more than \$10,000 of resources (excluding house or car).

- Individuals with incomes under 150% of poverty pay no premiums; individuals with incomes of 150-250% of poverty will pay premiums calculated at 3% of earned income and 7.5% of unearned income.

- Medicaid Buy-In enrollees who are later determined to be medically improved on a Continuing Disability Review but who retain a severe medical impairment can still qualify if they are working 40 hours per month or more. □

Amsterdam from page 15

potentially threatening effect of earned income on disability pension. Although American and Dutch consumers share a

fear of losing social assistance or disability payments, the consequences are more deeply felt by Americans who cannot rely on the state for essential medical benefits. (next column)

The Dutch learn from us as well. 'Evidence-based practice,' pioneered by American researchers, is gaining momentum in the Netherlands. The Individual Placement and Support (IPS) model of evidence-based supported employment has taken root in four demonstration sites, part of an implementation study associated with the New Hampshire-Dartmouth Psychiatric Research Center. Consistent with the essential principles of supported employment, IPS emphasizes competitive and integrated employment. Mental health researchers in the Netherlands look positively upon IPS, viewing it as potential leverage to transform the existing mental health employment system to one which provides consumers with greater opportunities for integrated and competitive employment. Can we learn from them?

The Dutch have another saying: never stand out in a crowd. They value teamwork and consensus above all else – entrepreneurship in the Netherlands is a collective endeavor. North Americans are more likely to value individuals who stand out in a crowd, and are strongly inclined to use work as a measure of individual self-worth. We can't change this, nor would we necessarily want to. But, if we better understand our own attitudes regarding the relationship between work and self-worth, we might better understand the monumental pressures we assert on people for whom work is difficult.

Alysia Pascaris is the Director of the New York Work Exchange, Coalition of Voluntary Mental Health Agencies. She is currently on leave in Amsterdam, living with her family.



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The Effect from page 1

How Fear Works

The fear reaction occurs automatically as a consequence of the brain's threat response system. This system operates with extreme rapidity, making split second "yes/no" decisions as to whether something is or is not a threat to our survival. Failure to defend oneself has greater consequences than responding too often. We cannot afford to debate whether something is dangerous when we need to act immediately, either by fighting or fleeing.

Our fear response "turns on" faster than our higher mental functions, such as reason. It operates largely outside of conscious awareness, as our vision, hearing and other senses continually scan the environment for potential threats. However, more conscious mechanisms like reason, planned behaviors, and remembered distinctions between what is safe and unsafe, can be used to override the initial response.

The fear response is both emotional and physical. The primary physical reactions are a pounding heart and rapid, shallow breathing. Often these physical reactions become automatically associated with being frightened, even if they result from other stimuli. Various relaxation techniques, which help to calm these physical reactions, can be learned. When practiced regularly during times of relative safety, they can also help promote a sense of self-control.

If fear is turned on repeatedly, a bias towards overreacting to possible threats can develop even though we may eventually realize they are non-threatening. Mobilizing the capacity to accurately distinguish real threats from overreactions can actually reverse learned fear responses.

Exposure to trauma interferes with the ability to properly evaluate threats causing seemingly inconsequential events to trigger fear.

How Can These Observations Be Helpful to Anxious/Fearful Persons?

Knowing that these reactions are automatic and occur in everyone can help individuals to:

- Stop blaming themselves. Frightened individuals may personalize their reactions, often wrongly concluding that they are the only person "getting so upset." Furthermore, if the individual's fear reaction is interpreted as a sign of something being inherently wrong with them, intense shame can occur.
- See that their reactions are explainable, which can help contain feelings of being "out of control."
- Reduce overestimation of potential risks, which only magnifies the feeling of danger.
- Counteract helplessness by preparing and learning adaptive ways to cope.

Explaining that fear is a natural, universal reaction and not a personal fault can:

- Promote learning to contain the often intense, confusing emotions that interfere with effective action.
- Foster the realization that even though one can't stop the fear from "turning on" there are things that can be done to turn it "off."
- Reduce secondary reactions such as shame, guilt and a feeling of being "weak."
- Reduce helplessness and feeling out of control by recognizing that a seemingly inconsequential trigger can turn the fear response on.

How Can A Person Function In Spite Of Being Afraid?

Just as the brain has mechanisms to instantaneously activate the fear response, other mechanisms involving thinking, learning and planning can be mobilized to overcome learned fear responses. These techniques can promote new understandings about threatening experiences, teach ways to restore calmness and enhance active coping, even when intense emotions originally clouded thinking. These techniques allow one to:

- Acknowledge frightening feelings rather than trying to suppress them.
- Learn techniques to calm oneself down.
- Challenge self-defeating assumptions.
- Clarify unrealistic or catastrophic expectations.
- Learn about the universal and natural basis of the fear response.
- Develop effective ways to release tension.
- Increase social connections.
- Recognize what makes one feel safe and take steps to increase such activities.
- Learn to distinguish physical security from psychological and social safety.
- Learn to approach problems by breaking them into smaller more manageable proportions.
- Learn to use healthy compartmentalization.
- Access sources of moral/spiritual support.

How to Promote Preparation and Resilience

First, the capacity to elicit a counterbalancing relaxation response needs to be learned. The use of the following calming techniques can regulate and contain intense feelings: breathing exercises, meditation, progressive muscle relaxation, active visualization of positive imagery, relaxation tapes, emotional and physical grounding techniques.

Once people feel they can contain and regulate intense emotional reactions, rather than being overwhelmed by them, they can be helped to acknowledge fearful feelings rather than suppress them. This counteracts the perception of more threat than actually exists, which can keep a person hyper-alert, jumpy and prone to interpreting innocuous stimuli as dangerous.

Stress that they can learn to cope with fear and keep it within tolerable limits.

Discuss their fear while using learned calming techniques to insure that the level of fear arousal doesn't exceed the person's capacity to tolerate it. (See techniques above.) Stop the discussion if too much discomfort occurs but work toward increasing tolerance levels. (Desensitization)

Respect their fears—there are no right or wrong ones. Remember we aren't trying to tell people "Don't Be Afraid."

Help them recognize that constant worry and tension is emotionally and physically exhausting and can cause fatigue, body aches and pain.

Help them recognize physical signs of suppressed feelings and ways to tell others how to help calm them down, especially if physical contact, such as, a hand on the shoulder, a hug or holding hands can produce soothing.

Help to calm distressing emotions is necessary, but not sufficient unless one also pays attention to thoughts and assumptions. Confident functioning in the face of distress is undercut by self-defeating assumptions, such as: "Only weak people get frightened," "If I were brave, I wouldn't be afraid," "There's no way to feel safe," and "I can't cope. I feel

totally overwhelmed."

Rather than challenging the content of such statements, help to increase the person's ability to monitor thoughts and recognize how absolute and negative such statements are and how such beliefs increase distress. Their confidence can increase by becoming aware of their negative self-talk, challenging their assumptions and substituting more positive self-talk.

Fear and trauma exposure changes people's expectations and affects their ability to properly assess threats.

We see more threat than actually exists because of the tendency to misperceive non-threatening events as possible dangers.

Our estimates of the probability of certain risks shift. This causes less likely, but very frightening events (nuclear attack, plane crash) to be ranked as more probable while more likely risks (smoking, car accidents), which actually cause more death and harm, are ranked lower.

Constantly having our "guard up" and expecting a past trauma to recur can evoke re-living of events even though we are actually safe (responding "as if" then is now).

The tendency to expect the worst can be confronted by actually encouraging people to discuss their "worst case scenarios." This helps develop perspective and promote the realization that certain fear-provoking thoughts are unreasonable or irrational.

Educating clients about the universal, automatic, intense nature of our fear response system can help to enhance control over what otherwise seems like a personal weakness. Understanding that the response is rapid and occurs automatically outside of awareness makes it more objective rather than a personal failure of will power or intentions. This, combined with the understanding that fear is a product of evolution and shared by many species, helps to relieve guilt and anxiety that "there is something wrong with me."⁵

Helping people to develop successful ways of releasing tension can promote a greater sense of control and counteract the helplessness that often intensifies fear. This includes: physical activity, use of humor and sublimation, use of creative non-verbal outlets: dance, drawing, painting, writing, keeping a journal, and playing or listening to soothing music.

The goal is to increase the focus on those things that give pleasure and meaning. It is useful to have a few different techniques. In particular, one needs methods that can be done briefly and/or alone (at work or in other public places). These can be added to other methods that require planning, facilities or other people.

How to Promote Feelings of Safety

Psychological safety and social safety

must be distinguished from physical security, which is necessary, but not sufficient. Psychological safety refers to our ability to feel that we can regulate our emotions, as discussed above. Social safety refers to our ability to feel safe in a group and to experience an enhanced sense of connection.⁶ Exposure to threats immediately intensifies a person's need to be close to their loved ones. Following the attack on the World Trade Center, everyone felt this urge very strongly. This increased "bonding and attachment" serves as an antidote to danger and trauma and can help mitigate their intensity.

One maladaptive response to fear is to "circle the wagons" and thus isolate oneself. In fact, withdrawal and avoidance of social contact can increase distress because it deprives one of social support, one of the most helpful counterbalances to fear. ("There is safety in numbers.") Suggest that people build connections to family, friends, and work colleagues, community groups and religious organizations. Help them recognize what makes them feel safe and to take steps to increase those activities. It is especially important that attention to physical security not override the building of psychological and social safety. Excessive focus on locks, guards and other physical security measures may increase anxiety by serving as a constant reminder of danger.

Efforts should be directed towards increasing the range of options that are available in a dangerous situation by helping with the development of a personal safety plan. This must be thought out in advance and mentally rehearsed.

Expanding personal coping options, practicing how to act effectively under highly stressful conditions and knowing how to connect with close family members reduces the fear response, especially in children. By increasing the feeling of control and effectiveness, being prepared acts as a counterbalance to the helplessness induced by the inability to clearly think of options.

When people feel unsafe there is a tendency to generalize it to all situations, rather than keeping it to a specific response. Creating an inventory of places, people and things that help one feel safe can promote the realization that the lack of safety is not all-inclusive and may increase participation in situations where they feel most safe.

References: 1.) *Le Doux*, 2.) *Chemtob*, 3. & 4.) *Rutter*, 5.) *Goldman*, 6.) *Bloom*. For additional copies of this document and other trauma-related materials, including tips on self-care and secondary trauma, contact: J.J. McConnell, Publications Manager, JBFCS Marketing and Communications Department 212-632-4549.

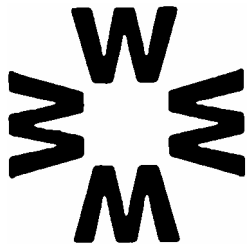


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Mood Disorders In Children: Diagnosis and Treatment - Two Case Studies

By Joseph P. Damore, M.D.
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Joseph P. Damore, M.D.

Childhood depression is an important and timely topic facing parents and health care professionals today. For the purposes of this article, childhood is defined as the period between ages five and twelve. I will share with you two clinical narratives—two cases about childhood depression. Each case will be used as a template to discuss various issues associated with each disorder. These cases are fictional composites from my own clinical experience and are designed to represent, as closely as possible, typical children affected with these disorders. It is my hope that these cases will stick in your memory and rise to the surface when you encounter children who present with similar symptoms.

Before I begin with the first case, I'd like to share a bias. I believe that any discussion about depression is not com-

plete unless it covers information about both unipolar and bipolar depression. I hold this bias for several reasons. First, according to many researchers—Akiskal, Jamison and others—the distinction between unipolar depression and bipolar depression is not as clear-cut as we would like it to be. A full one fifth (20%) of adults who walk into a psychiatrist's office with neurovegetative signs of major depression are in the throes of their first affective disturbance of bipolar illness. These “pseudounipolar depressed” patients will go on to have a manic or hypomanic episode and thereby declare themselves as having bipolar depression and bipolar illness. The number is probably higher in the child and adolescent populations. Barbara Geller reported in the American Journal of Psychiatry in 2002 that of those subjects who had a prepubertal diagnosis of major depression, one-third (33.3%) developed bipolar disorder Type 1 by their 20's, and nearly half (48.5%) went on to develop some form of bipolar disorder. To make matters worse, we know that antidepressant use in patients with bipolar illness has been associated with manic switching, and the development of rapid-cycling bipolar disorder. Many authors, Bowden and Calabrese among them, are discouraging the use of antidepressants with these patients. Patients who are diagnosed as unipolar, treated with antidepressants, and who then flip into mania or rapid cycling don't appreciate it, nor do their families. To avoid this, one must become familiar with the sometimes-subtle differences between the two disorders. Working with children, adolescents and adults, I have begun to rule out a bipolar disorder first, and to consider a diagnosis of unipolar depression only when I am convinced that the symptoms reported do not represent the depressed phase of bipolar illness. Correct diagnosis depends upon

obtaining a clear and complete history of symptoms, along with a multi-generational family pedigree for affective illness, alcoholism and substance abuse, and suicide.

Childhood Unipolar Depression: Case #1

Alexander is a nine-year-old white male who was referred to the local emergency room for evaluation of suicidal thoughts. His mother reports that over the past six months, but especially over the past three months, Alex's school performance has deteriorated from his previous level of good functioning. He has become withdrawn, sullen, and very sensitive, particularly to the criticism of others. He cries easily. His mother states that he has become somewhat more irritable over the last several months, especially in situations where tasks requiring concentration are asked of him. She reports that he does not appear particularly interested in sports or playing with his friends as he used to. He tends to have difficulty falling asleep, and reports to his mother that when he tries to fall asleep, he often has bad thoughts. Alex's mother states that his appetite is currently very poor. It's a struggle to get him to eat three meals a day. When asked about suicidality, Alexander states that he often thinks of a world in which he is dead, though he does not currently have a plan to harm himself, nor does he have any intention of harming himself at the present time. He reports major stressors in his life, including the divorce of his parents, which became final six months ago, his mother's engagement to a new fiancée, which took place several months ago, and many episodes of teasing which occur at school. He feels hopeless almost every day. All lab tests performed at the time of the exam came back normal. What, if anything, have we learned about

Alexander?

Keep in mind that in the United States, mood disorders in children have long been under diagnosed largely because of the psychoanalytic tradition of the 1950's, which posited that a child's immature superego and personality structure would not allow the development or experience of a mood disorder. If one reviews the psychoanalytic literature at that time, it can be seen that well up into the 1970's this belief was still posited by a substantial number of child and adolescent psychiatrists. However, detailed case descriptions of depressed children who experienced sadness, irritability, changes in concentration, suicidal thoughts, hopelessness, changes in appetite and sleep, and other depressive symptoms, have long been reported in the psychiatric literature. Kraepelin, for example, reported as early as 1921, that mood disorders, particularly bipolar disorder, were rare, but did occur in children, and that a substantial number of new cases could be seen in adolescents.

In 1971, the union of European peditopsychiatrists officially recognized the needs of depressed children and adolescents by declaring that depression is an important illness that constitutes a significant proportion of mental disorders in children and adolescents. In 1975, the National Institute of mental health followed up on this sentiment, and in 1977, published their finding in a book entitled *Depression in Children: Diagnosis, Treatment, and Conceptual Models*. Even though the existence of depression in children and adolescents was first officially recognized at this time, it was not until the 1980's that interest in defining and diagnosing mood disorders in children and adolescents began to increase.

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What further became clear was that it was difficult to diagnose depression and mania in children because language does not begin to be used as an effective method of communication until approximately seven years of age. Even today, verbal communication remains the best tool for diagnosing psychiatric disorders. Without direct evaluation of the patient, one misses the core symptoms of a mood disorder, i.e. feelings of sadness, low self esteem, feelings of inadequacy, and the focus is primarily on the symptoms that motivated the parents to bring their child to the clinic in the first place, i.e. irritability, getting into fights, and other disruptive behaviors. The diagnosis of depression in children is also complicated by the fact that developmental processes affect the way the clinical picture is presented. Spitz and Bowlby by, in their classic papers, described the phenomenon of anaclitic depression, the depressive reaction seen in children separated from their primary caretakers at an early age. These children look depressed, cry excessively, react slowly to stimuli, and may have sleep and appetite disturbances. In somewhat older children, the clinical picture becomes a bit easier to figure out. Preschoolers with depression appear very sad, and appear slowed down. They have limited verbal communication. Mothers may describe that their child has lost his or her spark. In this age group, not gaining weight, not growing, and weepiness with 'tummy aches' are common symptoms. As children reach the age of six or seven, their verbal repertoire increases, and this allows them to become more accessible to be listened to and to be understood. Older children usually have no problem admitting to symptoms such as low mood, trouble concentrating, poor school performance, irritability, crying, and suicidal thoughts, which their parents are often unaware of. As a society, we often have difficulty believing that children can be suicidal, as childhood is typically equated with happiness, lack of worry, and lack of responsibility. However, it needs to be stressed that depressed children can be, and often are, suicidal. They may not be able to act on their suicidal impulses because they lack access to lethal means, but they certainly may

have the thoughts. Finally, somatic symptoms may coexist with depressive symptoms in children. The most common symptoms are headaches and abdominal pain. Oftentimes, depressed children are seen by the pediatrician, who conducts extensive laboratory and procedural workups for these symptoms. From an epidemiological standpoint, Kashani et.al. reported that in 1983, 2% of a general population of children met criteria for major depression, 7% of children admitted to pediatric hospitals for medical reasons met criteria for depression, and Ling et.al., reported that as many as 40% of children in pediatric neurology clinics presenting with headaches met criteria for depression. With this information in mind, let's go back and consider Alexander, our first case. As a professor, in my discussions with medical students and psychiatric fellows, I share that the adequate gathering and understanding of family history is vital in determining the correct diagnosis. Nowhere is this truer than in the diagnosis and treatment of depression in children and adolescents. A positive family history for mood disorders is more frequent in depressed children than in depressed adults.

There are three generalizations that are consistent across family studies regarding affective illness.

Affective disorders are familial, since the rate in relatives of patients is consistently about two or three times the rate in relatives of appropriately chosen case controls.

The most frequent affective disorder in relatives of bipolar patients is not bipolar illness, but unipolar illness. Bipolar illness is the next most frequent.

Among relatives of unipolar patients, there is a tendency, not always significant, for bipolar disorder to appear more frequently than it does among controls. Similarly, alcoholism can be a key diagnostically. For example, Strober reported a higher rate of affective disorder and alcoholism in adult relatives of patients with bipolar disorder or schizophrenia. In a study conducted by Barbara Geller, the rates of alcoholism were higher in adult relatives of bipolar children, 20% higher, than in relatives of those children diagnosed with depression only at 12%. Demetri Papolos reported that in a majority of children diagnosed

with bipolar disorder before the onset of puberty, the family histories revealed mood disorders and/or alcoholism coming down both the maternal and paternal sides. Finally, the presence of suicidal behavior in family members can be helpful in separating unipolar from bipolar depression. In a study by Goodwin and Jamison on bipolar patients, suicides in the probands' generation and later generations largely occurred in people with symptoms in antecedent affective disorder. Let's discuss Alexander's family history. In taking a family history, I always ask parents the following questions: I start off with mom, and I ask her age. I am interested in knowing what she does for a living. I ask her, when she thinks about herself and her parents and her grandparents, her aunts and uncles, her nieces, her nephews, her cousins, everybody that would ever get together at a family gathering, is there anyone in that group that has ever been diagnosed with, or treated for depression, or who she thought was probably depressed, could have benefited from treatment, but never got any? I ask, in that group, was anyone diagnosed with bipolar illness, was anyone in that group ever diagnosed with an anxiety disorder, and I explain exactly what that means: social phobia, panic attacks, Obsessive Compulsive Disorder. I ask about a history of schizophrenia in this group. I ask if anyone in the group has had a problem with alcohol or with drugs. I ask if anyone in this group has ever been psychiatrically hospitalized or had a nervous breakdown. I am continually amazed at the number of positive responses to this question after a series of negative responses to the previous questions. Finally, I ask if anyone in the family has attempted to kill themselves or actually succeeded in harming themselves. I then ask, what is the status of the marital relationship, and I ask about the father. I am interested in what he does for a living... and I ask the same questions in the same order. Now, it may seem as if such a discussion would take a substantial amount of time, but it usually only takes about ten minutes to gather this information, and this information is vital diagnostically. Alexander's family history reveals the following: his mother is a 38-year-old divorced white female who is currently employed as a bank teller. His

maternal grandmother is currently in her 80's and taking Zoloft for depression. There is a maternal aunt with panic attacks. There is no maternal history of bipolar disorder, schizophrenia, alcohol or substance abuse, nervous breakdown or psychiatric hospitalization, or suicidality. Alexander's father is a 42-year-old white male who is employed in his own computer firm. Alexander's parents have been in the process of divorcing for the last five years, and the divorce became final one year ago. His father has sporadic visits with Alexander. Alexander's father has been in treatment for "personality problems," but denies a family history of major depression, bipolar disorder, anxiety disorder, schizophrenia, alcohol or substance abuse, nervous breakdown or psychiatric hospitalization, or suicidality. Alex has one sibling, who is five years of age, and apparently in good health. Given the above family history, it is my clinical opinion that the likelihood that Alex's symptoms are related to a bipolar disorder are low. The family history demonstrates few episodes of affective illness, no evidence of alcoholism or substance abuse, no evidence of suicidality. In addition, there are clear-cut social and familial factors, which could contribute to Alex's current poor performance. Finally, Alexander's neurovegetative signs are not so severe as to warrant inpatient treatment. Treatment recommendations for Alex, given a diagnosis of major depression, would include a combination of antidepressant therapy and outpatient psychotherapy. Prior to the initiation of any medication, I would obtain lab work consisting of a complete blood count to rule out anemia, electrolytes, BUN/Creatinine, Liver function test, Thyroid function tests, to rule out hyper or hypothyroidism, Lyme titres to rule out Lyme Disease, ceruloplasmin, and serum copper to rule out Wilson's disease, and a baseline EKG. A full physical exam including height, weight, blood pressure, and a neurological exam is also necessary. Careful, informed consent is always obtained from parents prior to the start of any medication, and children should be medically cleared as well by their pediatrician. The use of SSRI medications has demonstrated clinical anecdotal efficacy for children.

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Paxil is my first-line treatment choice because of its easy tolerability and favorable side effect profile for this population. Occasionally, when Paxil has not been tolerated, I have used Zoloft or Prozac. It has been my experience that an improvement in mood begins to take place within the first three to four weeks of treatment, with full effect, as seen in the adult population, by four to six weeks. During this time, I meet with the child on a weekly basis to monitor the effect of the medication and to deal with the psychological issues which contribute to his or her difficulty in functioning. Parent counseling is also scheduled during this time. Patients who show a response to the medication are usually kept on the medication for one year, after which time I slowly taper the medication and discontinue it. The patient is then watched for the return of symptoms, and if they recur, medication is restarted. Occasionally, it is seen in practice that a child demonstrates a partial response to an antidepressant or no response at all. In this situation, I tend to stop the antidepressant and switch to another agent in the same class. I then give the second agent a full four to six week trial. Usually, there is a response to the second antidepressant. In situations where there is a poor response to the second agent in the same class, I tend to switch to an antidepressant in a different class, such as Wellbutrin. If at least a partial response is not obtained with this strategy, I begin to question my diagnosis and

consider other etiologies for the symptoms the patient is experiencing. It is not my clinical experience that children with unipolar depression routinely require augmentation strategies such as the co-administration of Lithium or Cytomel, as is true in the case of adults. Usually, children respond to the first agent, if not to the first agent, to the second agent, and if not to the second agent, to Wellbutrin. It has also been my experience that in situations where mothers or first-degree relatives are depressed, children tend to respond to the medication that has been most helpful for the parent. Occasionally, in the treatment of these children, one may notice a profound improvement in mood within two weeks. I tend to be very cautious about this phenomenon because in my experience, it tends to be a harbinger of impending hypomania. We know pharmacologically that antidepressants take four to six weeks for a full effect to be achieved. Though some improvement may be seen at two weeks, it is usually not a robust response. Other hallmarks of impending hypomania include sleep disturbances, increased irritability, aggressiveness which is out of character for the child, new interest in sexual topics, and disordered, racing thoughts. Any of these findings should signal the clinician to stop the antidepressant medication. Though it is recommended to taper antidepressants, especially SSRI antidepressants, when changing to another agent or stopping them, symptoms consistent with impending hypomania warrant abrupt discontinuation.

**Childhood Bipolar Depression:
Case #2**

Anne is a ten-year-old white female who presents to the emergency room for evaluation of gradually worsening and bizarre behavior. According to Anne's parents, Anne has become markedly irritable and aggressive in the classroom setting. She has been disciplined for threatening other children on the playground with sticks and with sharp pencils in response to being teased and provoked. Parents report that temper tantrums, often lasting hours in duration, can be precipitated merely by telling her "No," in response to a request. She is reported to be markedly moody and can go from periods of elation to periods of sadness and crying despair in cycles of hours to days. Her parents report that it is difficult to get her to settle down for sleep, and that she seldom falls asleep before 11 or 12 at night. Her mother wakes her at 7:30 for school and reports waking her is like "waking the dead." When she awakes, she is irritable, oppositional, and nasty. Her interests include playing Nintendo and playing with her dog. Her energy level is reported to be variable—extremely high at times and extremely low at others. Her concentration is described as poor. Her appetite is voracious and includes a diet of junk food and carbohydrates. She has expressed to her mother a wish to be dead with a plan to jump from the balcony of their apartment. Her mental status is significant for behavior which is psychomotorically retarded, irritable, and angry. There are no stereotypes or tics noted.

Her speech is slow in rate and low in volume. Her thought process is organized, but markedly circumstantial. She admits to episodes of hearing voices of a "devil and an angel telling her to do bad things or to do good things." She reports mild ideas of reference—of peers at school talking about her behind her back. She admits to having "confusing thoughts," and reports that she often thinks about suicide, and wishes that she were dead.

What can be concluded about Anne?

Evidence that manic-depressive illness frequently emerges in adolescents, perhaps even in childhood, has generated increasing interest in the early features of the illness. The clinical presentation of early onset illness differs from bipolar illness with later onset, as does the patient's experience of it. Diagnosis is difficult, and bipolar illness is frequently mistaken for conduct disorder, schizophrenia, or ADHD. Difficulty in correctly diagnosing childhood bipolar illness can be traced to several sources. Although bipolar disorder is a relatively common diagnosis, many clinicians continue to associate manic depressive disorders with a later age of onset. Many, also wishing to avoid psychiatric labeling during adolescence, tend to avoid probing and explicit questioning of adolescents, and fail to inquire sufficiently into the presence of depressive symptomatology. Likewise, there is a tendency for some child psychiatrists to avoid the use of medications, and consequently,

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they are likely to choose a diagnosis that does not require drug therapy. In addition, the DSM-IV criteria apply poorly to the diagnosis of depression and bipolar depression in children. For instance, duration criteria for the diagnosis of a depressive episode requires at least a two week period with five or more depressed symptoms. However, a significant proportion of early onset bipolar children demonstrate frequent mood and energy shifts that occur several times within a single day. By DSM-IV definition, mood states that occur less than the required duration cannot be formerly diagnosed. It is becoming clear that bipolar disorder in children requires its own criteria. Hypomania can be misdiagnosed as hyperactivity because of its psychomotor component and cognitive changes, such as distractibility and shortened attention span. Several features of hypomania can aid in differentiating it from hyperactivity. It is more episodic and characterized by rapid mood swings, a family history positive for affective illness, and episodic hyperactivity. Manic children show significantly greater behavioral pathology and overall maladjustment. Their psychopathology manifests itself in psychosis, depression, aggression, excitability, rapid mood swings, hostility, inappropriate affect, and disregard for the feelings of others. In evaluation of children with bipolar disorder, a history of separation anxiety is common, as are rages and explosive temper tantrums, which may

last several hours. Marked irritability, oppositional behavior, distractibility, and aggressiveness are also commonly seen features. Grandiosity, carbohydrate cravings, and lethargy, especially upon morning awakening, are also features seen commonly in bipolar illness in children.

Children with bipolar disorder tend to cycle from depression into mania and then back again quite rapidly. Some may cycle over a period of days. Others may seem to alternate mood states throughout the day. Because the mood shifts are so rapid, some children become trapped in the switch process and develop what is called a Mixed State. At this time, they may report feeling agitated and constantly restless with a high degree of energy. At the same time, however, they may feel worthless and self-destructive. While mixed states are not as common in adults, unless induced by antidepressant treatment, they tend to be a hallmark of the ultra rapid cycles found in childhood onset bipolar disorder. Parents may also report that children with bipolar depression demonstrate sensitivity to stimuli of all kinds. Not only are they bothered by sensations, odors, and noises, but they seem to have great difficulty making shifts from one context to the other. Children with bipolar depression tend to demonstrate difficulty maintaining peer relationships. Children can often be described as bossy, intrusive, or too overwhelming and aggressive. Parents may describe periods of intense silliness, giddiness, goofy behavior, grandiosity,

and outrageous comments.

Children with bipolar depression may demonstrate psychotic thoughts and report auditory hallucinations which are mood-congruent. Occasionally, children with severe neurovegetative signs and hallucinations will be misdiagnosed as having major depression with psychotic features. According to Dr. Maria Kovacs, a major researcher on childhood mood disorders at the University of Pittsburgh, the diagnosis of major depression with psychotic features is most often encountered in the elderly. In children, it is exquisitely rare, and should prompt the consideration of a different diagnosis, and most probably a bipolar depression.

With this in mind, let's consider Anne's family history. Anne's mother is a 35-year-old white female who is employed in retail sales. She has been diagnosed with depression and is currently on Effexor. Her maternal grandmother was also depressed, as is a maternal aunt. There is no maternal history of bipolar disorder, schizophrenia, or anxiety disorder. Her maternal grandfather, maternal uncle, and another maternal aunt are all reported to be active alcoholics, and have attended rehab several times. Her maternal aunt has attempted suicide several times and has been hospitalized. Anne's father is a 38-year-old retail distributor, and they have been married for 15 years. He has been depressed off and on since his late teens and is currently on Prozac. Anne's paternal grandfather and paternal aunt are also depressed, and there is some question that her paternal aunt may actually have bipolar disorder. There is no other history of bipolar disorder, schizophrenia, or anxiety disorder. Anne's paternal grandfather "drinks heavily" and there is a family history of suicide attempts by her paternal first cousins. Anne has one younger sister who has been evaluated for possible ADHD. In this case, it is clear the family history is markedly more complicated than in Alex's case (case #1). We see unipolar depression on both sides of the family, as well as histories of alcohol abuse, and suicidality. Given these features, a diagnosis of bipolar depression for Anne is likely, and the likelihood that she will have an adverse reaction to an antidepressant medication is high. Treatment of this disorder is more complex and requires thorough psychoeducation for the parents, who need to understand clearly the difference between unipolar and bipolar depression. In addition, informed consent about mood stabilizing medications needs to be obtained, and the substantial risks, both short term and long term, must be explained clearly. I tend to begin treatment of these children with a mood stabilizing medication such as Depakote or Lithium. If the child is markedly suicidal, Lithium is the first line of treatment, as it is the only mood stabilizer clinically and statistically associated with a decrease in suicidal behavior—approximately a sevenfold reduction of suicide attempts and fatalities in patients diagnosed with bipolar disorder. This is a major consideration when discontinuing Lithium after long-term maintenance therapy has been considered for a patient. Ross Baldessarini

reported that discontinuing Lithium rapidly over fourteen days led to sharp increases in suicidal risk. The risk increased twenty fold in the first twelve months, but was only half as great following slow discontinuation over fifteen to thirty days. Lithium has also been associated with an anti-depressant effect, though some studies seem to suggest that Depakote is equally efficacious in the treatment of bipolar depression.

In situations where the child is experiencing rapid cycling, as most do, or is in a mixed state, I tend to use Depakote first. As in the case of the treatment of depression, the duration of treatment with Depakote depends on clinical efficacy. Medication education with parents always includes the discussion that the duration of treatment depends on the efficacy of the medication, and what the child has to gain or lose by coming off of the medication. We know that bipolar disorder is a chronic illness, and best treated by the use of prophylactic medication for many years. The duration of treatment with Lithium is similar to that of Depakote, dependent upon the efficacy of the medication and the cyclical nature of the illness. Newer medications such as Trileptol, a metabolite of Tegretol, Topamax, and Neurontin have also been reported to be helpful with this bipolar disorder, though they are less well studied. Several studies seem to indicate that Neurontin seems to be a very poor mood stabilizer, though it has demonstrated efficacy for control of anxiety symptoms in children with these disorders. Oftentimes, clinical improvement in response to these medications can be witnessed within a two-week period of obtaining a correct blood level. In situations where Depakote produces no response after a period of one month despite patient compliance and good blood levels, I will opt to switch to Lithium or some other agent. In situations where Depakote produces a partial response, I will often add Lithium as an adjunctive treatment.

In addition to the mood stabilizing medications, the atypical neuroleptics, such as Risperdal and Zyprexa, have shown promise in the treatment of bipolar mania and psychosis, either as first line medications or as adjuvants to the mood stabilizers. As with all neuroleptics, however, the risk of long term sequelae, such as tardive dyskinesia, weight gain and lipid and glucose metabolism abnormalities are real concerns, and the risks of these conditions must be weighed against the benefits of prolonged treatment. As in the case of treatment of unipolar depression in childhood, treatment of bipolar depression requires the presence of a therapist as a consistent and abiding presence to the patient and to the family. Medication must be managed by a doctor, and is not the complete answer. Individual and family therapy are essential components of therapy, particularly as it applies to the treatment of children and adolescents.

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Mental Health Treatment in the Context of Ongoing Threat

By Randall D. Marshall, M.D.

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Instructor of Clinical Psychology, Department of Psychiatry, Columbia University College of Physicians and Surgeons

The fact that terrorism is psychological warfare has direct implications for the mental health community. Although the loss of life on 9/11 is tragic and appalling, the consequences for the nation and for greater New York extend far beyond the actual destruction of life and property. Because of the attacks, it is now documented that hundreds of thousands of persons developed PTSD and depressive symptoms in New York and across the country; our community and state was plunged into recession, bringing with it all the mental health risks and suffering of unemployment; and our nation has waged 2 wars. The nation is being drained of billions of dollars for security and defense. Regardless of one's political viewpoint, we are all trying to adjust to a new uncertainty about our safety from random attacks on civilians from terrorists.

Prior to 9/11, a patient wanting to discuss politics in session might have been seen as defensive intellectualization. I believe that perspective is no longer tenable. It is worth noting that many of our theories and maxims about therapeutic process were developed in the states during peacetime, or certainly during a time in which we were not physically threatened by attacks on civilians for political reasons in North America. Furthermore, the theoretical framework of traditional psychotherapy is rooted in a now obsolete perspective, with its roots in the culture of individualism, that most symptom manifestations can be entirely explained from the individual's personal history, character, and defensive structure, with little credence given to environmental events. It is our experience that many persons are having genuine and powerful reactions to current world events that are not idiosyncratic but rather best understood in terms of an interaction between the individual's place in his or her culture, psychiatric vulnerabilities, and prior life experience.

A patient with a serious anxiety disorder that is in full remission, who lives in New York but did not see the Towers attacked on 9/11, recently presented with an exacerbation of old symptoms, some new symptoms, and vivid dreams of a large plane being forced to land because of a kidnapping. All these symptoms coincided with the war in Iraq. Another patient, after watching two days of news coverage, awoke with a full-blown panic attack that had been in complete remission. Yet another patient, a Vietnam

veteran who had managed with sub-threshold PTSD for many years with moderate success, presented with full PTSD after 9/11 and sought treatment for the first time. Most clinicians I have spoken with in community trainings have similar stories.

In each case, the personal implications of these new political developments appeared to be the source of symptoms. Each patient felt more vulnerable than before because of fears of witnessing 9/11-like events again (patient 1), fears of being killed by bioterrorist or other attacks, or evoked memories of being constantly in danger in Vietnam (patient 3).

Our center has provided training in trauma-focused psychotherapy to over 500 clinicians in the greater New York area in the past 1 and a half years. We are frequently asked for advice as to how to handle the many fears expressed by our patients. Some basic guidelines culled from our experience are below:

1. *Don't underestimate the effect of terrorism fears and the war on our patients*—One of the great embarrassments of the mental health field is the way in which trauma histories were minimized or interpreted as fantasy in the past. We make the assumption that the current situation in the U.S. is affecting everyone, and research as to the vulnerabilities to PTSD in adults demonstrates unequivocally that psychiatric patients are particularly at risk for developing significant symptoms after trauma. By extension, patients may also be vulnerable to symptom exacerbation under our current conditions. It is the rare patient who is entirely unaffected, and this may in fact be a manifestation of social isolation, alienation, or extreme avoidance.

2. *Be willing to discuss these fears with your patients*—If the patient senses that we are dismissive of their worries, or are made anxious by such discussions, the opportunity to work with such fears therapeutically may never present itself.

3. *Make sure you are clear about your own conclusions as to the risks present in the current situation*—If we as mental health practitioners have not consciously considered our own reactions to the current situation, and made conscious decisions as to how we are going to live in the context of these new threats, it will be all the more difficult to work with patients on these topics since the discussion will evoke uncertainty and anxiety in ourselves.

4. *Engage the patient in a realistic discussion about the threats in day-to-day life*—The tendency to focus on new potential threats in the environment and exaggerate their risk appears to be almost universal. The risk of dying of cardiovascular disease in the U.S. is approximately 1 in 2; of being killed in a long automobile trip, 1 in 14,000; of being killed by a tornado, 1 in 450,000; of being struck by lightning, 1 in 1,900,000; and of being killed in a plane crash in the year 2001, approximately 1

in 1,400,000. Nevertheless, most persons give no thought to driving every day. Such facts can be extremely comforting to persons who want to use their rational capacity to overcome fear. A good example is the following: if a person witnesses someone killed by lightning, this fear will likely seem greatly exaggerated. By analogy, the fact that millions witnessed the attacks of 9/11 led to a collective irrational fear response related to flying.

5. *Encourage conscious decisions about daily behavior and risk appraisal that are not influenced by exaggerated fears*—Since anxiety is a normal reaction to the perception of threat, new reports of attacks, arrests of alleged terrorists in the U.S., and hypothetical scenarios such as bioterrorism will inevitably produce anxiety in most. However, functional disability in our patients (and in ourselves) will largely depend on our response to such emotions. If a patient does not go to work every time there is a new potential danger reported on the news, she will soon lose her job. If a patient keeps his children from school, his family and children will suffer (particularly since the New York data suggests that children with anxiety reactions are greatly influenced by their parents' reactions to the current situation). In other words, our task is partly to promote resilience in the face of adversity, rather than to treat anxiety.

Confronting the feared situation in turn leads to habituation to the anxiety fairly rapidly in most persons.

6. *Encourage patients to limit unnecessary exposure to anxiety-provoking cues such as "what if scenario" media speculation*—In addition to this basic principle (which has actually been extensively covered in the media), patients having clinically significant catastrophic reactions to news coverage are probably personalizing the information and imagining catastrophic scenarios as if they are certain or highly likely.

7. *The basics of self-care should be conscientiously maintained*—This public health message from (Federal Emergency Management Agency) and Project Liberty still applies to worried patients, and to ourselves. Although it may seem concrete and obvious, these reminders are beneficial to most patients because they reinforce common sense practice, support healthy coping strategies, and divert attention away from anxious worries. The basics of self-care include eating, sleeping, avoiding exhaustion, limiting intake of alcohol and other substances, exercise, restorative activities, and social interaction.

Being Mental Health Providers in an Uncertain Time

Clinicians are also worried. We are members of the community too, and have families whose safety concerns us daily. In addition, many of us working in this area have heard countless tragic and fearful stories related to the 9/11



Randall D. Marshall, M.D.

attacks, and are saturated with apocalyptic fears from anxious and depressed patients.

How can we continue to work in this new environment? The field of trauma has always emphasized the important role of ongoing psychological support for clinicians working in this area. Such support is necessary because maintaining an empathic capacity requires a sensitivity that makes us vulnerable to absorbing some of the affect expressed by our patients. This maxim is no longer an abstract, theoretical recommendation for clinicians but a necessary way of life.

Attending our Trainings or Referring Patients

If you would like to attend our intensive trauma-focused psychotherapy trainings, please call 1-800-LIFENET to schedule your attendance. Trainings are free of charge and sponsored in part by the United Way 911 Fund.

We are studying a wide range of therapeutic approaches for all the anxiety disorders and provide treatment at no cost in this context. If you would like more information or wish to refer a patient, please call us at 212-543-5367.

Anxiety Disorders Clinic, Trauma Studies and Services, New York State Psychiatric Institute (NYSPI) Columbia University College of Physicians and Surgeons. The New York State Psychiatric Institute: Founded in 1896, the New York State Psychiatric Institute (PI) continues to make vital contributions to our understanding and treatment of psychiatric disorders, and is ranked among the best psychiatric research facilities in the world today. Noted for its research on anxiety, depression and suicide, schizophrenia, and child psychiatric disorders, PI is at the forefront of research dedicated to developing better and more efficient therapies and medication treatments, as well as to unraveling the brain's mysteries. For more information please visit our site at www.nyspi.org.

New York State's Wall of Stigma and Discrimination Beginning to Crack Thanks to Timothy's Law Campaign

Staff Writer
Mental Health News

Seven weeks before his 13th birthday, Timothy O'Clair completed his suicide. The youngest of three children in his Schenectady family, Timothy hung himself in his bedroom closet on March 16, 2001.

Two years later, on March 18, 2003, his parents, Tom and Donna O'Clair, took part in a press conference in Albany to announce Timothy's Law Campaign (TLC), a campaign to finally end health insurance discrimination against persons with mental illness and chemical dependency in New York State.

At press time, Timothy's Law is about to be introduced into both houses of the state legislature, the first time the same "parity" bill has been introduced into both houses. The bill has garnered 32 majority cosponsors in the Senate and 50 cosponsors in the Assembly. Initially submitted on April 2nd, the bill is "on hold" at the request of the Senate leadership, which asked for time to seriously review it.

Key sponsors of Timothy's Law in the Senate are Thomas Libous, Chair of the Senate Mental Health Committee, Patricia McGee, Chair of the Senate Alcohol and Substance Abuse Committee and Hugh Farley, the senator who represents the district the O'Clairs reside in. Key sponsors in the Assembly are Paul Tonko, who represents the district the O'Clairs reside in, and Peter Rivera, Chair of the Assembly Mental Health Committee.

The bill was written with the input of a coalition of 25 organizations, including NAMI-NYS. It seeks equal benefits for mental health and chemical dependency services for health insurance policies written in New York State, contingent upon federal limitations.

Commenting on the legislation, Senator Libous said, "No family should have to experience the pain and suffering of the O'Clairs. Working together, we can ensure the best possible mental health services and coverage for all New Yorkers so we can prevent tragedies like Timothy's before they happen."

Timothy was a typical boy. He climbed trees, brought home stray animals and played the piano. Problems began to develop in his life as he grew, however, beginning with attention is-



Tom O'Clair speaking at the press conference

ues. By age seven, he was becoming easily frustrated and developing a serious temper. By the time he was eight, his family and his school knew he needed help.

Over the years, Timothy was diagnosed with Depression, Attention Deficit Hyperactivity Disorder, and Oppositional Defiance Disorder.

At the press conference, with Donna at his side, Tom O'Clair described how their son was systematically denied access to the health care he needed. While the family's health insurance allowed only 20 outpatient visits a year for Timothy's psychiatrist and psychologist combined, Timothy needed weekly visits to his psychiatrist to monitor his medication and twice-a-week visits to his psychologist.

Even the visits the insurance covered took their toll. While the family's copayments for both physical and mental health services were \$10 per visit initially, mental health visits quickly jumped to \$35 each.

Once the insurance was used up, Tom and Donna were left to fend for themselves, paying for care they could not afford.

Meanwhile, Timothy grew steadily worse. Two hospitalizations occurred, each limited to a week by the health insurer. For the latter hospitalization, the family paid out-of-pocket for three extra days, even though he had used only

seven out of his annual 30-day allotment for inpatient services.

Because the insurance would not pay for desperately-needed residential care, Tom and Donna finally had to "share" custody of Timothy with the state, and pay child support.

When the O'Clairs were able to access care and services, they found the treatment they attained to be high quality. The problem was that it was limited and sporadic, available only as insurance and the family budget allowed.

For more than five years, the O'Clairs struggled to obtain the care their child desperately needed while trying to make ends meet. Even after Timothy's death, the family continued to pay child support to cover his stay at the residential program -- \$226 out of every paycheck -- and they were still paying for the "extra" days of his last hospitalization. The family had to go to court to get the child support garnishment stopped.

"If Timothy had diabetes or cancer our health insurance would have provided unlimited coverage. Instead, simply by the nature of Timothy's illness, our coverage was limited," Tom O'Clair said. "We are confident that had Timothy received the services he needed, he would be with us now."

At the press conference, the O'Clairs were joined by representatives of the TLC coalition, which currently consists of 25 organizations, including advocacy

organizations, service providers, unions, hospitals and professional organizations. These representatives made their comments in a press release:

"It is too late to save Timothy's life, but that doesn't mean other children and families in New York should be forced to suffer the same fate," Paige MacDonald of Families Together of New York State said.

Referring to a recent actuarial study that shows the cost of parity in mental health and chemical dependency benefits would be minimal, Joseph Glazer of the Mental Health Association in New York State said, "It would have cost \$1.26 per month to save Timothy O'Clair. For pennies a day, our children and families could be getting the full complement of mental health and chemical dependency services."

"Not only would there be minimal premium costs, but studies have shown that equal mental health benefits raise productivity and lower overall health costs," J. David Seay, Executive Director of NAMI-NYS said. "With Timothy's Law, everybody wins."

The O'Clairs were also joined by Jessica Lynch, the reigning Miss New York City, who began to suffer from depression while in the third grade. She described how, at the age of 14, she was admitted to a psychiatric hospital weighing only 79 pounds, and how, after the number of days her insurance would pay for was up, the hospital found that she had been "magically cured," and released her, even though she still weighed 79 pounds. She said she was appalled that such practices were still happening.

Speaking at the Press Conference, Assemblyman Tonko he said he would do his utmost to pass Timothy's Law.

"I will implore my colleagues to open their doors so they can open their hearts," he said. "We need to change his devastating discrimination, and we're going to make this happen. We're going to bring about Timothy's Law, so we don't artificially restrict and deny the care that is needed."

NAMI-NYS urges all of its members to actively participate in the Timothy's Law Campaign, and challenges its affiliates to advocate for Timothy's Law with their legislators and Governor Pataki as they have never advocated before.

Show your appreciation for the legislators who support this law, and generate support for it in your community.

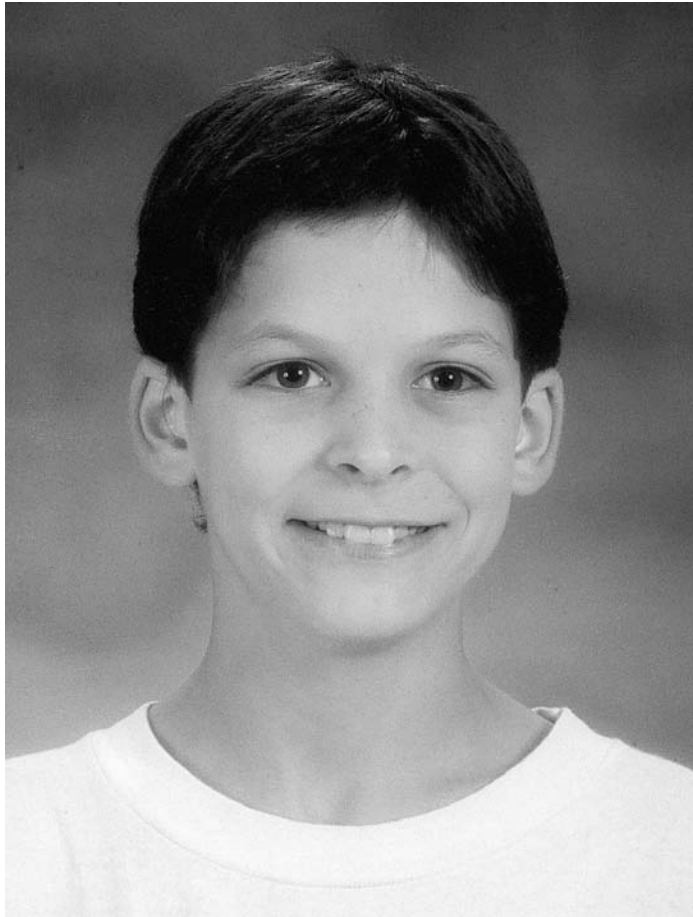
"If Timothy had diabetes or cancer our health insurance would have provided unlimited coverage. Instead, simply by the nature of Timothy's illness our coverage was limited. We are confident that had Timothy received the services he needed, he would be with us now." Tom O'Clair

You Can Crack the Wall of Stigma and Discrimination Together We Can Bring It Down

*With a record 32 Senators and 50 Assembly members
agreeing to sponsor Timothy's Law, this year's movement to end
mental health and chemical dependency insurance discrimination in New York State
has made more progress than any efforts in years past.*

Senators

- | | |
|-------------|----------|
| Balboni | Marchi |
| Bonacic | Maziarz |
| DeFrancisco | McGee |
| Farley | Mendez |
| Flanagan | Morahan |
| Fuschillo | Nozzolio |
| Golden | Padavan |
| Hannon | Rath |
| Hoffman | Robach |
| Johnson | Saland |
| Larkin | Skelos |
| LaValle | Spano |
| Libous | Trunzo |
| Little | Verella |
| Maltese | Volker |
| Marcellino | Wright |



Assembly Members

- | | |
|-------------|------------|
| Benjamin | Hikind |
| Bing | Jacobs |
| Bradley | Karben |
| Brennan | Koon |
| Canestrari | Lafayette |
| Clark | Lavelle |
| Cohen | McEneny |
| A. Cohen | McLaughlin |
| M. Colton | Millman |
| Cook | O'Donnell |
| Cusick | Ortiz |
| Cymbrowitz | Paulin |
| DiNapoli | Pheffer |
| Dinowitz | Powell |
| Eddington | J. Rivera |
| Englebright | P. Rivera |
| Galef | Sanders |
| Gianaris | Seddio |
| Glick | Sidikman |
| Gottfried | Stringer |
| Grannis | Sweeney |
| Green | Tonko |
| Greene | Towns |
| Grodenschik | Weinstein |
| Gromack | Weisenberg |

To show your support for Timothy's Law, please:

Call, write or e-mail your State Senator and Assembly member, if they are a sponsor of Timothy's Law, to thank them for their support. Educate your communities about why the law is needed. Hold events (be sure to include your Legislators) and get the message out through your local newspaper, television and radio. For more information on why New York State needs Timothy's Law, and for links to the latest "calls for action" as it goes forward, go to:

<http://www.naminycmetro.org/TLC.htm>, www.mhanys.org, and www.ftnys.org

Now under construction: www.timothyslaw.org

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- *In the Residential Program*, our staff works with each resident to select the level of supportive housing and the specific rehabilitation services which will assist the person to improve his or her self-care and life skills, with the goal of returning to a more satisfying and independent lifestyle.
- *The Housing Services Program*, available to low and moderate income individuals and families in Post Chester through the Neighborhood Preservation Company, includes tenant assistance, eviction prevention, home ownership counseling, landlord-tenant mediation and housing court assistance.
- *Hope House* is a place where persons recovering from mental illness can find the support and resources they need to pursue their vocational and educational goals. Located in Port Chester, the Clubhouse is open 365 days a year and draws members from throughout the region.

Human Development Services of Westchester

930 Mamaroneck Avenue
Mamaroneck, NY 10543

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The Mental Health News

New York City Section

The Workplace Center of Columbia University is Promoting Successful Employment Outcomes for Consumers

By Sheila H. Akabas, Ph. D., Lauren B. Gates, Ph. D., Suzanne Weidberg, MSW, Virginia Oran-Sabia, MSW

Gordon wants to get a job and *keep* it. He is 34 years old, diagnosed with schizophrenia. Gordon is bright and seems well put together so he can usually get hired. Because of his mental health condition, however, he easily becomes confused and uses abusive language when overwhelmed. As a result, Gordon has been fired from many short-term jobs. Gordon has asked his counselor to help him find work, but the counselor feels that Gordon is not ready for work because of his inability to keep a job. Can there be another ending to Gordon's story? What can Gordon's counselor do to help him find a job and *maintain* it?

This situation is typical of many consumers who are ready and able to work but do not have the supports they need to make long-term connections to employment. The Workplace Center of Columbia University believes that access to competitive employment is a civil right, the accomplishment of which warrants attention from the provider and

research communities. We are supported in this belief by the resources from both the New York State Office of Mental Health (NYS OMH) and the New York City Department of Health and Mental Hygiene (NYC DHMH). Recent initiatives, carried forth by the Workplace Center, open new opportunities for consumers through enhanced vocational services.

The WORC[®] Program, developed by the Workplace Center and funded in part by NYC DHMH, is a systematic approach to help providers of vocational services support consumers in making life long connections to work in a way that best meets their career interests, builds on their strengths and promotes their well-being. It is integrated into an agency through a comprehensive consultation process. To date, 19 agencies have participated in the WORC[®] Program throughout New York City.

The first Program component, *Individual Assessment and Workplace Intervention*, begins with identifying and resolving the potential barriers to employment that need attention in order to insure successful work outcomes. At the same time, this assessment helps consumers identify a career path and select a job along that path. Because some consumers may experience symptoms or side effects of their medications that can interfere with job performance, this component also helps identify the need for workplace accommodation and guides negotiating these accommodations with employers.

The second component of the WORC[®] Program, *Career Clubs*, is groups that offer consumers the information, support and feedback essential throughout the employment process. Each session includes the opportunity for mutual support and presents content that covers such topics as how working affects benefits, consumer rights under the Americans with Disabilities Act, and developing a disclosure plan. With this information, consumers are empowered to make employment decisions that best meet their needs and to carry them out with or without provider support, according to their own choice.

Through the third program component, the *Neighborhood Labor Market Strategy*, providers secure work opportunities by establishing a network of on-going relationships with local employers. Network development helps providers gain an understanding of how to work with consumers to meet employer needs and helps to increase employer understanding of consumers as qualified workers.

Utilizing EAPs and Unions as natural supports: EAPs and Unions are largely untapped sources of support at the workplace, often poorly understood by consumers and mental health providers alike. The Workplace Center, funded in part by the New York Work Exchange of The Coalition of Voluntary Mental Health Agencies, studied what EAPs and Unions currently do to help consumers in New York City maintain work. EAPs are a benefit offered by many employers to help their employees with personal problems that might interfere with job performance. Results of a survey confirmed that EAPs provide a wide range of services that would be helpful to consumers but typically the services are not targeted to, or utilized by, them.

Unions understand the culture of the workplace and have unique knowledge and skill needed to clar-

ify workplace structures and systems for consumers and providers. Although Unions have the potential to make connections between consumers and providers of vocational services and the workplace, results of the study indicated that these connections often are not made.

Based on study findings, the Workplace Center developed training curricula and an educational video to help providers of vocational services and consumers learn how to access these workplace supports and to help EAP professionals and Union representatives rally their expertise and knowledge in new ways to support working consumers.

Evaluation of the Performance Based Contracting Demonstration: To promote integrated, competitive employment for consumers, the NYS OMH is funding a cutting edge demonstration program, the Performance Based Contracting (PBC) Demonstration. It reimburses providers of vocational services once they successfully help consumers reach specific employment outcomes such as securing a job or achieving job retention at three, six and nine months. The program's six milestone structure is developed from evidence based supported employment technology that includes rapid placement into jobs, individualized job planning and consumer self-determination of a career path. Seven mental health agencies throughout New York State are providing vocational services through the PBC Demonstration and the Workplace Center has been selected by the State to evaluate its effectiveness.

Preliminary findings indicate that the program reaches those consumers who often have difficulty sustaining employment, promotes rapid placement in permanent, competitive jobs for a significant proportion of participants, and encourages provider agencies to adopt evidence based practices to achieve employment outcomes. Evidence also suggests that providers are expanding their definition of work readiness and embracing competitive employment as a realistic goal for a more varied group of consumers.

Initial findings also begin to identify areas that pose challenges to effective service provision through the PBC approach. These include *coordination* of service systems to resolve barriers to employment posed by nonvocational issues; staff *stability* to ensure that consumers do not lose momentum toward their employment goals; effective *benefits counseling* to help consumers overcome their hesitancy to secure work because of fear around the impact of work on their benefits; adequate *job development efforts* to provide a pool of possible employers with jobs that will meet consumers' interests and abilities; and *post-placement supports* that include accommodation at the workplace in order to promote retention. The PBC Demonstration will continue for two more years, supporting NYS OMH's commitment to an employment outcome and permitting further research of factors that best support successful employment for consumers.

Enormous advances have been made toward opening the world of work to consumers. These initiatives help identify approaches that are most effective and bridge the gap between research and practice. For more information, please contact the Workplace Center, (212) 854-5173.

Mental Health News

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committee in formation

Job Links Continues its Success

By Michele Fontaine, Coordinator
Job Links

The award winning Job Links supported employment program of Project Renewal, Inc. has been in existence since July of 1999. Our mission is to provide vocational rehabilitation to homeless individuals with a mental health background. Our ultimate goal is to mainstream these disenfranchised individuals by placing them in competitive, mainstream and permanent employment.

We are currently in our fourth year, and we have made a total of 81 placements in various industries. Some of these industries have been business services, health services, food services, maintenance, clerical, entertainment, mailroom, security and retail. At the time of this writing, Job Links has served 184 homeless individuals with a mental health history.

Job Links has had a number of success stories since we began in 1999. Perhaps the greatest success has been mainstreaming challenging clients into the competitive job market. Most of our clients have had numerous hurdles to cross over such as the following: severe and persistent mental health issues; numerous hospitalizations for these mental health issues; major medical problems as serious as HIV/AIDS, kidney failure and cirrhosis of the liver; little to no marketable skills; extensive learning disabilities and cognitive dysfunction often undiagnosed and left untreated. Perhaps Job Links most challenging area has been with the homeless piece. Up to 50% of our clients upon entering the program were still living in the shelter system. The remainder had a recent homeless history as early as 2-3 months prior to admission. At the point of discharge from the program, 36% were still in the shelter system and had been for the duration of their vocational activity- a tough venue to work out of when one is looking for competitive work in this current market!

In addition to this, Job Links ini-

tiated a close collaboration with Fountain House in June of 2001. The idea was "born" from the knowledge that some of our clients pursuing permanent and competitive employment didn't have enough of a work history to do this successfully. The original plan was that referrals could be made to Fountain House's highly acclaimed transitional employment program with the understanding that after one or two transitional employment experiences, the client would return to Job Links to continue their pursuit of a competitive job, this time better equipped to do so. At the same time, clients at Fountain House that have been doing 'te's' for a long time and that have been difficult to place competitively, would be referred to Job Links for supported employment. Clients would uniquely remain on both caseloads simultaneously during this collaborative effort benefiting by two solid teams working closely together towards the client's vocational health.

Our goal for the future is complicated and challenging. The current economic picture has had a big part to play in all this as well as the long-range impact of 9/11 on the city and on the overall mental health of our clients. Since we began in July of 1999, our clientele has needed more intensive, vocational supports particularly in the long term. Meeting programmatic goals for our funding source has been difficult primarily from our third year to the present. However despite all these odds, Job Links remains optimistic and strongly committed towards mainstreaming one of the most disenfranchised populations in the city via the world of work. We hope to continue our collaboration with Fountain House, which is doing quite well, and we constantly look for other creative collaborations and ideas to help "link" our clients to the overall community.

For information on Job Links, please contact Michele Fontaine, Coordinator at 212-620-0340, ext. 388 or by e-mail at mich-elef@projectrenewal.org.

Recovery and Employment The Journey Back

By Minnie Berman, Program Manager
and Julia Blydenburgh, FECS
Manhattan IPRT Consumer

Julia Blydenburgh, 56, can look back and see how mental illness--Bipolar Disorder, hospitalizations for suicidal depressions, manic episodes and subsequent homelessness caused the unraveling of her life since July 2000. This pleasant woman went from being a middle-class wage earner to living in a shelter with frightening uncertainty about her future. But since 2002, when she began the FECS Manhattan Intensive Psychiatric Rehabilitation Treatment program and Counseling Center, Julia has moved into a studio apartment in midtown Manhattan and started a part-time job as a Peer Advocate in the Mental Health Voter Empowerment Project.

Ms. Blydenburgh was a Brooklyn girl who was educated in Catholic schools. After high school she worked as a secretary for Eastman Kodak. She gave birth to her only son, Adam in 1975 and stayed out of the work force for two and a half years to raise her son, living in a quiet suburb in West Babylon, Long Island and then Queens. Temporary office jobs afforded her the opportunity to spend the summers with her son. "When Adam turned 6, I got a full-time permanent job at the IRS as a tax preparer. Eventually, I had to get a night job at the IRS so I could be home to make sure my son got to school and did his homework. The job at the IRS meant I didn't get home until 2 a.m., and it was hurting my marriage. My husband I never saw each other.

Over time things got worse; Julia and her husband separated. Julia began to be plagued by self-doubts and felt increasingly stressed and disturbed at her job. "I was at work and I couldn't make simple decisions. I had to quit." She became reclusive and suicidal. A friend helped her to get outpatient psychiatric treatment, but the medications were not working. Her mood swings were severe and by May 2001 she signed herself into St. Lukes-Roosevelt Hospital and was diagnosed as bipolar. After her discharge, she was referred to FECS Manhattan IPRT and Clinic for

rehabilitation and treatment services. After Julia accomplished her housing goal through the IPRT program, she felt free to explore what she wanted to achieve next and chose to pursue a vocational goal. Surveys indicate that the majority of consumers with persistent mental illness ranked employment as an important personal goal.

Since Julia entered the FECS Manhattan IPRT program in January 2002, she has not only gained greater stability in her mental health condition and found permanent housing but she also recently completed training as a Peer Advocate and is working part-time for the Mental Health Voter Empowerment Project.

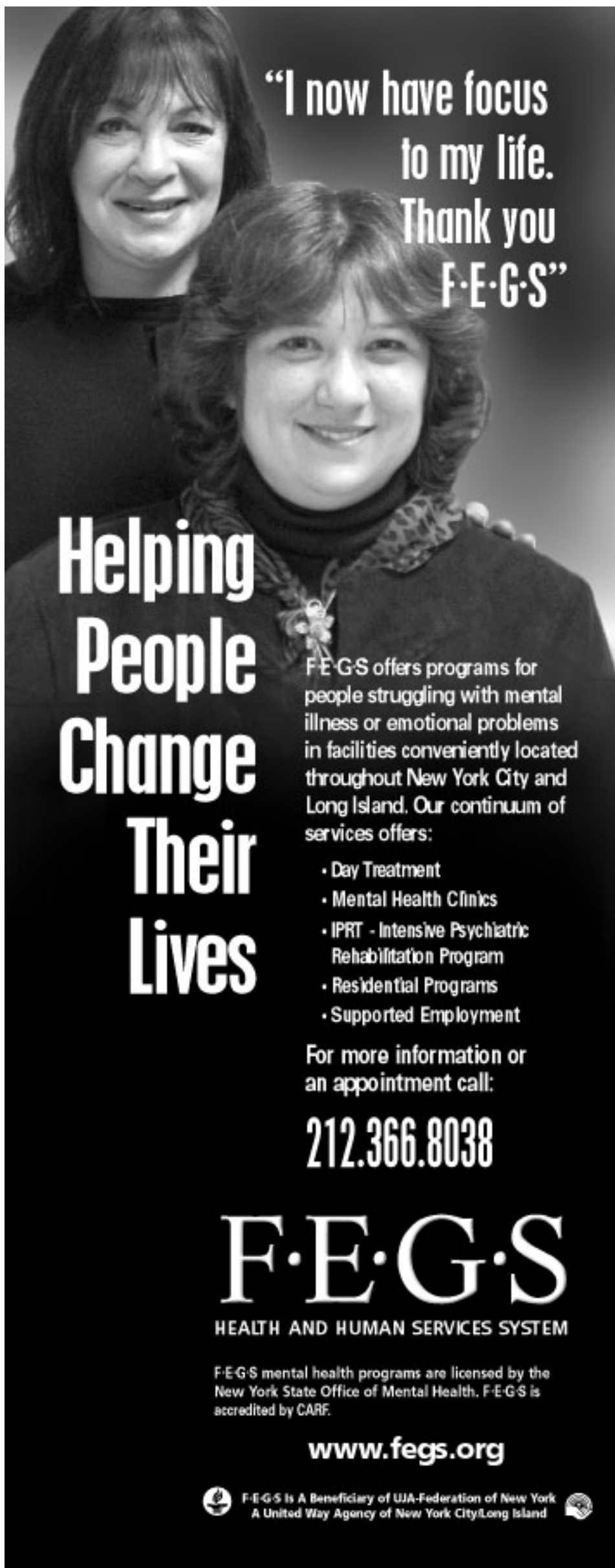
"My job is to visit mental health programs and educate consumers on how important it is for them to vote on the issues they feel are important for their lives. I help them to register to vote and make them aware of their need to be heard and how their vote can make a difference. I have also decided to apply for part-time office work through FECS Work Services Supported Employment Placement program."

When asked why work is important to her, Julia had much to say. "I'm really looking forward to making money so that I can afford to buy presents for Christmas like I used to be able to give. I also would like to go out to dinner and a movie. I feel like I'm ready to take on more responsibility and learn more. The favorite part of a job for me is the learning process. I like to get into every "corner" of what it takes to be good at the particular job I'm doing. It makes me feel so proud when I am working and responsible. I'm also thinking of one day going back to college to continue my education."

Julia continues to attend the FECS Manhattan Intensive Psychiatric Treatment program (IPRT) part-time where she has made many close friends and serves as a role model to her peers. She volunteers as a peer counselor on the IPRT Consumer Warm Line and tutors peers in reading and writing skills toward GED preparation.

"FECS has been extremely supportive, and now that I'm back in the world I'd like to give back all the favors I've received. I'm finally getting my life back."

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FEGS L.I.F.E. Program: Building Careers in Human Services

Staff Writer
Mental Health News

“Two Workers Tell their Stories”

According to Ed Brown, Director of the L.I.F.E. Program at FEGS: “People in recovery have skills, abilities, and insight that are essential to transforming the “helping process.” They provide a powerful supplement to a wide range of professional rehabilitation, treatment, and recovery-oriented services.”

Careers in Human Services, is part of the L.I.F.E. Program, a consumer-run multi-service program of FEGS' Long Island Division. Funded as a Transitional Employment Program through the New York State Office of Mental Health's Special Vocational initiatives, CHS offers mental health consumers paid work experience and teaches them how to work in the Human Service arena, using their own recovery as a tool to help others.

In 1986, Sandra was diagnosed with depression and anxiety; she also had brief psychotic episodes. Sandra's story exemplifies the benefit of work in a recovering person's life.

“The experiences I had growing up with my father were extremely abusive. My father was a Holocaust survivor who became sadistic with his family in all areas. I remember when I had my first psychotic breakdown, I was very fearful that my husband was Hitler, my father was Mengele, and that they were ready to kill me at any moment. Over the years psychotropic medicines and treatment have helped me a great deal. Working and rehabilitation services have also helped me to focus and concentrate better.

“In the summer of 1998, I took a risk and became an IPRT Program participant at FEGS. The structure, social atmosphere, and groups that were offered helped me to become more stable. Slowly my depression lifted. Helene, a friend and peer at the IPRT, started working part-time at the LIFE Program, I decided to try too. I was hired as an Assistant Case Manager at Catholic Charities, escorting people to doctor's appointments, to Social Security for Medicaid/Medicare, for Food Stamps, clothes shopping, etc. In December 1999 I was asked if I would like to be a Job Coach. I could have stayed on at Catholic Charities, but I decided instead to stay with FEGS /LIFE because I still had anxiety and stress and found the LIFE environment helpful. I liked the staff and colleagues, and I had friends at LIFE. I decided to take the position as Job Coach with Careers in Human Services.

“Being a Job Coach is wonderful. I have nine to twelve consumers to

work with each year, and I am able to see the progress that they are making in their jobs and how they are able to find successful employment after their internships. It gives me a great feeling of satisfaction to see their success and know that I am part of it. Most every person went on to employment and/or school and improved their situation. I was able to support them in their process and assist them to discover the strengths and resources in their recovery experiences.”

Helene, now Supervisor at Careers in Human Services at FEGS/LIFE, was diagnosed with Schizophrenia in 1990. “I have come to realize, through my tenure with the LIFE Program that I am also an abuse survivor and experience periodic PTSD symptoms. The LIFE Program is a very important place to me. It is a place that has allowed me to grow, at my own pace, as an individual as well as an employee. When I first began working at five hours a week that was all I could handle. I slowly increased my hours until I was working 15 hours a week.

After a few years, when the position became open for a full-time clerical worker, I felt ready to take that step and I applied for it. In the two years I have worked in this capacity, I have grown a great deal. When the position became open for the Coordinator of Careers in Human Services, I felt confident in applying for it. The LIFE Program has been both supportive and encouraging for me, a place where my recovery is primary. I feel I have developed tremendously in this nurturing environment and I am very grateful to be successful as a full-time FEGS employee with the LIFE Program.”

The Transitional Employment Program is unique because it pays people in recovery while they transition from a difficult past to secure jobs in the Human Services arena. FEGS Careers in Human Services believes people in recovery have unique expertise that can increase the success, skills, and resources they bring to Human Services work. Careers in Human Services is a year-long Internship Program where people work ten hours a week in a Human Service environment, receive training, and participate in a weekly support group to share their successes and struggles in the workplace.

The program outcomes are impressive: 70% - 80% of all participants transitioned to full or part-time work in the Human Services, 10% - 20% pursued advanced educational goals, and 5% have transitioned to permanent part-time or full-time work in other fields. After seven years, we believe this project has yielded tremendous results, as Sandra and Helene's stories show.

Small Business Defies Challenging Economic Times

Staff Writer
Mental Health News

These are difficult times for small businesses in New York City, and that means difficult times for individuals with disabilities to find employment. The war has the economy stalling after a brief increase in investor confidence at the beginning of the New Year. The jobless rate in December, according to The New York Times, increased by 1 percent to 8.4 percent in NYC, exceeding the national average; the small business has to create and remain flexible when designing and finding creative ways to increase and sustain revenue streams while adhering to operational fiscal control and vision. Phoenix Recycling and Maintenance Inc., a janitorial and renovation company located in Brooklyn has over the last six years developed a solid business strategy based on competitive service and pricing. Phoenix has a solid track record with for-profit companies and not-for-profit mental health agencies and a consistent, reliable and dedicated workforce of employees with mental health disability histories that has shown Phoenix capable of enduring this challenging economic trend as well as being a company with growth potential.

Phoenix was founded in 1997 by the Institute for Community, Inc. (ICL) a not-for-profit agency that provides services and opportunities to individuals with mental health, physical and developmental disabilities to improve their quality of life and participation in their communities as residents and contributors. As a for-profit subsidiary of ICL, Phoenix is charged with realizing in daily practice one of the agency's goals of providing real career opportunities for individuals with disabilities in the employment of their choice. Phoenix began, as do most affirmative businesses, small; with 10 employees working part time and three ICL contracts in providing residential janitorial and recycling services. Phoenix learned early to understand its strengths, improve on weaknesses, and learn its customers' needs. Phoenix has grown to 45 full and part-time employees, (95% individuals with disabilities or employment barriers), over 30 contracts in all five boroughs and over one million dollars in revenue. More important to ICL and Phoenix than breaking even at the end of the year is the commitment of not laying off employees who are striving, (many for

the first time) to develop career paths in employment. Gina Genovese, Business Manager of the company, stated, "Many of our employees work part-time and realize there may be times where their hours need to be reduced from a particular site, but there are usually opportunities to work on different sites or projects to make the hours up." "This flexibility allows stability, diversity in skill development, and continuity of their employment, which increases their marketability when they choose to leave Phoenix."

All about Team

The success of Phoenix is measured by the success of its employees. Over the last six years, Phoenix has modeled the company after Japanese automobile manufacturing practices of the seventies like Honda and Toyota and technology corporations of the eighties like Microsoft and Apple. These companies learned from the fall of the American auto and iron ore industries during the oil crisis of the mid-seventies that cost effectiveness and company growth are impacted positively when employees and management both share vested interest and direct input in how products/services are produced and provided. This team concept can improve product quality and maintain it via company pride, employee development investment and employee respect. In keeping with this team attitude, Phoenix utilizes "work clusters." This means that two or three janitors work side by side with a cluster manager. They arrive as a team, work as a team, and trouble shoot as a team. Each employee carries his/her own weight, with the supervisor acting as a liaison between the team and the client. Each cluster can provide services to two or more facilities each day. Each supervisor is expected to participate as a full working member of these teams. So everyone is important to the goal, and no one person is greater than the whole. The team attitude is pervasive throughout Phoenix: Each individual worker has the ability to contact Ms. Genovese on a daily basis with any and all concerns they may have. This ability to communicate on all supervisory levels is important for individuals with disabilities to feel part of and not isolated from an effective band of contributing equals.

Over the past six years, Phoenix has shown impressive numbers in employee diversity, retention and career advancement opportunities. The workforce consists of people with severe and pervasive mental

illness, physical disabilities, mental retardation, felony records, drug and alcohol histories, as well as language barriers. Over the past twelve months, Phoenix has maintained a 60% retention rate for individuals employed twelve months or longer. The national average for the population to obtain and retain employment is 10 to 15% based on employment research done by Anthony and Blanch, 1987; Salyers and Muesur, in press. "Because the majority of the workforce has a history of disability there is an understanding and sensitivity, but there is not a compromise in the quality of our work." Ms. Genovese added, "Everyone is expected to do their job; we hire people not based on their past but based on their personal commitment to work." This ideology has served Phoenix well.

How to Get into Phoenix

These concepts of teamwork and assertive communication become familiar to ICL consumers early on as they prepare for employment training. Phoenix has partnered with the agency's Vocational and Rehabilitative Services Department and provides a 90-day, paid janitorial training internship. Individuals interested in this field of work get the opportunity to work along side Phoenix employees, learn the same tasks and skills and show their desire and commitment. "Most of our employees are selected from our internships because we have a better sense of what they can do." Ms. Genovese states, "They also have a clearer understanding of what we expect and the people they will be working with. It helps them become comfortable as new workers and introduces them to and reinforces the teamwork attitude we work to instill in all of our employees." Paula Rivers, Director of the Vocational Department, supports the notion that the arrangement supports consumers. "The partnership has been very successful; Phoenix is major employer of ICL consumers. Over the last five years the best retention rate of all the businesses we place consumers in comes from this relationship. Our people do better as workers."

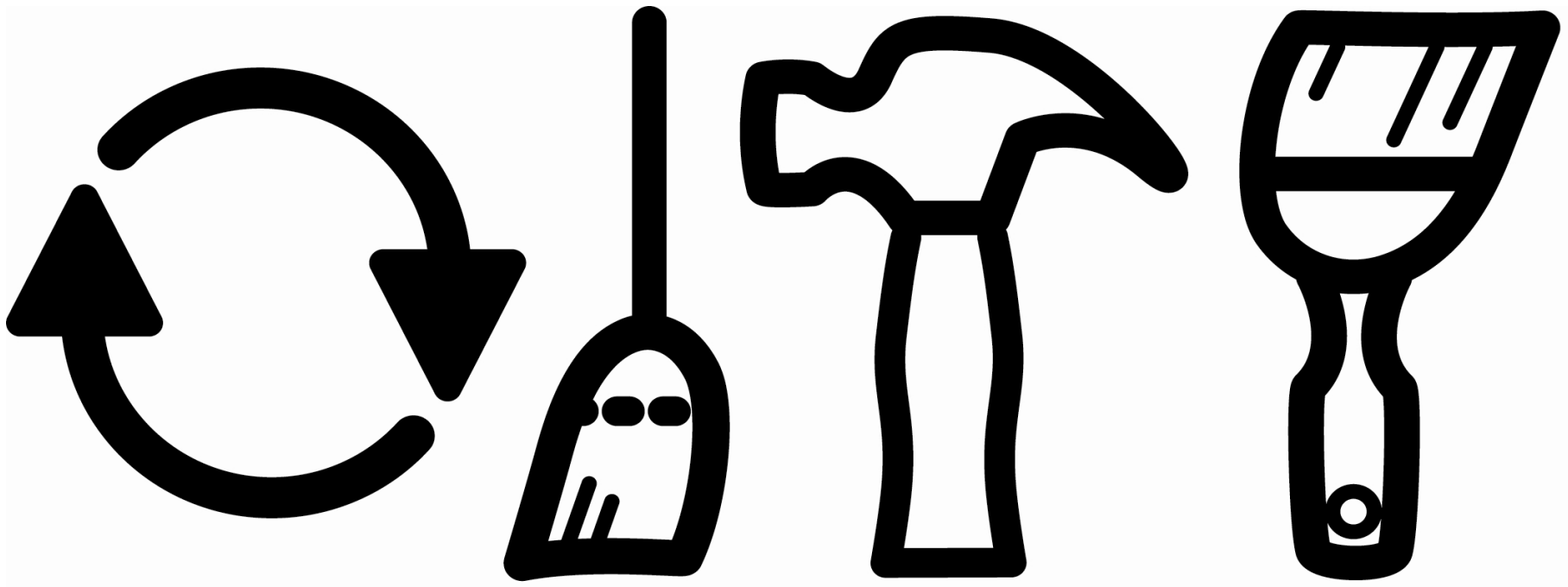
Partnerships That Work

Phoenix has also developed a number of partnerships with not-for-profit agencies throughout the six years: Community Access, Center for Urban Community Services, and Fast Track To Employment. These partnerships have supported business growth and the quality of the em-

ployees associated with the company. The partnerships are built and maintained on a win-win objective. Consumers get quality, real work training and the opportunity to gain employment in Phoenix while the partner agencies these trainees are associated with gain a committed employment resource and a future experienced vendor with an extensive knowledge of mental health organizations. One of the areas of expertise for Phoenix is consultation and services for agencies as they prepare for state and city regulatory audits. "We can help agencies assess the maintenance and janitorial needs for residential programs, day treatment centers and residential/treatment facilities for the mentally retarded/developmentally disabled. Our consultants can help agencies plan service needs and costs for an entire year. Many times this cost is lower than that of the competition." Ms. Genovese adds, "We understand the tight maintenance and janitorial budgets agencies face so we work to develop a strategy that makes sense and can save money throughout the course of a year."

Future Vision

Phoenix is faced with a number of challenges as it looks to the future as a growing small business. The most clear is the reality that Phoenix must increase the number of outside for-profit contracts to balance the number of not-for-profit and ICL contracts it has. Currently Phoenix still provides a large amount of services to its parent agency. Ms Genovese, "The more Phoenix can do outside of ICL, the better understanding we have of our competitiveness in the market." The other challenge is increasing the complexity of work the company does and increasing the skill level of all employees. One of the possibilities for rapid growth potential for the company is to merge with an existing company, preferably one that specializes in areas of floor care and installation or construction and renovation. This type of merger is always a risk because in many cases two different processes and philosophies are combined, and time and patience are required to allow collaboration and unity to find a stable foundation. Ms. Genovese noted, "Growth as a company and growth as an employer continues to be our major focus. We hope to continue to provide our employees the best career opportunities possible while delivering quality services to our clients."



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JBFCs Addresses Employment Needs for People with Mental Illness

Staff Writer
Mental Health News

One of the most prevalent and misunderstood disabilities in the United States is mental illness. Mental illness, in all its various forms, is more common than cancer and diabetes combined with more than five million Americans experiencing an acute episode at some point in their lives. One out of five families is affected by a severe mental illness, bipolar disorder, schizophrenia, or major depression of a family member (Source: NAMI). While significant progress has been made in the fields of mental health diagnosis and treatment, the challenges of daily living continue to confront those suffering with mental illness. As the U.S. moved away from mass institutionalization of the mentally ill, the challenge became how to help people living with mental illness become self-sufficient. Training for and securing employment were key elements of this challenge.

Those with a serious mental illness face the greatest barriers to employment and the highest degree of stigmatization in the workplace. The unemployment rate for this population is reported to be as high as 70-90%. The majority of people with a mental illness want to work and recent surveys report that approximately 70% of those with significant psychiatric problems rank work as an important goal for themselves (Source: Matrix Research Institute, 1995).

Historically, services for the mentally ill have primarily focused on the psychiatric needs of consumers. As individuals have moved from state institutions into community and self-sufficient living over the past twenty-five years, more and more social service programs incorporated daily living and vocational skills into treatment and rehabilitation.

The Jewish Board of Family and Children's Services (JBFCs) is a leader in the development of programs for the mentally ill, offering extensive psychiatric treatment and rehabilitation programs and a range of housing options. As treatment has evolved, so have JBFCs' programs, which today include innovative vocational education and training programs.

The JBFCs Bronx REAL (Rehabilitation and Education in the Art of Living), provides a range of supportive and rehabilitative services for adults who have been diagnosed with a psychiatric illness. Bronx REAL clients are individuals with diverse backgrounds but share a common struggle against the symptoms of mental illness. The clients of Bronx REAL are functioning at many different levels and are thus exposed to several types of vocational training. Psychoeducational groups, support groups, pre-vocational, internships and externships are vital in helping these clients feel successful and satisfied with their lives.

Begun in 1999, the vocational training program at the Bronx REAL not only helps consumers prepare for employ-

ment but also assists in their psychiatric recovery. As part of their treatment program, consumers learn a wide range of office and vocational skills including the fundamentals of computers, working in a professional kitchen and office clerical duties. The skills that clients develop in the program help them manage stress in all aspects of their lives, not just job-related.

Dror Nir, Director of Bronx REAL, explains the multi-layered goals of the vocational training program. "Our program," he says, "helps people with severe mental illness manage their illness in a way to find more meaning in their lives."

In 2002, JBFCs introduced a program at their Coney Island CSS Project to help people with mental illness secure local employment. The Coney Island CSS Project consists of four Continuing Day Treatment (CDT) Programs and three Mental Health Clinics which help consumers who have serious and persistent mental illness. Approximately 400 clients are helped each year through these programs.

The New York Work Exchange, under the auspices of the Coalition of Voluntary Mental Health Agencies, developed a program called the "Ways To Work" which is being implemented at the Coney Island CSS Project. The program provides grant money for hiring and training staff and technical assistance and equipment to prepare mentally ill client for the workforce.

Peer counselors and a job developer

were hired to assist in locating community job resources and working with the Department of Labor. The job developer meets with clients in groups and in individual sessions to measure each client's work readiness. The peer counselors are an essential part of the project, escorting consumers to appointments and interviews, and conduct work readiness groups. Each staff member at the Coney Island CSS Project addresses the issues of interviewing skills, resume writing and proper appearance for interviews and jobs.

JBFCs' Coney Island CSS Project is a success in many ways. Clients learn to think beyond the limits imposed by their illnesses and consider different ways to obtain skills and employment. Clients set a variety of goals with their counselors, such as how to prepare for work, which can include obtaining interview clothes or practicing typing. Accomplishing such a goal is a success in itself and helps build the individual's self-confidence. "With their newfound skills and confidence, consumers are able to venture into areas of the community where they would not have gone without the vocational training and personal development programs," said Bob Ferrer, Director of Coney Island CSS Project.

The agency's ability to provide a wide range of vocational programs grew out of their commitment to respond to the changing needs of mentally ill clients. Today, vocational education and placement are an essential part of treatment and support services.

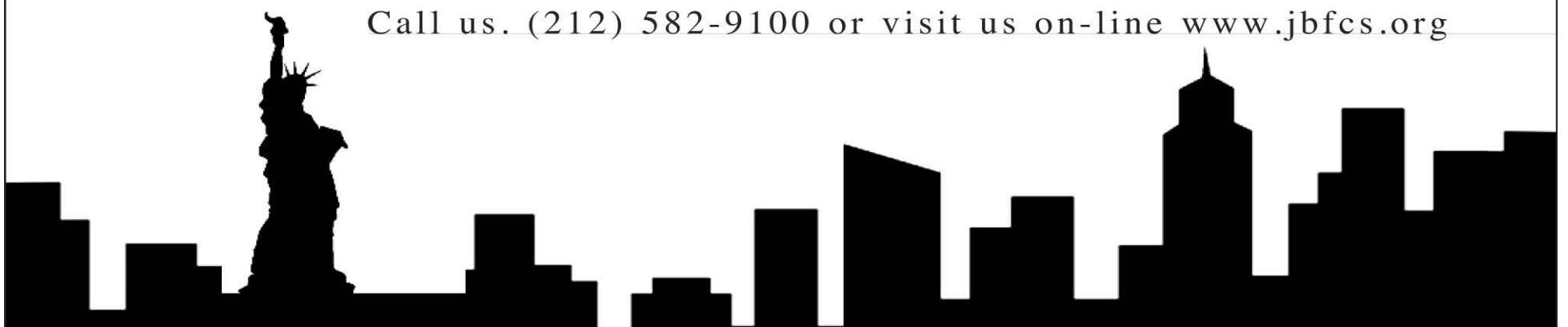


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New York Works Success Story

By: Nicole LaCorte-Klein
NY WORKS Program Coordinator

The New York WORKS project, a Social Security Research and Demonstration program funded by the Social Security Administration, began in 1998. One of twelve states funded, New York decided to design its project for individuals with an Axis I diagnosis that receive SSI or eligible for 1619b, the Medicaid Program for SSI recipients.

The unemployment rate for individuals with mental health disabilities is close to 90% yet individuals want to return to work! The New York WORKS project addresses barriers to returning to work such as health care benefits, fear of losing your SSI check and obtaining training and job placement assistance.

The New York WORKS project has obtained special Social Security work incentives that allow participants to make and save more money without the risk of losing their SSI or Medicaid Benefits. Working participants also have the opportunity to save above the \$2,000 resource limit that SSI recipients are subject to. Working closely with its partners, New York WORKS offers Benefits Advisement and Employment Coordination to enrollees residing in New York City and Erie County (Buffalo) New York. The New York WORKS project is in the early stages of

gathering research data and statistics that show that coordination of both benefits advisement and employment counseling lends to individuals returning to and maintaining employment. The New York WORKS project is funded through the end of 2003, however, a two-year extension has been requested. It is our hope that the approved Social Security work incentives will one day be available to ALL SSI recipients. The following story is reported from one of the Benefits Advisors working with a New York WORKS participant who is currently utilizing the New York WORKS waivers.

Elena was a reserved, rather passive, 28 year-old woman when she enrolled in the New York WORKS project. She had recently begun a part-time job as Outreach Worker for Project Liberty for which her main responsibility was to assist people in need of mental health and accompanying services. Working twenty hours per week at \$10 per hour, she grossed about \$800 per month. Elena felt that the special rules and work incentives she would be entitled to under New York WORKS would help her to become financially independent. She also believed that the project offered the necessary support system to assist her along the way. Elena immediately began reporting her wages to her Benefits Advisor to take advantage of the New York WORKS 3-for-4 waiver allowing her to

keep more of her SSI check each month. One of the first questions she posed to her Benefits Advisor was, "What will happen to my residence payments once my SSI check decreases?"

At Libby House, a community residence, Elena's SSI check was sent directly to an Entitlements Coordinator. She never saw or knew the amount of the original check and did not even know the amount of her monthly rent. Elena told her Benefits Advisor that she wanted to be informed about rent and benefits transactions so that she would be sufficiently knowledgeable to reach her future goal of independent living.

Elena and her Benefits Advisor worked together each month calculating her SSI check from her gross earnings, then figuring out how much she would need to pay to cover her rent. She learned that she could receive a maximum of \$980 from SSI each month based on her living situation. Her rent/program fees totaled to \$759, which left her a difference of \$221 per month. This was the calculation for the maximum amount of SSI. Since Elena was working, her SSI check usually came out to about \$800 per month. Once the rent was subtracted, she was left with a stipend of \$42.

After Elena understood how to budget her income and SSI to figure out her rent, her Benefits Advisor encouraged Elena to open up an "Independence

Account." This was the next step in achieving her goal of financial independence. Elena believed that the SSI resource limit of \$2,000 was not realistic if one was aspiring to financial independence. An "Independence Account" (IDA) would allow her to take advantage of an \$8,000 savings-from-earnings limit. Each month Elena designated about \$250 for direct deposit from earnings into her IDA.

A year after entering New York WORKS, Elena moved out of her supportive housing residence and into her own apartment. With the money that she has saved, a little over \$2,000, she has purchased a bed, a couch, and plans to buy kitchen items for her new home. Without support from her Benefits Advisor and the knowledge that she has the IDA as a safety net, Elena stated that she would not have felt sufficiently confident to move out of supportive housing. Each month Elena continues to meet with her Benefits Advisor to review budgeting and provide documentation of her wages and account information. Elena has also recently applied for her own computer through the Beaumont Foundation. Since her main goal has been accomplished, Elena has set a new goal for herself: To always be proactive instead of passive, to obtain full-time employment and to continue saving.

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Can Cognitive Remediation Services Improve Employment Outcomes for Individuals with Psychiatric Disabilities?

By **Barbara A. Cohen**
 Director of Work Services
 MHA of New York City

Vocational services for individuals with serious mental illnesses are still relatively new. Most began by adapting service models designed for the developmentally disabled. They offered services characterized by lengthy vocational assessments, extensive, and sometimes perpetual, pre-placement training, sheltered employment, or, not infrequently, no employment at all. With experience, vocational service providers made modifications, and new models emerged, such as Individualized Placement and Support, which emphasized integration with clinical services, job matching, on-the-job training, and competitive employment. As a result, program placement rates improved.

Why is a 50 percent Placement Rate Considered Realistic?

A 50 percent placement rate is widely used as a standard for supported employment programs, appearing in performance-based contracts and service quality goals. Yet, why has the bar been set so low? Why is it acceptable that 50 percent of the individuals that a program serves don't become employed? And for those that do get employed, why do so many terminate employment in the first six months?

As any supported employment provider will tell you, the reasons are both complex and numerous. Some are systemic - limited funding and the associated difficulties of recruiting and retaining qualified staff, the seemingly different goals of the vocational rehabilitation and mental health treatment systems, in which some clinicians are wary of work as a potential destabilizing factor. Other factors often cited include societal stigma and the increasingly competitive job market, which requires people to be more versatile and to work harder and longer. Individuals and their families fear the loss of benefits, the potential for relapse, and stigma in the workplace. Lack of belief in self-efficacy and fear of failure also come into play.

But another reason is that, until recently, vocational service providers have not been able to integrate into their programs what the latest behavioral science research tells us about cognition and

mental illness. Vocational service providers for people with mental illnesses have long recognized that many of their participants have difficulties paying attention, remembering and processing information, planning, problem-solving, and dealing with novel situations. Service providers viewed these problems as secondary to other symptoms like psychosis, as medication-related, or related to institutional stays. It was thought that they would go away or significantly improve when people recovered, when their medication dosages could be lowered or newer medications tried, or when they became fully integrated into a community or an employment setting.

Program administrators have responded to these issues in a variety of ways. They've sought to place their participants in low-demand environments and matched them with entry-level jobs that required repetitive work and minimal decision-making. Such environments have been perceived as more suitable, regardless of the educational backgrounds of the participants, given their observed limitations. They've provided job coaches, sought accommodations from employers, and taught an array of compensatory strategies such as partializing tasks, note-taking, use of recording devices, alarms, checklists, and use of reminders to prioritize tasks and to perform sequential tasks. Sometimes these strategies worked, quite often they didn't.

Even after months on a job, participants continued to have difficulty maintaining attention and focus, organizing and mobilizing themselves to get a task done, following instructions, absorbing information, mastering new tasks, and setting priorities. Frequently participants could not increase the speed at which they were performing certain tasks. Although employers tolerated slower work speeds in the first months of a job, they expected employees to increase their speed as they gained experience on the job. And when that didn't happen, terminations often resulted. In addition, some people felt stuck in jobs they were initially happy with but then felt limited by. Yet they were fearful about moving on because they were already having difficulties in their current job.

Mental Illness and Cognition

Over the past several years, numerous articles have appeared in the behavioral science literature regarding the impact of

serious mental illness, schizophrenia in particular, on cognition. In their excellent handbook "Dealing with Cognitive Dysfunction Associated with Psychiatric Disabilities," Drs. Alice Medalia and Nadine Revheim define cognition as "...thinking skills, the intellectual skills that allow you to perceive, acquire, understand and respond to information. This includes the abilities to pay attention, remember, process information, solve problems, organize and reorganize information, communicate and act upon information."

The cognitive problems observed in individuals with mental illnesses are now recognized as primary symptoms of mental illness, caused by the way mental illnesses impact the brain's ability to receive and process information. The result is that many people with mental illnesses have impairments in cognitive skills such as attention, memory, the ability to process and respond to information rapidly, to think critically, to plan, organize and problem-solve, and in some instances, to quickly coordinate eye-hand movements. Most, if not all of these skills, are important to successful workplace functioning. It is now known that these cognitive skills can be improved, facilitating the type of learning required in the workplace.

What Is Cognitive Remediation?

Cognitive rehabilitation services have been widely used to treat the cognitive impairments of traumatic brain injury patients. In recent years, they have been made available to consumers of mental health services in a small number of inpatient and outpatient facilities. Cognitive rehabilitation services may involve remediation, which uses techniques to directly improve a targeted skill, compensatory strategies which teach alternate ways to perform a task, for example using mnemonic devices to compensate for poor memory, and adaptive approaches which modify an individual's environment, for example, using a watch alarm to remind someone to take their medication.

Cognitive remediation interventions consist of an array of educational and training techniques designed to improve a broad range of thinking skills. They involve a series of highly specific exercises that help the brain to practice and strengthen certain cognitive skills, just as physical therapy may involve a specific

series of exercises to strengthen weak muscles. Remediation interventions can be provided on an individual basis or in a group. They may involve pencil and paper, or the use of a computer.

A typical computer-assisted cognitive remediation exercise designed to improve attention might provide a computer simulation of a conveyor belt carrying manufactured objects through a quality control checkpoint at a certain speed. A participant would be required to repeatedly identify flawed items on the conveyor belt and remove them by clicking a mouse. An computer-assisted exercise targeting attention and reaction time might require a participant to stop a moving clock hand at designated times.

Integration of Cognitive Remediation and Supported Employment Services: A Research Project

The Mental Health Association of New York City, Goodwill Industries, and the Institute for Community Living are participating in a cognitive remediation research project sponsored by the New York Work Exchange and funded by the New York State Office of Mental Health. This research project, led by Dr. Susan McGurk, Assistant Professor, Department of Psychiatry, at the Mount Sinai School of Medicine, will help to determine whether combining cognitive remediation services with supported employment services will improve the ability of individuals with mental illnesses to acquire and maintain employment. Specific cognitive skills targeted include attention, memory, motor speed and problem solving, all believed to be linked to successful employment outcomes. Supported employment program participants who choose to enroll in this research project will receive an initial neurocognitive assessment in the areas of attention, problem-solving, motor speed, learning and memory and reading level. As a result of this assessment, participants, employment program staff and the research team will jointly develop priorities and goals for an individualized service plan. A supported employment staff member, trained in cognitive remediation techniques, will provide three computer-assisted cognitive remediation sessions for forty-five minutes to an hour each week for approximately eight weeks. Throughout the eight-week

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Pathways to Housing Provides Consumer Choice: Housing First...Employment Next

By Annora Karas MS, CRC
Director, Vocational Services
and Human Resources

The right to a place to live, the right to a job and the right to choose them both are values that fuel the passions of creative and dedicated Pathways to Housing staff! Pathways staff work together with their tenants—formerly homeless men and women who have coexisting psychiatric and substance abuse problems—to develop equal opportunities and a life with possibilities. Pathways to Housing Inc., a progressive, community based, not for profit organization established in 1992 by its visionary leader Dr. Sam Tsemberis, founded the agency on the belief that the *cure for homelessness is a place to live*. People living on the street cannot contemplate matters such as treatment, recovery and employment when they are waging a war for daily survival. Pathways treats homelessness by giving people apartments of their own. Once housed, Pathways Assertive Community Treatment (ACT) services, provided by a team of professionals reach out and actively work with these tenants to address basic psychiatric, medical and human needs, in a respectful and consumer driven way, for as long as each tenant desires. Once housed safely, with basic human needs met and psychiatric and substance abuse problems addressed, Pathways found that many of the tenants wanted to work. *If the cure for homelessness is a place to live then why is the cure for unemployment not a job?* Pathways believes that it is!

Vocational Initiatives

Tenant Worker Program

Driven by consumer choice, Pathways modeled their first vocational initiative, Pathways Tenant Worker Program, on the *housing first principle* and gave tenants who wanted to work a job. Keeping with the housing first model, no requirements for medication compliance, abstinence or sobriety were established. When most vocational programs were administering interest inventories, evaluating skills, abilities, motivation and training people for employment, Pathways' tenants were earning better than minimum wage and performing necessary work in jobs which would have been otherwise filled through traditional staff recruitment measures. Tenant worker jobs, when available, are scheduled for 20hrs or less a week dependent upon the position and tenant choice. Jobs are often shared and per diem "back up slots" have been created to allow tenants to "try" rather than commit. What Pathways staff shortly discovered was (1) nothing succeeds better than a "try" and that most who tried succeeded (2) the demand for jobs began to snowball; the motivation to work is often proportional to the reality of getting a job, and (3) peer success serves as a strong role

model. Pathways to Housing, today, has approximately 75 tenants employed as receptionist/clerical workers, maintenance workers, messengers, building repair people, nutritionist assistant, medical clerk and activity leaders at the six ACT team office sites located in East and West Harlem, Queens, Brooklyn and Westchester County. Cleaning/moving teams have been developed to provide cleaning services for tenants who need and want a little extra help around the house or when a tenant moves in and out of an apartment. Driver assistants, stock clerks and cashier/sales associates work at the Pathways Thrift Store in Jamaica Queens. All tenant workers are employed at \$5.25 hr. during an initial three-month introductory work period. Following a satisfactory evaluation of work performance, at the end of this time, a salary increase is awarded. Most tenant workers currently earn \$6 hr. and some who do more difficult and grueling work can earn up to \$10-12 an hour.

Thrift Store: A Social Enterprise

October 2002 heralded the opening of Pathways Thrift Store, our first Social Enterprise located in the busy shopping district of Jamaica, Queens at 92-10 147th Place, off Jamaica Avenue. The Thrift Store is an entrepreneurial project with a social purpose and is operated as a business that expects to be self-supporting and, *indeed*, generate a profit. Pathways Thrift Store offers quality goods at very low prices to residents in surrounding communities. The store also provides both transitional employment for tenants seeking to enter the mainstream job market and primary employment for others. While providing a supportive work environment, the manager of the store, a person who has both a business and clinical background, expects his staff who are tenant workers to report to work on time, fulfill the demands of the job in a professional manner, provide customer friendly service and maintain appropriate work behaviors. Allowances are not made for sloppy work and abusive conduct. Accommodations are made for those who want to work and need guidance and support to realize this goal.

Pathways Thrift Store is an attractive, clean, and welcoming place to work and shop. The interior and windows are decorated seasonally; there are warm smiles to greet you and a dish full of candy to taste. Customers quickly learn that the thrift store is not only a relaxing and courteous place to shop, but also a place to visit, browse and engage employees in friendly conversation. Pathways is educating the community about mental illness. Tenant workers are selling more than merchandise; they are "selling" their abilities and making friends with the community. As employees, tenant workers are honing social skills, realizing self worth and developing the social confidence (so often lost in the illness process) to relate to the pub-



Employee, Manager and Assistant Manager at the Thrift Store

lic. Pathways Thrift Store can only provide regularly scheduled part time employment for 9-12 workers and this job is highly coveted among the tenants. It is certainly, we feel, an empowering employment opportunity.

Donors and shoppers alike quickly embraced Pathways Thrift Store! What have been some of the reasons for the early success that established this thrift store as a credible social enterprise business? We believe that the overreaching reason has been that donors and customers, alike, have been treated equally with respect and appreciation, a basic Pathways practice that has governed all of our operations. This practice in concert with a (1) focused donor solicitation plan, (2) defined advertising campaign and (3) customer driven merchandising, have been the building blocks of our early success.

Practical and operational keys to our successful donor solicitations included (a) developing a targeted mail campaign which is repeated at defined intervals, (b) responding to donors requests for pick up of large donations in a timely manner and (c) the small business, customer friendly, respectful approach of the thrift store employees. Pathways Thrift Store, has been the fortunate recipient of increasingly large donations from many new donors. Among merchandise donated, in addition to clothing, shoes, accessories, toys, books, home furnishings, collectibles, and costume jewelry, have been many unique items of furniture and fur coats as well as artwork and electronics. On any given day a full house can be furnished and a large family clothed for all seasons at Pathways Thrift Store. No small accomplishment for a 6-month-old fledgling business with the heavy New York City competition for donors!

Practical and operational keys of a defined advertising campaign that established the thrift store as a visible community presence included (a) creative and repetitive advertising in many local

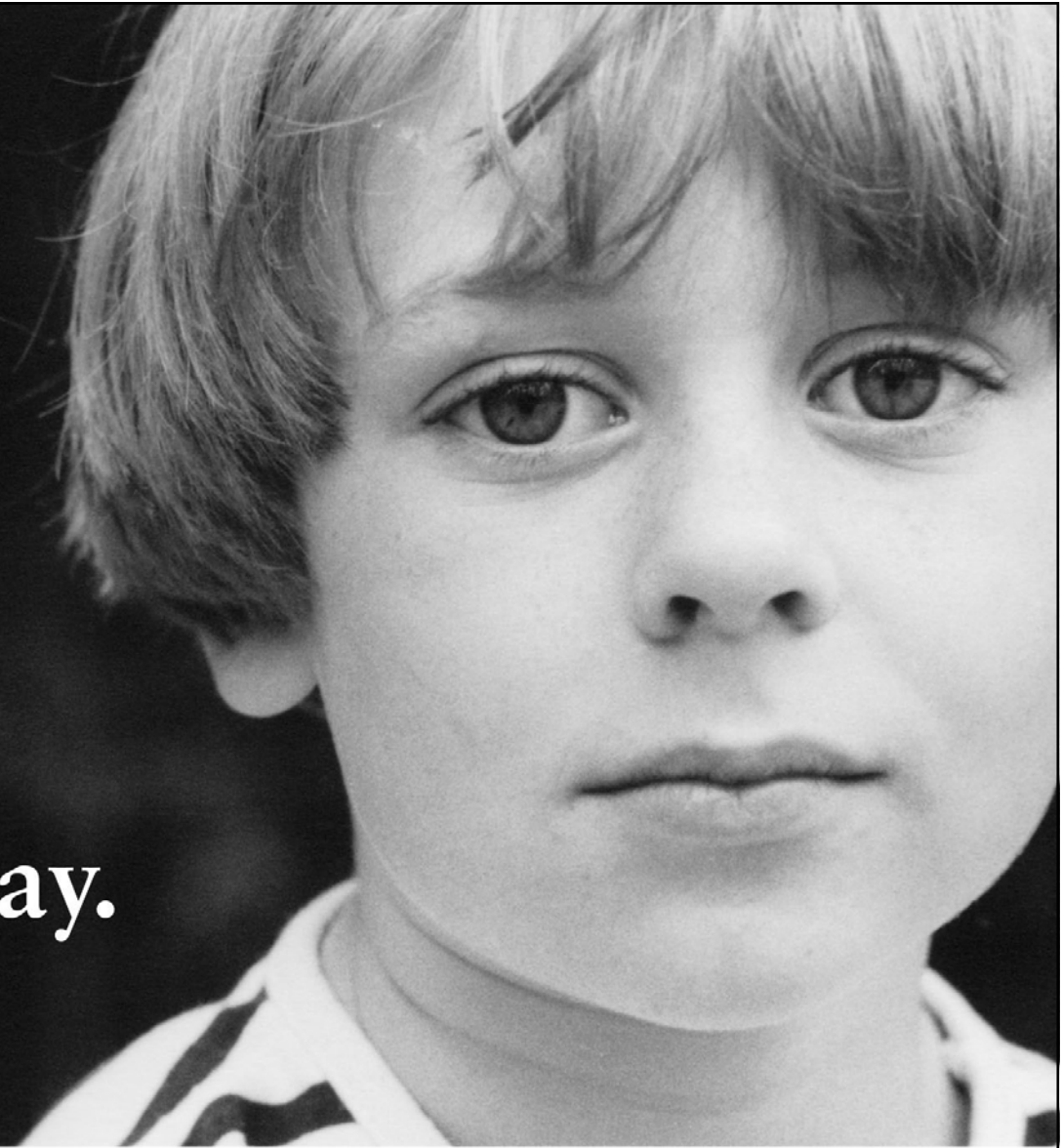
newspapers featuring discount coupon campaigns (b) distribution of flyers by our own tenants on the sidewalks of Jamaica Avenue and (c) publicity derived from a human interest article about the thrift store published in a local newspaper.

From the very beginning Pathways Thrift Store has been responsive to the needs of the community, providing a place to shop that offers quality, gently used, personal and home furnishings at very low prices. A loyal customer following was developed by giving the community what it wants. Pathways did not attempt to walk in the footsteps of other thrift stores e.g. developing inventories of antiques or exclusive designer clothing. Although valuable, costly and collectible merchandise has been donated and sold, the mainstay of Pathways' business has been the sale of merchandise, at very low cost, that residents of the surrounding communities need and want and can afford. We believe that is the primary reason that the community has shopped Pathways and have sent their friends and relatives to shop as well.

Mainstream Competitive Employment

Some of Pathways tenants are working competitively in the community. Often these are people who are highly resourceful, have more recent work histories and have found their own jobs. Some people are former tenant workers who were, with support from the ACT team, able to secure and maintain competitive employment. Many of them developed the confidence and gained the work experience to enter the competitive job market in the Pathways Tenant Worker Program. We are very proud of all of these people and seek to assist others in this goal—if they chose to do so. Staff from Columbia University, School of Social Work, Work Opportunities for Rewarding Careers (WORC) Program, is

see Pathways on page 44



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Recovered Therapist Treating Eating Disorders

**Judy Scheel, Ph.D., Director
Center for Eating Disorder Recovery**

Arguments for and against recovered practitioners treating patients with similar diagnoses have appeared in the literature (Renfrew Perspectives 2002) and are ripe topics for annual conferences. Often practitioners who are in recovery from substance abuse (i.e. drug and alcohol) treat substance abusers. Eating disorders, however, are often not viewed within a substance abuse model; therefore, etiology and treatment of eating disorders is different, and some of the issues regarding recovered practitioners providing treatment are different as well.

The risks for patients treated by individuals recovered from Anorexia Nervosa, Bulimia or Binge Eating Disorder can be potentially significant. Issues include identification with the patient, which can cloud professional judgment, relapsing of the practitioner, and the practitioner's lack of adequate training or insufficient theoretical knowledge.

If the practitioner over identifies with the patient, the professional can lose her/his professional distance and regard and respond to the patient as a mirror image of the practitioner. Eating disorders develop for a multitude of reasons and are as unique as the sufferer. A practitioner who attempts to fit the patient into the practitioner's own historical mold is as inappropriate as believing that all individuals who suffer with Anorexia Nervosa are perfectionists and rigid.

What happens if the eating disorder practitioner relapses? Is s/he 'fit' to handle the needs and treatment of the symptomatic or distressed patient? A practitioner who provides eating disorder treatment ought to have her/his own recovery well integrated and be able to identify when/if s/he may be headed for relapse. A recovered practitioner who is undergoing stress or re-experiences the

conflict that caused the eating disorder can identify these vulnerabilities and triggers before the symptoms reappear, and seek appropriate help. Full recovery is possible. The psychological depths the practitioner plumbs during her/his recovery, the longer the recovery period, and the ability to listen to warning signs/triggers before symptoms develop are keys to long-term recovery.

A potential risk, which perhaps supercedes all others, is the practitioner who limits her/his theoretical framework to a 'gut' understanding of how to treat an eating disorder, or utilizes an understanding or techniques found to have been helpful to her/him during her/his own recovery. The scope of this practitioner's practice will be narrowly defined interpretations and understandings about the particular eating disorder diagnosis learned during her/his own recovery, whether the interpretations apply to the patient or not. (This is different than over identification with the patient.)

For instance, the treatment of eating disorders includes the use of the symptom as a metaphor for the individual's conflicts. If the recovered clinician understands this – "fat is a metaphor for negative emotions that are projected on to the body," for instance – but does not understand the roots of the negative emotions or how the emotions came to exist in the individual, the clinician may be unable to make the connections to the patient's use of the symptom as a metaphor. In fact, if the clinician does not understand key psychological theories (i.e. psychodynamic theories, including object relations/attachment theory or cognitive behavioral theory) the clinician can perform the tasks of recovery but will miss the essence of the disorder and the issues that brought the individual to the disorder in the first place. Eating disorders develop in response to a history of psychological unrest, which existed long before the first symptoms of the eating disorder emerged. A full un-

derstanding of psychological theory is necessary because an eating disorder is not a here-and-now disorder. It is based on historical or recent past conflicts, which are relived/relieved in the present through the symptoms.

The major positive use of the recovered clinician as practitioner is that the recovered clinician is more aware of the subtle communication cues of the patient. The eating disorder speaks volumes; the goal in recovery is to enable the patient to express verbally what s/he has used the symptom to convey. The therapist can make pivotal links between the patient's symptomatology as metaphors and can link responses to the patient's unconscious motivations or underlying/unexpressed emotions or conflicts. These critical connections generally are identifiable by the well-trained, well-versed professional whether the professional has had a history of an eating disorder or not. These connections, however, may be more readably accessible to the recovered practitioner than the moderately trained one or the one who has not had a history of an eating disorder. In either case, a practitioner without

solid training, experience, and supervision should not be treating patients with eating disorders.

Another positive aspect that a recovered therapist can offer her/his patient is the first hand knowledge in conveying hope, in knowing that there is freedom in recovery and in opening the window for a patient to see the possibilities in life. L. Hall (Full Lives, 1993) poignantly described her recovery this way. "Healing my abusive relationship with food forced me to look at every fear, every pain, every barrier that I had erected to keep myself from living and loving fully. What's more, the very act of eating [normally] had become something positive – an affirmation of my self-worth and growth as a person."

Judy Scheel, Ph.D. is the Director of Center for Eating Disorder Recovery (CEDaR) with offices in Westchester and Rockland County, NY, and is President of Eating Disorder Foundation, Inc., (EDF), a not for profit which provides prevention & educational programs about eating disorders.

We're Also on the Web: www.edrecoverycenter.org



CEDaR is here to help those who struggle with eating disorders. Our compassionate staff is specifically trained in treating eating disorders. We are happy to speak to doctor's groups, organizations and hospitals about eating disorder treatment. For those already under the care of a therapist, we can provide additional support through our groups and nutritional care. Call to schedule a visit, or to ask about our varied groups, including our new Intensive 10-Week Group for Individuals Suffering with Bulimia.



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period, participants will be monitored and periodically evaluated for skill improvement. They will then be followed for two years to determine how helpful these services are in reaching their employment goals.

This research project brings important, previously unavailable, resources to supported employment participants, with the potential to significantly improve their employment outcomes. Neurocognitive assessments, a costly service normally not available to participants, will provide insight into individuals' cognitive strengths and weaknesses. Computer-assisted cognitive remediation services will help individuals to improve

in areas of weakness. The Project's outcomes will help to determine the benefits and feasibility of making these services available to supported employment participants on a larger scale.

Note: For more information on cognition and mental illness, read "Dealing with Cognitive Dysfunction Associated with Psychiatric Disabilities, A handbook for families and friends of individuals with psychiatric disorders", written by Alice Medalia, Ph.D and Nadine Revheim, Ph.D. and sponsored by the New York State Office of Mental Health. This publication is available on the New York State Office of Mental Health's website www.omh.state.ny.us/omhweb/resources

**Fall 2003 Issue Theme:
Understanding and Treating Adolescent Depression**

**Winter 2004 Issue Theme:
The Crisis of Suicide in America**

**Spring 2004 Issue Theme:
Eating Disorders: The Conflict Within**

**Summer 2004 Issue Theme
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Mental Health News

Fairfield County Section

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Southwest Connecticut Mental Health System Forges Model for Employment Services

By Rebecca Allen, MSW, CCM
Director of Rehabilitation Services

A job plays a significant role in our lives. It is one of the reasons we wake up in the morning, helps us put food on the table, and broadens our support system. This is no different if you have a disability. Employment is a vital component to recovery and the Southwest Connecticut Mental Health System (SWCMHS) recognizes that importance and is discovering ways to further promote employment in the lives of people that we support.

The daily grind provides many opportunities. It promotes finan-

cial independence, provides meaningful activities and facilitates constructive contributions to society. A job provides a person a chance to learn and grow. For those with a mental illness, being a part of the workforce increases their self-esteem and contribution to the community in which they live.

The feedback from consumers seeking employment and those already employed is unanimous. They want and need a paycheck and they need a job that matches their interests. They recognize that it takes a good deal of effort to find a job and they are ready to embark on that adventure. Those who are employed enjoy reflect-

ing on their role in the workplace and take pride in the duties for which they are responsible. They have worked through the initial fear that employment will impact their entitlements and see that it is all achievable.

The understanding that occupational responsibility and accountability promote personal growth, and the motivation that follows, are steps in the right direction. However, the gap between motivation and achievement is a large one and precisely where the competitive employment strategies of SWCMHS can assist. In order to help consumers as they pursue their employment interests, SWCMHS contracts with local private non-profit organizations to provide support for them in competitive employment. The array of services includes career exploration, job seeking and developing, job placement, and job coaching supports.

Two years ago, an interagency collaboration of vocational providers began meeting to assess the employment services opportunities in the community. Under the joint sponsorship of the Chief Executive Officer of SWCMHS and the District Director of the Bureau of Rehabilitation Services, the providers, which included contracted private non-profit organizations, The Workplace, Veteran's Administration, etc., began meeting to assess what was currently being provided and what needed to be improved. It was concluded that there needed to be a union of funded and required services based on individual need that was flexible in nature and would provide the opportunity for more consumers to be employed while remaining within the current budget allocation. That flexi-

bility, desirable both for services and spending, was already evident in practice at Bureau of Rehabilitation Services, Fee for Service (FFS) funding mechanism.

FFS allows a consumer to receive only the services that he/she requires at a given time. As needs change, the services adjust in kind. For example, when a consumer is successful at a job and requires minimal follow-along supports, the FFS allows that funding to continue. Over the last year, Goodwill Industries and Kennedy Center have been working with SWCMHS in rolling out the FFS program. By working together with the FFS method of reimbursement, the Department of Mental Health and Addiction Services is able to utilize the same amount of funding to serve more people.

In the next fiscal year SWCMHS will continue to maximize the flexibility of FFS. Additionally, more efforts will be applied to the promotion of employment services through the education of consumers, clinicians and other natural support systems.

SWCMHS is the first local mental health authority in the state that has implemented this model for delivering long-term employment services. SWCMHS and all the providers cooperating in this project are dedicated to seeing consumers involved in meaningful employment.

SWCMHS is a Local Mental Health Authority of the Connecticut Department of Mental Health and Addiction Services. It covers fourteen (14) cities and towns in lower Fairfield County and serves nearly 5,000 different people annually.

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Searching for Meaning in Recovery

OmiSaide Ali, MA, LADC, CCS
Regional Director, Consumer Affairs

Mental illness affects many individuals and families in Connecticut. Although many forms of mental illness involve genetic and biological factors, recovery is possible. As we begin to acknowledge that recovery can and should be expected, we must also begin to recognize the important role that can be played by people who have had first hand experiences with mental illness. These "consumers" of mental health care by virtue of their personal knowledge can make powerful and meaningful contributions to the quest for recovery for others afflicted by psychiatric disorders.

It only makes sense

The Recovery Model, a philosophy of service delivery being implemented in the State of Connecticut through the Department of Mental Health and Addiction Services, cites meaningful employment as playing a major role in the recovery process. Programs that are consumer driven and that employ people in recovery create a win-win situation for all involved.

Southwest Connecticut Mental Health System (SWCMHS), a community-based agency operated by the Department of Mental Health and Addiction Services embraces the Recovery Model and has developed several programs that employ and train consumers as Human Service Trainees.

PEP (Peer Engagement Program)

In the final stages of planning, the Peer Engagement Program is modeled after the Ellis Hospital program in Schenectady, New York. The Ellis program places consumers into the Emergency Department of its hospital to work with other consumers who need urgent evaluation and/or treatment of psychiatric symptoms. It has been demonstrated that the presence of the consumer-workers in the hospital emergency department reduces the feelings of fear and anxiety common among consumers being evaluated during emergency situations. The Peer Engagement Staff work as part of the Emergency Department Team, offering an empathetic ear, talking with families, making phone calls, getting blankets or something to drink



OmiSaide Ali

for those seeking emergency psychiatric care. Yale-New Haven Hospital, through the South Central Behavioral Health Network, has an active Peer Engagement Program operating in the Psychiatric Crisis Unit of its Emergency Department at Yale. Hospital staff is pleased with the level of competence of the Peer Engagement staff and have found consumer workers to be invaluable in assisting them with their work.

A Team has been hired to replicate this highly successful program in the Emergency Department of Norwalk Hospital. In Lower Fairfield County, consumers are hired as Human Service Trainees and a number of them have already become interested in obtaining certificates through the MERGE program at Housatonic Community College. MERGE provides training for men and women desiring to enter the behavioral health care field.

Training for the Peer Engagement Program will begin by late spring and the staff will be ready to begin work by early summer. It is hoped that teams will be established eventually in all hospital emergency departments in Lower Fairfield County.

PRO (Peers Reaching Out)

A young woman rides the elevator to the sixth floor of GBCMHC, the Greater Bridgeport Community Mental Health Center, and rings the bell outside of a set of heavy locked doors. The sixth floor is PICU I, or Psychiatric Intensive Care Unit, one of the inpatient units in the nine floor facility that serves the indigent, uninsured and underinsured of

Fairfield County and surrounding areas. She is going to visit with a woman struggling with symptoms related to bipolar disorder and an eating disorder. She understands. She has been there.

The young woman, L., a consumer of services in GBCMHC for over ten years, is now in recovery from her psychiatric symptoms and wanted to give something back to the facility and its staff who have helped her gain the health she so desperately wanted. She has found a way to do that through a program called PRO (Peers Reaching Out). PRO is a creation of the Office of Consumer Affairs of the SWCMHS. In Greater Bridgeport, PRO utilizes consumers as human services trainees to work with consumers being treated on the Inpatient Units where one third of consumers receiving services have no family or friends with whom to interact on a meaningful level.

In the Stamford/Norwalk area, PRO accepts referrals from the private, not-for-profit agencies in the service area. SWCMHS is the Local Mental Health Authority in Region I, Lower Fairfield County. These referrals are for consumers who are either elderly or shut-ins who are living with a mental illness and benefit from the visits and companionship the PRO consumers provide.

The PROs, by virtue of their status in recovery and their personal knowledge of mental illness, are uniquely qualified to do this work—work that requires sensitivity, empathy and the ability to be firm and to set boundaries when necessary.

The consumers who receive services from the PROs are impressed with the level of understanding and insight they have into the problems related to their illnesses. The PROs who work with other consumers are able to help them see the road to recovery while acknowledging their own accomplishments.

Pet Therapy

A consumer in recovery leads a woman with a dog on a leash onto the elevator on the ground floor of GBCMHC. The dog is one of two registered Pet Therapy dogs that visit regularly on the inpatient units at GBCMHC. Stevie and his owner, Virginia Stevenson and Mitzie and her owner, Dolores O'Neal, are part of a program run by P., a consumer of services at GBCMHC. P. keeps a schedule of the visits and makes certain that Stevie and Mitzie are well

received on the units where they visit. She proudly looks on as consumers who might ordinarily be isolative, fearful and uncommunicative with others come out of their rooms when the dogs enter the units. She is presently working on another program like the one in Bridgeport for the F.S. DuBois Center, one of the programs of SWCMHS in the Region.

In Conclusion

In an article entitled *Recovering Our Sense of Value After Being Labeled* by noted psychologist and consumer, Pat Deegan, Dr. Deegan writes of her feelings of loneliness and isolation, even when surrounded by well-intentioned doctors, nurses and mental health professionals. For Pat, the power of recovery is in someone saying, "I've been where you are today. I know the feeling. I'm here to tell you there is a way out and that your life does not have to be about being in mental institutions. I'm around if you want to talk." Pat further states "the great thing is that I have learned that it is possible to live a whole and healthy life and still have a disability." She explains that once a consumer believes that he or she is *the illness* with which he or she has been diagnosed, then there is nothing left of the person to fight for recovery. Consumers trained to work with other consumers act as role models and are examples of recovery for those still struggling.

Consumer-run initiatives, peer support groups and educational programs such as the MERGE program make good sense. They serve two purposes; to build a strong, well-trained workforce of persons with tremendous insight into brain chemistry disorders that can have devastating consequences and they act as a profoundly important component of the process of recovery by providing meaningful activity for those living with and in recovery from these disorders.

The consumers being trained to work with other consumers serve as warm, insightful and poignant examples of everything that is good about the Recovery Model in the State of Connecticut.

OmiSaide Ali is the Regional Director of the Office of Consumer Affairs for the Southwest Connecticut Mental Health System, a program of the Department of Mental Health and Addiction Services, State of Connecticut, and may be reached at either (203) 551-7434 or (203) 388-1593.

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currently providing training and technical assistance for twenty selected Pathways staff to enrich and expand their current vocational expertise, to develop jobs in the local labor market and place and support tenants in competitive employment. We are currently poised to hire an experienced job developer to work with those tenants who want jobs.

Look for Pathway Career Clubs & Pathway Job Banks - -coming soon to an ACT Team site near you!

The Future -Pathways Florist

Future plans include the development of a second Social Enterprise business, Pathways Florist, at a designated, vacant store in East Harlem. The business plan has been developed and Pathways has

located consulting resources in the area of floral design and the Florist industry. Pathways Florist is expected to provide employment in floral design, cashiering, sales, messenger, maintenance and tele-marketing for 6-10 part time employees. Pathways needs fiscal support to realize the establishment of this business and is actively pursuing funds through private foundations and corporations and researching alternative legal business

structures that would, both, maintain the integrity of a social enterprise business and invite private investors. Pathways, as always, will be brainstorming and planning, along with our tenants, in a meaningful, problem solving, consumer driven and respectful manner to make the future, Pathways Florist, a reality.

For more information, contact Pathways to Housing at (212) 289-0000.

Getting To Work

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

True fans of Fyodor Dostoyevsky's work may know his more obscure novel, *The House of the Dead*. The book is a first person account of a miserable decade spent in a Siberian gulag under the harshest conditions known to man. The narrator, who describes some of the lowest and most despicable interactions imaginable, declares that unequivocally, beyond all questioning, stands one privation above all: depriving a man of his right to work. Dostoyevsky pictures in exquisite and painful detail the kinds of work that inmates will do in order to stay sane. The convicts will shovel snow from daybreak to dusk. They will gladly if you will believe pile rocks one upon another, take down the resulting mound, and at a site just a little further removed, start to build once again. All in the name of dignity.

If you visit or have had the ill fortune of spending time in some of the more deteriorated state hospitals, you are soon enough struck by the sheer weight of time and pointlessness in these places. The residents of these living mausoleums shamble up and down the endless seeming corridors, scanning the walls, looking into the rooms, for discards, for eye contact, for cigarette butts. Many are functionally 'lifers,' committed to asylum ostensibly for treatment. Essentially they are warehoused, placed in custody for their protection and ours, under the aegis of medical treatment. With too few exceptions, they do not work.

One of the great ironies of mental health reform is that the so-called 'moral treatment' of the insane—substituting sobriquets and supportive words for shackles—also brought about a politically correct distaste for 'forcing' the patients to work.

Rob a person of meaningful activity, of the opportunity to be creative—even if only with a hillock of jagged stones—and you have at the same time stripped them of their dignity, their self-worth, and even their humanity.

Yes, medical treatment including diagnosis, pharmacology, and humane psychotherapy, have made significant inroads in suffering. Yes, many more people are able to live and function outside the diocese of the sanatorium. Nonetheless, it is naïve to imagine that weekly or even daily visits to the case manager, the social worker, the psychiatrist, will remove the strata of social and financial and existential baggage that comes with being mentally ill.

Those who have or are still struggling with psychiatric illness, unless acutely or massively impaired by symptoms, need to spend their lives pursuing meaningful activity. They need to work.

Dr. Donna McAlpine, co-author of the study 'Barrier to Employment

among Persons with Mental Illness: A Review of the Literature, asks "Why are we still sending people to pre-vocational programs?" Her intensive study of the evidence shows that "skills training and sheltered workshops don't work. What does is getting people right into the work force." The author of the NIMH-funded study states categorically that as a society we "underestimate the skills among people with mental illness. Many of those in treatment work at executive-level positions."

Dr. Lynn Warner (Rutgers Institute for Health, Health Care Policy and Aging Research), co-author of the paper, commented on the short-term political perspective. "Given the current budget situation, it's uncertain what the [political] priorities will be. The direction that social service supports is taking is more toward ad hoc supports than lasting ones." The social scientist is especially concerned about employment prospects for the dually diagnosed (addicted and mentally ill) patients. "What kind of jobs will be available for them when employment rates are so low?" she asked.

One point of view of course is that having to work is itself a sure sign of mental illness.

If you must work, though, the idea is to succeed to the point where your income outstrips your doctor's!

Towards that end, there are a number of employment resources worth knowing about in Fairfield County. These agencies pull for the mentally ill, some providing not only job guidance and training, but a fuller range of services such as public entitlement access. The Human Services Council (Elaine Anderson, Director) in Norwalk is one of these. Keystone House (Alex Berardi, Director), also in Norwalk, provides supervised housing as well as a host of essential support services for both sub-acute and chronic mentally ill patients. Keystone Inc. (contact person Thais Gordon) offers employment opportunities for those only able to tolerate working a few hours a week, including positions with local merchants in house-cleaning, retail and landscaping.

The department of psychiatry at Norwalk Hospital has a large and highly effective team of case managers, many of whom are registered nurses, who actually go out into the field, making home visits, supervising medication administration, and hooking patients up with other kinds of social service functions they need. QUIP (Search for Change) offers free computer training, job assessment, resume assistance, on-line job searches and job coaching. Laurel House in Stamford (Steven Dougherty, Director) supports clients through their clubhouse and consumer advocacy programs. They also offer some scholarships to Norwalk Community College. This is the short list of community resources. As we advocate for more mental health dollars at every level, the list will grow.

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Updates in Addiction Psychiatry and Pain Management Discussed at Silver Hill Hospital Seminar

Staff Writer
Mental Health News

The latest developments in Addiction Psychiatry and Pain Management were discussed by five prominent experts in the field at a recent seminar at Silver Hill Hospital in New Canaan, a nationally recognized behavioral health and substance abuse treatment facility.

In his introduction, Dr. Richard Frances, President and Medical Director of Silver Hill Hospital, said, "The field of Addiction Psychiatry has advanced tremendously since the American Academy of Addiction Psychiatry was established in 1985. There have also been many advances in Pain Management."

"However, in cases of Dual Diagnosis (patients with both psychiatric disorders and addiction to alcohol or drugs), we need to work on learning about the interaction between addiction, psychiatric problems and pain management. Addiction can cause pain and alleviate pain for patients suffering from Dual Diagnosis. We really need to get pharmaceutical companies to step up to the plate in developing medications that help patients alleviate the problems of Dual Diagnosis," said Dr. Frances.

Integrated Group Therapy in the treatment of substance abuse and mood disorders was discussed by Roger Weiss, M.D., Associate Professor of Harvard Medical School and head of McLean Hospital's program in alcohol and substance. Patients with psychiatric disorders are most likely to have substance abuse disorders, especially those with bi-polar diagnosis (manic depressive) and schizophrenia.

People with psychiatric problems are likely to self medicate, using drugs or alcohol to stimulate their level of hypermania, or to relieve symptoms of depression – as a means of escape because they cannot tolerate anger or pain. Addiction can also cause or worsen psychiatric problems.

Recent research indicates that the most successful treatment is Integrated Group Therapy which addresses both the psychiatric and the addiction problems.

The group aspect, which functions a little like weight watchers, was very effective. As members reported whether or not they had had alcohol or drugs in the past week, emphasis was placed upon "sticking with the program, no matter what" for those who had lapsed.

Research on **Healing Through Social and Spiritual Affiliation** was presented by Marc Galanter, M.D., Professor of Psychiatry, New York University Medical Center. He noted some parallels between the religious cults of the 1970's and the 12 step programs of Alcoholics Anonymous. Both groups caused a remarkable change of behavior in participants, the stabilization of people who were very depressed and a considerable decrease in anxiety and the use of alcohol or marijuana.

His studies indicated that what the two groups had in common was commitment to a higher power with a transcendent idea, and the social cohesiveness of being part of a group. He said, "People have very different ideas of what spirituality means. But today there is a transformation of the sectarian religious views of the past to a more generic all inclusive, ecumenical view. This is similar to AA which is all inclusive and more powerful than most medical counseling. The idea of spirituality can be translated into a movement like AA, and such 12 step programs are very important because people feel alienated from society and this is an opportunity to become engaged in a group and share a commitment."

The importance of an integrated system in treating psychosis and addiction was stressed by Dr. Richard Rosenthal, Chairman of Psychiatry at St. Luke's Roosevelt Hospital and Professor of Psychiatry at Columbia University. He said, "There is a disconnect between mental health delivery systems and professional training programs. Clinicians are typically undereducated in one of the two domains: addiction and psychiatry. Patients with both addiction and mental illness are almost always under-treated. Although half the population never has any mental disorder in a lifetime, a majority of the people with disorders have



From l to r: Barry Kerner, M.D., Physician-in-Chief, Silver Hill Hospital, J. David Haddox, D.D.S., M.D., Vice President Health Policy, Purdue Pharma, L.P., Roger D. Weiss, M.D., Associate Professor of Psychiatry, Harvard Medical School, Richard J. Frances, M.D., President and Medical Director, Silver Hill Hospital, Richard N. Rosenthal, M.D., Chairman of Psychiatry, St. Luke's-Roosevelt Hospital Center, Marc Galanter, M.D., Professor of Psychiatry, New York University Medical Center

more than one."

"The biggest problem, the lack of an integrated system, is due to a lack of attention and research in dual diagnosis, and training of health care professionals. What's often missed in a psychiatric diagnosis is the drug or alcohol disorder. Doctors must ask patients about alcohol or drug use and type and amount of medication taken. Many primary care doctors believe that alcoholism cannot be treated effectively and so they ignore it Recovery is non-linear – like the stock market, there are many ups and downs, but if patients stay with the treatment, they recover over time. In integrated treatment for schizophrenia and substance abuse, such as Silver Hill provides, the patients do better in retaining sobriety, said Dr. Rosenthal.

Recent Developments in Pharmacotherapy (the use of drugs as medications in treating addiction and psychiatric disorders) were described by Henry Kranzler, M.D., Professor of Psychiatry at the University of Connecticut Health Center. He stressed the importance of matching patients to treatment, saying, "Treatment for alcohol dependence clearly works, although not for everyone and maybe not forever." Twelve steps programs are most effective, especially if combined with motivational enhancement therapy or cognitive behavioral therapy. There are medications designed for alcohol rehabilitation which either reduce the pleasurable effects of drinking or cause unpleasant reactions if combined with a drink. There is a relationship between negative moods and drinking. We need to be creative in prescribing medications with therapy. Medications are primarily used in alcoholism treatment to prevent adverse effects of alcohol withdrawal, but some medications, such as solterexone and antabuse show beneficial effects in preventing relapse. There is a growing interest in producing these products.

The Interface of Pain and Addiction was discussed by David Haddox, D.D.S., M.D. and Vice President, Health Policy for Purdue Pharma L.P. He said, "Pain Management becomes entwined with addiction when controlled substances are utilized in pain care. Toler-

ance is the state of adaptation through exposure to a drug that induces changes in the body which diminish the drug's effect over time. When patients ask for an increase of dosage there are many different diagnoses possible other than addiction or diversion (intent to sell the drug). The effect of the drug could be diminished through tolerance, a progression of the disease, development of a new disease, pain due to increased functional activity (over-exercising), or emotional distress. Physical dependence is not an addiction; sometimes the nervous system gets used to having a drug around and suffers from withdrawal symptoms.

Doctors should get patients to define expectations and explain that "making me feel better" is not making a patient feel like they did at 18. Doctors should also explain the big difference between patients taking pain killers on their own versus taking them in a very structured situation monitored by a doctor.

All people suffering from untreated addictions abuse drugs, but all people who use drugs are not suffering from untreated addiction. Pseudo addiction is a misinterpretation of the patient by the doctor, caused by untreated pain which the doctor thinks is inappropriate drug-seeking behavior.

New trends in pharmacology described by Dr. Haddox include "developing a potent analgesic that is not an opiate, and efforts to design a drug that cannot be tampered with to get a quick high – making it undesirable to the population that would try to use it inappropriately."

In his concluding remarks, Dr. Frances said, "If we don't administer to our pain suffering patients, whether psychological or physical, we are not doing our job."

Silver Hill Hospital provides a full range of behavioral health and substance abuse treatment for adults and adolescents, from inpatient and partial hospital to halfway houses and outpatient programs.

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