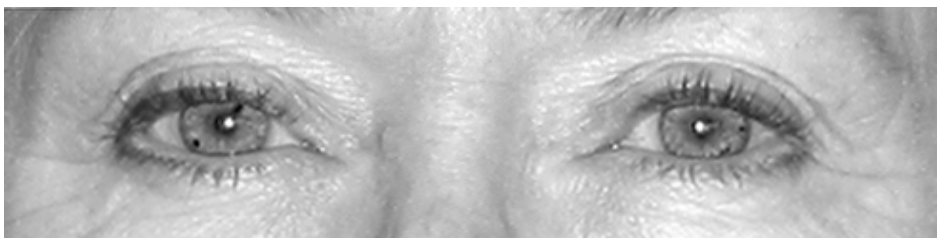
MENTAL HEALTH NEWS™

YOUR TRUSTED SOURCE OF INFORMATION, EDUCATION, ADVOCACY AND RESOURCES

SUMMER 2004 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 6 NO. 3

Sleep Disorders: Why Millions Of Us Are Suffering

By The National Institute of Neurological Disorders and Stroke of The National Institutes of Health



Until the 1950s, most people thought of sleep as a passive, dormant part of our daily lives. We now know that our brains are very active during sleep. Moreover, sleep affects our daily functioning and our physical and mental health in many ways that we are just beginning to understand.

Nerve-signaling chemicals called neurotransmitters control whether we are asleep or awake by acting on different groups of nerve cells, or neurons, in the brain. Neurons in the brainstem, which connects the brain with the spinal cord, produce neurotransmitters such as serotonin and norepinephrine that keep some parts of the brain active while we are awake. Other neurons at the base of the brain begin signaling when we fall asleep. These neurons appear to "switch off" the signals that keep us awake. Research also suggests that a chemical called adenosine builds up in our blood while we are awake and causes drowsiness. This chemical gradually breaks down while we sleep.

During sleep, we usually pass through five phases of sleep: Stages 1, 2, 3, 4, and REM (rapid eye movement) sleep. These stages progress in a cycle from stage 1 to REM sleep, then the cycle starts over again with stage 1 (see Figure 1 on page 9). We spend almost 50 percent of our total sleep time in stage 2 sleep, about 20 percent in REM sleep, and the remaining 30 percent in the other stages. Infants, by contrast, spend about half of their sleep time in REM sleep.

During Stage 1, which is light sleep, we drift in and out of sleep and can be awakened easily. Our eyes move very slowly and muscle activity slows. People awakened from Stage 1 sleep often remember fragmented visual images. Many also experience sudden muscle contractions called hypnic myoclonia, often preceded by a sensation of starting to fall. These sudden movements are similar to the "jump" we make when startled. When we enter Stage 2 sleep, our eye movements stop and our brain waves (fluctuations of electrical activity that can be measured by electrodes) become slower, with occasional bursts of rapid waves called sleep spindles. In Stage 3, extremely slow brain waves called delta waves begin to appear, interspersed with smaller, faster waves. By stage 4, the brain produces delta waves almost exclusively. It is very difficult to wake someone during Stages 3 and 4, which together are called deep sleep.

see Sleep on page 9

NYS Has New "First Lady" At Office Of Mental Health

Staff Writer
Mental Health News

Sharon Carpinello, R.N., Ph.D., was unanimously confirmed as Commissioner of the New York State Office of Mental Health (OMH) by the State Senate on March 9, 2004. She had been serving as Acting Commissioner since July 2003, and prior to that served more than four years as OMH's Executive Deputy Commissioner.

"I am proud and honored to be confirmed as Commissioner of the Office of Mental Health," said Dr. Carpinello. "I have held various challenging positions over my 15-years with OMH, and I am both energized and enthusiastic at the prospect of taking on this new role."

Under her leadership as both Executive Deputy Commissioner and Acting Commissioner, the Office of Mental Health has undertaken a commitment to quality that has been the cornerstone of agency planning initiatives and is consistent with a sweeping national agenda for improving quality in health care. Dr. Carpinello spearheaded the development of OMH's "Winds of Change," the strategic quality-improvement initiative now in its third year. She co-chaired an internationally recognized Best Practices symposium attended by more than 700 people, was invited to speak to the National Institute of Mental Health about New York's quality agenda, and authored "New York State's Campaign to Implement Evidence-Based Practice for People with Serious Mental Disorders," published in the February 2002 Psychiatric Services. New York State is now recognized as a national leader in the mental health quality agenda.

"I envision a public mental health system that is consumer and family focused, that is responsive to individual needs and respectful of culture and language, one that promotes wellness and reduces the burden of mental illness. I believe in a system that facilitates recovery, she said. "I believe that the primary focus of mental health care should be in the community, enabling individuals to remain at home, at work, in school, with friends and loved ones. But be assured, I know that this does not mean that we can dismiss our need for a quality inpatient system of care that also provides sufficient capacity."

Sharon E. Carpinello

To achieve the vision of a recovery-oriented, accountable system, Dr. Carpinello is committed to a person-centered approach that includes:

- data-driven decision making, which results in improved service-system performance, improved service-provider performance, and improved individual clinician performance;
- the use of services that have a scientific base and have been proven effective;
- population-based planning that promotes focused attention on care coordination across diverse disability groups;

see Carpinello on page 46

New Column: The Mental Health Lawyer
Special Editorial: Do SSRIs Increase The Risk Of Suicide?

Mental Health News Education, Inc.
65 Waller Avenue
White Plains, NY 10605

NON PROFIT ORGANIZATION
U.S. POSTAGE PAID
WHITE PLAINS, NY
PERMIT NO. 153

Mental Health News Advisory Council

Mental Health News wishes to expresses its deep appreciation to the members of our Advisory Council for their inspiration, guidance and support.

Table Of Contents

Table Of Contents

Table Of Contents Continued On Page 8

Mental Health News™

is a publication of Mental Health News Education, Inc., a tax-exempt, not-for-profit organization located at 65 Waller Avenue, White Plains, New York 10605.

See page 50 for subscription and advertising information.

Note: all articles and letters to the publisher must be e-mailed.

Our office hours are from 9-5 (M-F) at (914) 948-6699
Our e-mail address is mhnmail@aol.com Please visit our website

www.mhnews.org

From The Publisher

Trivializing Mental Illness

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

If someone you knew had cancer or diabetes you would never joke about it—would you? Of course not. However, our society continues to joke about people with mental illness. If you or a member of your family had a serious illness, would you be outraged if your insurance company severely limited your access to treatment? You bet you would ! However, that's exactly what is still being done to people with mental illness in states which have not enacted parity legislation—the legislation that puts mental illnesses on a par with other illnesses for insurance coverage.

Joking about mental illness (one of the symptoms of a phenomenon known as *stigma)* and inequalities in parity legislation are only two examples of how we trivialize mental illness in America.

When something is not important we say "it's a trivial matter." That must explain why (with blatant disregard for the feelings of people with mental illness) manufacturers of products from candy to tee shirts to video games depict (for example) a scary looking person in a straightjacket with the words *schizophrenic inside* or *I forgot to take my medications* -- and why movie and television producers create senseless, ill-conceived scripts that poke fun at mental illnesses for cheap laughs. These purveyors of stigma think it's a trivial matter and that people with mental illness won't mind.

But it is not trivial, it's important. We *do* mind, and we are doing something about it. In fact, we mind so much that *StigmaBusters*, a campaign of NAMI (The National Alliance for the Mentally Ill) identifies stigma in high-profile situations on national media, in print, and on film, and takes action against the perpetrators. Case in point: *StigmaBusters* Alert, March 2004:

"Cracking Up: One of the Worst, On Tuesday, March 9, the Fox TV network premiered a new situation comedy: "Cracking Up," in which a wealthy dysfunctional family invites a psychology graduate student to live in their Beverly Hills mansion to treat their young son as part of his work toward his degree.

What the therapist-in-training discovers is that the son is fine; it's the rest of the family that gets to him. The mother has bipolar disorder exacerbated by alcoholism. The father is a business executive and latent sociopath. The oldest son exhibits obsessive-compulsive symptoms. Their Latino maid is an offensively stereotyped immigrant who wants to flee the "crazy" household, but can't because the family has hidden her immigration papers. The blonde cheerleader daughter? Well, never mind. You can imagine.

It's a lot like "The Addams Family" or "The Munsters" from the 1960s, except that the stereotypes and butts of jokes involve mental illnesses and substance abuse.

The premiere episode ranks as one of the worst examples of stigma in television history."

A letter writing and phone campaign by *StigmaBusters* expressing outrage over the shows' premise and stereotypes ensued. And the result? *StigmaBusters Alert, April 13, 2004: The Fox TV series "Cracking Up" goes off the air after episode six on May 5. Five remaining episodes may be aired this summer, but renewal is deemed unlikely.*

Hopefully one day we will not need *StigmaBusters* -- but for now we certainly do. Continually catching and educating perpetrators is an unfortunately tedious process, and very often the damage is done and felt by people with mental illness. Perhaps the federal government will one day enact stiff fines on those who disregard current and ethical standards for discriminating against and wrongfully depicting people with mental illness. *We must stop trivializing mental illness in America.*

For more information about *StigmaBusters,* go to NAMI's website at www.nami.org and go to "Fight Stigma" under the Take Action toolbar.

The inequalities and discrimination caused by the parity issue is also helping to trivialize mental illness. Many states across America (including Mental Health News' home state of New York) continue to block efforts to enact parity legislation that would elevate mental illnesses to the same level of insurance coverage as other medical illnesses.

In his April 16th editorial entitled *"Put mental, physical ills on par for insurance coverage"* in the *Rochester Democrat and Chronicle,* Dr. John McIntyre, Chairman of the Department of Psychiatry and Behavioral Health at Unity Health System, and past president of the American Psychiatric Association writes:

"On March 16, 2001, Timothy O'Clair, a 12 year old in Schenectady, hung himself. His parents point out that a major factor in their son's death was the inadequate insurance coverage for treatment of his mental illness.

Inadequate coverage is unfortunately the norm: It is estimated that well over 90 percent of private health insurance plans discriminate against persons with mental illness and substance abuse disorders by requiring higher co-payments, allowing fewer outpatient visits and days in the hospital, and setting higher deductibles than for other illnesses. This discrimination results from misconceptions and outmoded, unscientific thinking and is part of the stigma faced by people with mental illness and their families.

Mental illness and substance-use disorders are real and disabling illnesses. A large study of diabetes, hypertension, heart disease, lung diseases, arthritis and depression found that only severe heart disease was associated with more disability and impaired daily functioning than depression.

Ira H. Minot, CSW

The cost to our economy for untreated and undertreated mental illness and substance-use disorders is staggering. The National Institute of Mental Health estimates that the annual cost of untreated mental illness exceeds $300 billion, largely due to lost productivity and other societal costs. A 1999 surgeon general's report estimated that the direct business costs of the lack of parity for mental health coverage was at least $70 billion per year in the form of lost productivity and increased use of sick leave.

These illnesses can be reliably diagnosed—and treatment works. Great advances have been made in the development of criteria-based diagnoses of mental illnesses. Much evidence has emerged supporting specific treatments, and clear practice guidelines have been developed. Several years ago, a landmark NIMH study found that efficacy rates for the treatment of severe mental disorders ranged from 60 percent to 80 percent, exceeding the efficacy rates for many other treatments in medicine.

Nondiscriminatory (parity) coverage of mental illness and substance-use disorders is not only affordable, it would save money. In a 1993 report to Congress, the National Mental Health Advisory Council estimated that parity coverage for mental illness would result in more treatment and a net savings of $2.2 billion per year, largely in costs incurred in the general health care system and society at large.

A few years ago, The Wall Street Journal reported that a "four-year study of program effectiveness (good access to mental health services) at McDonnell Douglas yielded a four-to-one return on investment after considering medical claims, absenteeism and turnover."

States that have enacted nondiscriminatory coverage have found the resulting increase in health insurance premiums to be relatively small. An actuarial analysis by Pricewaterhouse Coopers, L.L.P. of "Timothy's Law," now being considered by the New York State Legislature, concluded that the expected employer health care costs for this nondiscriminatory health care coverage would rise about 0.8 percent or $1.26 per member, per month.

Most importantly, nondiscriminatory health coverage is not only the smart thing to do; it is the right thing to do. No matter the form, discrimination is wrong. It makes no sense that the insurance coverage of the treatment of the brain disorders identified as mental illnesses should be significantly less than the coverage of other illnesses.

Thirty-five states have now enacted parity laws with varying approaches to prohibit discrimination in insurance coverage of mental illness. Unfortunately, New York state is not one of them. On the national scene, two years ago, President Bush added his support for nondiscriminatory health care coverage, and there is strong bipartisan support for a national parity bill that Congress is now considering.

On March 16, the New York State Assembly passed Timothy's Law by 131-10. The fight for parity in New York is now in the Senate. More senators have co-sponsored the bill than are needed for passage, but the Senate leadership has kept the bill off the floor.

The Senate should pass Timothy's Law and end this discrimination against persons with mental illness and their families. The time is now."

How many more years will we trivialize mental illness and (in this case) have to continue the fight for critical initiatives like parity in insurance coverage? Why are some politicians and insurance company lobbyists able to have the power to block essential legislation, which certainly will result in thousands of people with mental illness being put in harms way?

Trivializing mental illness is the persistent discrimination of people with a treatable illness that sends the wrong message across our nation. It puts people with mental illness in physical danger and sends the message that our society doesn't really care the way it should. Parents and loved ones of people with mental illness also feel the effects and become discouraged when they should be supported in their difficult struggle.

Basic rights to housing, employment, and treatment services should and must be made available at the highest therapeutic levels possible.

The mental health community should not be left out in the cold each year with less funds to provide more services to an ever growing amount of people in need. We must decry budget cuts to mental health services for what they are: *the trivializing of mental illness.*

Have A Great Summer!
Ira H. Minot, CSW

Editorial To The Publisher

Do SSRIs Increase the Risk of Completed Suicide in Depressed Children or Adults?

An Editorial
By Joseph A. Deltito, M.D.

There have been many recent reports in the popular media that SSRIs (Prozac, Paxil, Luvox, Zoloft, Celexa, Lexipro) or other antidepressants (Effexor, Remeron, Serzone, Wellbutrin) may be implicated in increasing the risk that depressed patients under treatment with these agents may eventually commit suicide because of some change in their condition induced by these medicines. The basis for these contentions come from primarily two sources: 1) data from controlled clinical research trials showing increased suicidal thoughts or behaviors in patients taking investigational medicines, and 2) anecdotal reports of individuals who have attempted or completed suicide while receiving treatment with one of these agents.

This past February, 2 advisers to the Food and Drug Administration (FDA) made a recommendation to the agency that a formal warning be made to physicians and the general public that suicidal thoughts and behaviors might be increased in children taking SSRIs. The advisors noted that no clear nor definitive link could be scientifically established at that time, yet they felt that prudence would dictate a general warning be given that a link to suicide could not be totally disproved. The committee noted that such a warning would not prevent physicians from prescribing antidepressants to children, but would hopefully lead them to do so only while monitoring patients closely for evidence of emerging signs of suicidal thoughts or behaviors.

The prestigious American College of Neuropsychopharmacology (ACNP) had released a preliminary report sharing their conclusion that antidepressants do not increase suicidal risk in children treated for depression. J. John Mann, M.D. co-chair of the ACNP committee which studied the issue stated, "There are strong lines of evidence in youth—from clinical trials, epidemiology and autopsy studies—that led the ACNP task force to conclude that SSRIs do not cause suicide in youth with depression." The other co-chairman, Graham Emslie, M.D. stated, "The most likely explanation for episodes of attempted suicide while taking SSRIs is underlying depression, not SSRIs." Nevertheless, just this past March, the FDA did decide to provide a warning on the 10 most popular antidepressants, suggesting increased monitoring was indicated for emerging suicidal concerns while patients were under treatment. They have commissioned further scientific review of the issue, which hopefully will give more definitive information by this summer.

So, as Pontious Pilate once said, "What is Truth?" Here are some of my reflections on the issue.

A definitive answer with metaphysical certitude to the main question of the association of SSRIs to suicide is currently not available. Further inquiry and research is indicated. Any current data linking the two is tenuous at best. It is very hard to prove the negative: that there is absolutely no causal connection. Therefore it is prudent to note it as a clinical possibility. I do not feel that there are any depressed patients now who I would not treat with SSRIs whom I would have treated previously. What I would do is enact closer monitoring of such patients, particularly children. This can be accomplished in a variety of ways: more frequent outpatient visits, educating parents on how to assess potential suicidal risk, or having a lower threshold to have these children receive inpatient rather than outpatient treatments.

I do feel that in certain cases SSRIs may be somehow associated with an increased suicidal risk, but this is not because they are bad medicines, but because they are being administered by bad doctors or health care systems. I believe it is the poor clinical management of such cases that leads to bad outcomes, not the inherent properties of antidepressants. I will elucidate two situations where this may be potentially true.

In my first case, a patient has severe depression as evidenced by low energy, poor concentration abilities, sad mood and general apathy. He dwells on themes of hopelessness, worthlessness, pessimism and nihilism. When antidepressants are started, the patient may show the resolution of some of these symptoms more quickly than others. If, for instance, this patient has more energy and can concentrate much better, all while still retaining his other symptoms of depression, which have not yet evolved towards wellness, he may be in a period of specific risk for suicide. In a way, before he received any treatment he could have been conceptualized as being too depressed to commit suicide. The solution to this problem is clearly not to withhold antidepressant medication, but to carefully monitor the patient taking appropriate measures to guarantee their safety.

Joseph A. Deltito, M.D.

In my second case, a given patient who is depressed fails to have an adequate long-term history of his condition taken by his evaluating clinician. The clinician misses or does not understand that this patient, who is currently depressed, suffers not from unipolar depression but has a variant of bipolar disorder. The patient is then placed on antidepressant medication, which induces a mixed-manic state of agitation and poor impulse control. This state in a depressed patient is clearly of much greater risk for a potential suicide. The problem here is not any inherent negative effects of the medications, but the failure of the treating clinician to make an accurate diagnosis.

A common denominator in the story of many depressed patients who eventually kill themselves is the relatively unavailability of their treating physicians to monitor them properly or to be contacted quickly when problems may be developing. Many HMOs, managed-care operations, or clinics overly rely on non-medical clinicians to diagnose and manage the clinical care of patients. Non-physicians who evaluate the patients then may "inform" the doctor that the patient needs a prescription for an antidepressant. The physician may have no real knowledge of the patient, only meeting with them for the briefest amount of time. Many times, physicians used in such a manner in outpatient clinics are not even psychiatrists. Should something go wrong with the treatment, these physicians are hard to reach. Patients are oftentimes given all too infrequent follow-up appointments and may have no real continuity of care. This forms an essential prescription for malpractice. I can assure you it is happening all the time. The treatment of depression is a serious business. It needs to be done by competent and caring clinicians who are not given incentives to not spend the time they need to adequately treat depressed and potentially suicidal patients.

Such situations are compounded from bad to worse when insurance companies put up unrealistic barriers to have patients admitted for inpatient treatments. The criteria used by many insurance companies for initiating or maintaining patients in an in-hospital treatment are usually arbitrary and self-serving. Many hospital administrators "Play Ball" with these companies to stay in their favor. The patient gets lost in the equation.

So, why does this all occur: unsophisticated evaluations, poor monitoring of patients, lack of availability of treating physicians, too many difficulties in getting insurance payment for in-hospital treatments? In general the answer is simple and obvious: Greed! Somewhere, somehow those setting up healthcare delivery systems, or paying for treatment, are making more money by promoting poor care rather than good care.

If we did not treat depressed patients with appropriate antidepressant treatments, clearly many would go on to commit suicide at some point in their lives. We need to monitor all patients closely when under treatment for depression. Doctors, nurses, and other mental health professionals need to be able, affable and available. We need to further study antidepressants for any negative effects. At present it seems clear that these medicines, when used properly by well-trained clinicians, are dominantly safe and effective. Individuals need not worry too much about any of the above mentioned antidepressants; they do need to worry about those who administer them.

Joseph A. Deltito, M.D., is a Clinical Professor of Psychiatry at New York Medical College and is Co-Chairman of the Board of the Child Health Foundation, an organization devoted to research and health care delivery to children in the most impoverished areas of the world. He is a frequent contributor to Court TV and serves on the Clinical Advisory Board of Mental Health News.

Dr. Deltito has an office practice for psychopharmacological consultations and forensic psychiatry in Greenwich, Connecticut, and can be reached at (203) 552-1831.

Letter To The Publisher

Electroconvulsive Therapy

A recent article in *Mental Health News* by David Seay, Executive Director of NAMI, stated that legislation originating in the New York State Assembly was intended to end the use of Electroconvulsive Therapy (ECT) in New York State. This is not the case. The legislation crafted in the Assembly is in response to the issues raised during its review of ECT. It is intended to ensure that ECT is provided safely, in conformance with industry standards, and that individuals considering ECT as a treatment option are given the necessary information and supports to make an informed consent decision.

The use of ECT has been a subject of controversy since it was first introduced in 1938. The state Legislature had not conducted a formal review of ECT use in New York State since the mid-1970s. The New York State Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities began its examination of ECT use in February 2001, after receiving testimony at a public hearing in Syracuse regarding the use of ECT on a patient at the Pilgrim Psychiatric Center.

It was clear from testimony received at public hearings, held in New York City and Albany during 2001, that opinions varied widely with respect to the efficacy of ECT. Proponents claimed that ECT is a safe, effective procedure with no permanent side effects. In contrast, opponents maintained that ECT causes brain damage, can result in permanent memory loss and, in some cases, death.

In addition to the public hearings, the Assembly Committee on Mental Health met with proponents, opponents, and representatives of various state agencies. Committee staff also reviewed extensive literature regarding ECT, including the American Psychiatric Association's (APA) 2001 Task Force Report, *The Practice of Electroconvulsive Therapy, Recommendations for Treatment, Training, and Privileging, Second Edition*.

The committee sought information regarding the prevalence of ECT use within the state and found there were no available comprehensive statistics. During its review, the committee uncovered instances where ECT had been administered with equipment the APA stated should no longer be used, and on an outpatient basis in physician offices where emergency equipment and staff were unavailable, contrary to the APA recommendations in its 2001 Task Force Report.

The Federal Protection and Advocacy for Individuals with Mental Illness Amendments Act of 1991 provides legal advocacy supports for individuals diagnosed with mental illness. On March 15, 1996, PAIMI, a federally funded arm of the New York State Commission on the Quality of Care for the Mentally Disabled (CQC), issued a resolution requesting that New York State consider developing legislation that would provide for monitoring of the provisions of ECT, as well as for informed consent of ECT recipients. When contacted by Committee staff prior to the 2001 public hearings, PAIMI reaffirmed its support of its 1996 resolution.

A 1997 study, funded in part by the National Institute of Mental Health, the New York State Psychiatric Institute, and Columbia University, revealed that facilities varied considerably in many aspects of ECT practice, including frequent departures from field standards. The study concluded that, "the marked departures from the field standards of care and the wide variability in how ECT is conducted, undoubtedly raise public health concerns." The field standards reviewed in this study were less stringent than the standards recommended in 2001 by the APA.

The committee requested that the CQC conduct a study of ECT use at state-operated psychiatric centers. The CQC determined that protocols varied in detail regarding the procedure itself, as well as in issues such as physician privileging and determining capacity to consent. The CQC recommended that the NYS Office of Mental Health establish a Blue Ribbon Task Force charged with the responsibility of developing ECT protocols that can be consistently applied in state facilities administering ECT, and which promote the application of best practices while ensuring strict adherence to statutory and regulatory standards for safeguarding patient rights.

After extensive discussions with the Senate, legislation was passed in 2003 to require reporting of the incidence of ECT. This legislation was subsequently vetoed by the governor. Monitoring the prevalence of ECT use is one safeguard to help ensure that ECT is used appropriately and safely. I anticipate that the Legislature will again send an ECT reporting bill to the governor for his signature this year.

In 2003, the New York State Office of Mental Health issued guidelines regarding the use of ECT. These guidelines, which respond to several issues addressed by our legislation and are consistent with the most recent APA recommendations, are voluntary. I recently asked Sharon Carpinello, Commissioner of OMH, to place the guidelines into regulation, giving them the force of law. Until this happens, the Assembly will continue to act to ensure that ECT is provided safely, in conformance with industry standards, and that individuals considering ECT as a treatment option are given the necessary information and supports to make an informed consent decision.

Assemblyman Peter M. Rivera,
Chairman of the NYS Assembly
Committee on Mental Health,
Mental Retardation, and
Developmental Disabilities

Table Of Contents

Our Other Featured Articles

Upcoming Issue Themes

Cultural Issues and Diversity in Mental Health
Fall 2004 Issue - Deadline August 1st

Women's Issues in Mental Health
Winter 2005 Issue - Deadline November 1st

Thanks To Our Advertisers

SLS Health, J.P. Morgan Chase and Company

MHA of Westchester, New York-Presbyterian Psychiatry

CHOICE of New Rochelle, MHA of Nassau County

New York State Psychiatric Association

Center for Eating Disorder Recovery, Four Winds Hospital

Jewish Board of Family and Children's Services

Saint Vincent Catholic Medical Centers—Behavioral Health

MHA of New York City, Hall-Brooke Behavioral Health Services

Norwalk Hospital—Department of Psychiatry, Silver Hill Hospital

Family Service of Westchester, The Guidance Center, NARSAD

MHA of Rockland County, Putnam Family Support and Advocacy

Westchester Residential Opportunities, Search for Change

Human Development Services of Westchester, MHA in Putnam County

NAMI of Westchester & Rockland, F·E·G·S

The Psychiatric Society of Westchester

Institute for Community Living, The Center for Career Freedom

Putnam Family & Community Services,

Westchester Jewish Community Services, Social Work p.r.n.

Westchester Medical Center—Behavioral Health Center

Hebrew Hospital Home

Royal Bank Of Canada—RBC Mortgage

Sleep from page 1

There is no eye movement or muscle activity. People awakened during deep sleep do not adjust immediately and often feel groggy and disoriented for several minutes after they wake up. Some children experience bedwetting, night terrors, or sleepwalking during deep sleep.

When we switch into REM sleep, our breathing becomes more rapid, irregular, and shallow, our eyes jerk rapidly in various directions, and our limb muscles become temporarily paralyzed. Our heart rate increases, our blood pressure rises, and males develop penile erections. When people awaken during REM sleep, they often describe bizarre and illogical tales — dreams.

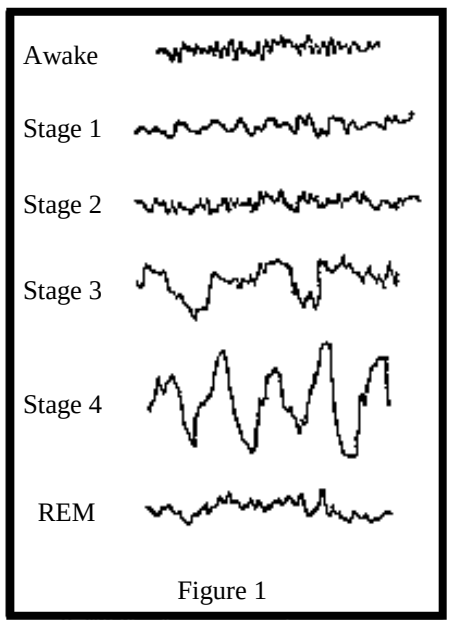


Figure 1

The first REM sleep period usually occurs about 70 to 90 minutes after we fall asleep. A complete sleep cycle takes 90 to 110 minutes on average. The first sleep cycles each night contain relatively short REM periods and long periods of deep sleep. As the night progresses, REM sleep periods increase in length, while deep sleep decreases. By morning, people spend nearly all their sleep time in stages 1, 2, and REM.

People awakened after sleeping more than a few minutes are usually unable to recall the last few minutes before they fell asleep. This sleep-related form of amnesia is the reason people often forget telephone calls or conversations they've had in the middle of the night. It also explains why we often do not remember our alarms ringing in the morning if we go right back to sleep after turning them off.

Since sleep and wakefulness are influenced by different neurotransmitter signals in the brain, foods and medicines that change the balance of these signals affect whether we feel alert or drowsy and how well we sleep. Caffeinated drinks such as coffee, and drugs such as diet pills and decongestants, stimulate some parts of the brain and can cause insomnia, or an inability to sleep. Many antidepressants suppress REM sleep. Heavy smokers often sleep very lightly and have reduced amounts of REM sleep. They also tend to wake up after 3 or 4 hours of sleep due to nicotine withdrawal. Many people who suffer from insomnia try to solve the problem with alcohol — the so-called night cap. While alcohol does help people fall into light sleep, it also robs them of REM and the deeper, more restorative stages of sleep. Instead, it keeps them in the lighter stages of sleep, from which they can be awakened easily.

People lose some of the ability to regulate their body temperature during REM, so abnormally hot or cold temperatures in the environment can disrupt this stage of sleep. If our REM sleep is disrupted one night, our bodies don't follow the normal sleep cycle progression the next time we doze off. Instead, we often slip directly into REM sleep and go through extended periods of REM until we "catch up" on this stage of sleep.

People who are under anesthesia or in a coma are often said to be asleep. However, people in these conditions cannot be awakened and do not produce the complex, active brain wave patterns seen in normal sleep. Instead, their brain waves are very slow and weak, sometimes all but undetectable.

How Much Sleep Do We Need?

The amount of sleep each person needs depends on many factors, including age. Infants generally require about 16 hours a day, while teenagers need about 9 hours on average. For most adults, 7 to 8 hours a night appears to be the best amount of sleep, although some people may need as few as 5 hours or as many as 10 hours of sleep each day. Women in the first 3 months of pregnancy often need several more hours of sleep than usual. The amount of sleep a person needs also increases if he or she has been deprived of sleep in previous days. Getting too little sleep creates a "sleep debt," which is much like being overdrawn at a bank. Eventually, your body will demand that the debt be repaid. We don't seem to adapt to getting less sleep than we need; while we may get used to a sleep-depriving schedule, our judgment, reaction time, and other functions are still impaired.

People tend to sleep more lightly and for shorter time spans as they get older, although they generally need about the same amount of sleep as they needed in early adulthood. About half of all people over 65 have frequent sleeping problems, such as insomnia, and deep-sleep stages in many elderly people often become very short or stop completely. This change may be a normal part of aging, or it may result from medical problems that are common in elderly people, and from the medications and other treatments for those problems.

Experts say that if you feel drowsy during the day, even during boring activities, you haven't had enough sleep. If you routinely fall asleep within 5 minutes of lying down, you probably have severe sleep deprivation, possibly even a sleep disorder. Microsleeps, or very brief episodes of sleep in an otherwise awake person, are another mark of sleep deprivation. In many cases, people are not aware that they are experiencing microsleeps. The widespread practice of "burning the candle at both ends" in

see Sleep on page 38

MENTAL HEALTH NEWSDESK

NYS Office Of Mental Health Housing Development Team Honored

Receive Supportive Housing Network's 2004 Supportive Housing Award

Staff Writer
Mental Health News

The Supportive Housing Network of New York recently hosted the 2004 Supportive Housing Awards honoring leaders from the business, government and non-profit sectors that have made tremendous contributions to the field of supportive housing. Supportive housing combines affordable rental housing for low-income and formerly homeless individuals and families with on-site support services such as mental health care, substance abuse counseling and employment programs. Over the past decade, the supportive housing movement has grown from 4,000 units of housing to over 25,000 throughout New York State. It is widely recognized as the cost-effective solution to ending homelessness.

"Supportive housing enables individuals and families who are homeless or living with mental illness, AIDS or other disabilities achieve housing stability, independence and hope," said Maureen Friar, Executive Director of The Network. "Thanks in part to the efforts of our honorees, thousands of low-income and formerly homeless New Yorkers now have a safe, affordable place to call home."

The Housing Development Team at the New York State Office of Mental Health (OMH) was honored at the event for its commitment and dedicated partnership to building supportive housing for New Yorkers living with mental disabilities. With 26,600 units statewide, OMH housing has grown over the past decade, evolving into various models to meet the needs of tenants. An additional 4,400 units are planned for development including rental apartments with visiting support services, supportive SRO housing, and children's congregate treatment programs.

Steve Coe, Executive Director of Community Access and members of the OMH Housing Development Team: (l to r) Steve Coe, Christine Madden, Keith Simmons, Dr. Robert Myers, Caren Abate, and Michael Newman

Other honorees included the successful *Housing First! Affordable Housing for All New Yorkers Campaign*, an initiative created to increase the supply of affordable and supportive housing in New York, and Gerald J. Flannelly, Principal, MMA Financial (formerly Lend Lease R.E.I.).

Two outstanding supportive housing tenants, Steven Fernandez, a resident at The Times Square in Manhattan, and Anna Sezenias, a resident at the YWCA of Binghamton & Broome County, were also honored. The tenants were selected based on their contributions to the community and their courage to overcome obstacles such as domestic violence and substance abuse while living in supportive housing.

The event, which was held at the Prince George, a former welfare hotel that has been transformed into permanent affordable housing, raised over $200,000. Proceeds from the awards will support the Network's advocacy and educational programs aimed at increasing New York's stock of supportive housing.

The Supportive Housing Network of New York, founded in 1988, represents nonprofit agencies that build and manage supportive housing across the state, setting the standard for the growth of supportive housing across the nation. Through advocacy, training, technical assistance and public education, the Network strives to increase the supply of supportive housing with the goal of ending homelessness in New York. For more information, please visit www.shnny.org.

Health And Human Services Approves First-Ever Multi-State Purchasing Pools For Medicaid Drug Programs

Department of Health and Human Services, Center for Medicare and Medicaid Services

Health and Human Service Secretary Tommy G. Thompson today approved plans by five states to pool their collective purchasing power to gain deeper discounts on prescription medicines for their state programs. The multi-state purchasing pool plans approved today include Michigan, Vermont, New Hampshire, Alaska and Nevada. This is the first time in the history of the Medicaid program that states have worked together in this manner.

While states are not required to offer prescription drugs through Medicaid, all states do. However, continued escalation in the cost of providing prescription medicines has strained many state Medicaid budgets. Today's historic action will give states unprecedented leverage in negotiating with drug manufacturers for lower prices. As part of our efforts to help states identify ways to reduce costs while improving quality, CMS will soon provide guidance to states on forming new purchasing pools and joining existing purchasing pools.

"By using the proven technique of negotiating lower prices, states will reap important savings on their drug costs," Secretary Thompson said. "The ability to purchase drugs at a lower cost will help states continue to provide critical medications to the millions of low-income citizens who depend on the Medicaid program."

Michigan, which began operating a joint purchasing pool with Vermont last year, estimates that it will save $8 million in its Medicaid program in 2004 as a result of the arrangement. Vermont reports that its Medicaid program will save $1 million in 2004 because of the purchasing pool. Altogether, the pooled purchasing program will cover approximately 900,000 beneficiaries.

"This new approach builds on our efforts to help states use the best private-sector purchasing tools to lower costs, while assuring appropriate standards for proper access to medicines and quality care," said Mark B. McClellan, M.D., Ph.D., administrator of the Center for Medicare & Medicaid Services, which oversees the Medicaid program.

Under the Medicaid law, drug manufacturers, in order to receive federal funding for their drugs, must first enter into discount or rebate agreements with HHS. The Bush administration has approved 22 state plans to negotiate extra, or supplemental rebates with manufacturers. States generally achieve negotiated discounts greater than those established by law for Medicaid by relying on a private pharmacy benefit manager to negotiate discounts based on a list of preferred drugs established by the state for their Medicaid beneficiaries.

CMS has worked with each of these states to assure effective implementation of price negotiations, including appropriate consideration of clinical impact. In determining what drugs are on the preferred drug list, states use a committee of clinicians and pharmacists to review medical needs before considering the discounts offered by drug manufacturers. The review ensures that the preferred drug list will provide Medicaid beneficiaries access to all drugs generally needed. In addition, federal law requires that drugs not on the list may still be prescribed for Medicaid beneficiaries but often require prior approval, generally leading to less utilization. Consequently, drug manufacturers often provide additional discounts to keep their drugs on the preferred drug list.

HHS has also defended the legal right of states to use these techniques. Earlier this month, the department won an important legal victory in the Circuit Court of the District of Columbia, allowing states to continue to use preferred drug lists.

All five of the states in today's announcement have signed agreements with First Health Services Corp., a pharmaceutical benefit manager, to negotiate lower prices on their behalf with manufacturers. Other pharmaceutical benefit managers provide similar negotiating services. Although the states are pooling their efforts in buying drugs, they all will maintain their own preferred drug lists and exercise clinical oversight of those lists to assure adequate access to needed medicines for their beneficiaries. Because there are some overlaps on the preferred drug lists, pooling across states can lead to larger discounts on certain drugs.

MENTAL HEALTH NEWSDESK

Dramatic Increase In People With Mental Illness Seeking Care At ER

Emergency Physicians Cite State Health Care Budget Cuts At Root Of Problem

National Mental Health Association
Washington, DC

A recent upsurge in people with mental illness seeking treatment in emergency departments is taking a significant toll on patient care and hospital resources nationwide, according to a new survey of emergency physicians conducted by the nation's leading mental health organizations and the American College of Emergency Physicians. Six in 10 emergency physicians surveyed report that the increase in psychiatric patients is negatively affecting access to emergency medical care for all patients, causing longer wait times, fueling patient frustration, limiting the availability of hospital staff, and decreasing the number of available emergency department beds.

Two-thirds (67 percent) of emergency physicians attribute the recent escalation of psychiatric patients to state health care budget cutbacks and the decreasing number of psychiatric beds. One in ten report there is nowhere else in the community where people with mental illness can receive treatment. Mental health leaders claim that without ongoing, community-based services, people may see their illnesses worsen and be forced to seek care in emergency departments.

The new survey by the American Psychiatric Association (APA), National Alliance for the Mentally Ill (NAMI), and National Mental Health Association (NMHA) is part of a larger campaign on the issue of access to treatment and services for people with mental illness.

Seventy percent of emergency physicians report an increase in people with mental illness "boarding," which is when patients are admitted to the hospital and forced to wait in the emergency department until inpatient beds are available in the hospital. More than 80 percent report that this practice of "boarding" negatively affects the care of emergency department patients. This agreement was almost universal (97 percent) among those who reported a rise in the "boarding" of psychiatric patients over the prior 6-12 months.

"Emergency department overcrowding is a growing and severe problem in the United States," said Dr. J. Brian Hancock, President of ACEP. "As dedicated as emergency physicians and nurses are to caring for patients, we are reaching a breaking point where we may not have the resources or the surge capacity to respond effectively. This affects everyone's access to lifesaving medical care."

The report finds psychiatric patients board in hospital emergency departments more than twice as long as other patients. And, emergency physicians say their staff spends more than twice as long looking for beds for psychiatric patients than for non-psychiatric patients.

"The findings underscore the serious consequences state budget cuts to programs like Medicaid are having not only to people with mental illness, but on anyone who may find themselves in an emergency department," said James H. Scully, Jr., M.D., Medical Director, APA. Medicaid is the single largest source of financing for mental health care in the U.S.

Other survey highlights include:

- About 2/3 (67 percent) of the emergency physicians in this sample reported a decrease in the number of psychiatric beds in their region in the prior 6-12 months. Those who reported such a decrease in beds were also more likely than those who did not to report an increase in the number of psychiatric patients "boarding" in their emergency departments: 85 percent for those who reported decreased beds compared to 52 percent for those who did not.
- More than 90 percent of survey respondents say "boarding" people with mental illness reduces the availability of emergency staff, decreases the availability of beds in the emergency department (96 percent), causes longer waits for patients in the waiting room (85 percent), results in patient frustration (89 percent), and increases the number of times the hospital diverts ambulances to other hospitals (31 percent).

"We caution states to think twice before slashing their Medicaid budgets. These budget cuts force people with mental illness to seek care in emergency

see ER's on page 45

One Year Later In New York State
Westchester County's Assertive Community Treatment Teams

Westchester County Department
of Community Mental Health

March 2003 marked the beginning of a new treatment model in Westchester County, known throughout the mental health community as ACT. This was a highly anticipated service for consumers, families, and professionals, since it would finally address the needs of person's suffering from mental illness whose needs had not previously been met by the more traditional service delivery systems. Many of these individuals had been difficult to engage and/or did not desire to participate in more structured outpatient programs.

The ACT model was designed for adults 18 and over, who were diagnosed with severe mental illness that seriously impaired their functioning in the community. Individuals who were homeless, had co-occurring disorders, and/or criminal justice involvement would all be eligible for the new ACT teams.

Part of the excitement of introducing this new model to residents in Westchester County is because ACT is an "evidence-based practice," a model in which there is significant scientific data showing its effectiveness in improving treatment outcomes for persons suffering with severe mental illness. The ACT teams are designed to support recovery through highly individualized approaches, which allows consumers to develop tools needed to obtain and maintain housing, employment, relief from symptoms, and medication side effects.

Westchester County currently supports four ACT Teams: Mount Vernon Hospital servicing lower Westchester, Saint Vincent's Hospital servicing Yonkers, The Mental Heath Association of Westchester servicing Central Westchester, and the Westchester Medical Center servicing Northern Westchester. Since the addition of the ACT Teams into Westchester's service delivery system, 203 individuals have been referred. The referral process is through the Department of Community Mental Health's Single Point of Access (SPOA), which also is the portal for case management services and housing in the county. Currently there are a total of 184 individuals receiving ACT Team services. The capacity exists to serve 272 individuals.

"What is so unique about the ACT teams is that the model allows for staff to use creativity and flexibility to truly individualize their work with a consumer. Meeting with consumers in their own community allows both the staff and the consumer to examine more closely any problems, and together work out quicker and longer-lasting solutions," said Dr. Grant Mitchell, Chief of Psychiatry at Mount Vernon Hospital. "What differentiates ACT from other mobile teams is that they are not crisis oriented and have the ability to work with consumers over long periods of time. ACT provides continuity to many consumers who have had none," said Jennifer Schaffer, Ph.D., Commissioner of Westchester County Department of Community Mental Health.

Even though we are only in the first year of the addition of the ACT teams, program leaders say they are seeing some early successes. Many consumers that staff have worked with over the years seem to be responding better to this newer model. One ACT team leader said, "I felt more frustrated in the past because the traditional non-mobile teams would not give me the tools I knew I needed to be of help. ACT finally has created a model with movable walls. We are starting to see that this flexibility is more helpful for some in their recovery process."

MENTAL HEALTH NEWSDESK

Consortium For Citizens With Disabilities Criticizes Bush Section 8 Proposal

Technical Assistance Collaborative
Boston Massachusetts

The Bush Administration's FY 2005 HUD Budget proposal calls for deep cuts in the Section 8 Housing Choice Voucher program. The budget also would radically alter the fundamental design of the program by converting it to a block grant administered by Public Housing Agencies (PHAs) for the benefit of higher income households. The Consortium for Citizens with Disabilities Housing Task Force (CCD Housing Task Force) is strongly opposed to the Administrations budget proposal which would cut more than $1 billion from current funding levels. We are also strongly opposed to the Administration's ill-conceived proposal to convert the program to the Flexible Voucher Program – a block-grant type approach which would eliminate many of the critical protections people with disabilities have under the current Section 8 program.

The CCD Housing Task Force is a coalition of national disability organizations working to promote access to affordable and accessible housing opportunities and community supports for people with disabilities. People with disabilities have the highest level unmet need for housing assistance of any group eligible for federally subsidized housing. In 2002, approximately 3.7 million non-elderly people with disabilities relied solely on federal Supplemental Security Income (SSI) benefits worth $545 per month. Priced Out in 2002(published by the CCD Housing Task Force and the Technical Assistance Collaborative) found that SSI recipients on average would need to pay 105 percent of their monthly SSI income to rent a modest one bedroom unit. The individuals whom we represent, many of whom depend solely on SSI or other disability benefits, are current participants in the Section 8 Housing Choice Voucher program or on Section 8 waiting lists. The Section 8 voucher program is central to their ability to have an opportunity to find affordable and accessible housing in the community.

Administration proposal would harm people with disabilities: The CCD Housing Task Force strongly believes that the Administration's Flexible Voucher Program proposal would significantly erode housing assistance for the poorest people with disabilities. We believe this proposal actually undermines stated Administration disability policy goals designed to promote community integration under the New Freedom Initiative and end chronic homelessness.

The Administration's proposal would cause serious harm to people with disabilities in the following ways:

Proposed reductions in funding of over $1 billion for FY 2005 would mean that at least 250,000 households, including at least 50,000 households with disabilities, would lose their Section 8 assistance within the next year.

The Administration's Flexible Voucher Program proposal would eliminate targeting to the lowest income households. The federal targeting is a current Section 8 program requirement that has helped people with disabilities to live in the community. The new program could be used for households up to 80 percent of median income and dedicated exclusively to homeownership – closing the doors on many people with disabilities Under the Administration's Flexible Voucher Program, people with disabilities could be required to pay much higher rents than they can afford. Current rules limiting tenant rents to 30-40 percent of income would be eliminated.

PHAs would be given incentives to assist higher income households, a policy that would result in fewer people with disabilities receiving vouchers. PHAs could establish time limits on voucher holders. When a person's

see Consortium on page 26

Senate Finance Committee Hearings On Improving Community-based Services

By Michael M. Faenza
President and CEO
National Mental Health Association

Recent Senate Finance Committee hearing on strategies to improve access to Medicaid home and community-based services present a valuable opportunity to spotlight the crisis in community-based care for individuals with mental illness. The National Mental Health Association commends Senators Grassley and Baucus for spearheading this effort to improve access to needed community services for people with mental illness.

Currently, our mental health service delivery system is "in shambles," according to the President's New Freedom Commission on Mental Health. In fact, the commission stated in its recent report that "the nation must replace unnecessary institutional care with efficient, effective community services that people can count on." Yet, millions of people with mental illness fall through the cracks of our health care system largely because community-based care is not accessible or available to them.

It is NMHA's hope that our nation will prioritize mental health, commit additional resources and strengthen coordination among state and federal agencies in order to improve access to community-based mental health services.

As the single largest source of financing for mental health care in this country, Medicaid plays a crucial role as a safety net for millions of Americans with mental illnesses. However, a lack of resources and certain Medicaid policies have blocked those who need assistance the most from receiving care. As a result, many people with serious mental illnesses wind up homeless or incarcerated in jails and prisons. Studies have indicated that an estimated one-third of individuals who are homeless and 16 percent – some 284,000 people – of those in our jails and prisons have a serious mental illness.

What's more, the state of children's mental health services, particularly community-based services, is just as bleak, if not worse than that for adults. Many children are placed in institutional settings – sometimes far from their families – even though they could be more effectively and efficiently treated in the community while remaining at home.

The inaccessibility of children's mental health services forces thousands of parents to relinquish custody of children with mental disorders to the state each year so that they will become eligible for Medicaid and gain access to services through the child welfare system. In fact, the General Accounting Office found that in 2001, 12,700 children in 19 states and 30 counties were placed in child welfare and juvenile justice systems solely to access mental health services. As horrible as this finding is, it grossly understates the problem since most states did not respond to the GAO's survey.

Medicaid, a critical lifeline for millions of adults and children with mental illnesses, has been stretched too thin by intense financial difficulties in the states, resulting in cuts to Medicaid coverage. NMHA calls on Congress to strengthen Medicaid coverage of community-based services by:

- Allowing states to use Medicaid home and community-based care waivers to cover services for children who would otherwise be in psychiatric residential treatment centers. This provision is critical to reducing unnecessary institutionalization and improving access to community-based care for children with mental disorders. The President included this provision in his New Freedom Initiative Demonstrations proposal.
- Passing the Family Opportunity Act (S.622/H.R.1811), tirelessly championed by Sens. Grassley and Kennedy and Representative Pete Sessions, to enable more families to receive Medicaid coverage of children's mental health services and prevent these children from being taken from their homes when they need their families the most.
- Improving, or at least preserving, existing community-based care by extending the state Medicaid relief legislation and rejecting the cut to Medicaid included in the House budget resolution. States continue to face extraordinary budget shortfalls, and the fiscal relief Congress provided last year is set to expire in June. This relief lessened the extent to which states have cut services for people with mental illnesses who rely on Medicaid.
- Expanding access to services for adults with mental illness by consolidating the different "options" states must choose to provide comprehensive mental health services into one option under Medicaid. States currently must piece together services through six different optional categories. This change would lessen the fragmentation in mental health service delivery that the President's mental health commission highlighted as one of the main barriers preventing people from accessing needed mental health care.
- Asking states to credential consumer-run mental health services for reimbursement under Medicaid. These services provide much needed support to people with mental illnesses in the community, and the President's commission recommended these services as important sources of community-based care.
- Encouraging states to suspend, instead of terminate, Medicaid eligibility of those who are incarcerated for less than 12 consecutive months. Most states terminate Medicaid eligibility anytime someone is incarcerated, even though this is not required. As a result, when individuals with mental illness leave jail they are unable to access the care they need to stay healthy in their communities and are at risk of cycling back into mental health or justice facilities.

NMHA urges Sens. Grassley and Baucus, and the entire Finance Committee, to build upon today's hearing by swiftly approving legislation that incorporates these proposals to improve access to community-based mental health services.

In The News...At The Office Of Mental Health News

Mental Health News Receives $20,000 Grant From United Way Of New York City To Further Vital Mission Of Providing Essential Mental Health Education To The Community

Staff Writer
Mental Health News

The United Way of New York City has awarded a $20,000 grant to Mental Health News Education, Inc., the non-profit organization that publishes *Mental Health News*. The grant represents the largest award received to date for the young and rapidly growing organization, and is a continuance of the support which the United Way of New York City has provided to Mental Health News Education, Inc. over the past two years.

According to Alan B. Siskind, Ph.D., Chairman of the Board of Mental Health News Education, Inc., "the United Way of New York City has recognized our vital educational mission, and we are extremely grateful to the United Way for its generosity and vision in bestowing this grant."

Dr. Alan B. Siskind

Lilliam Barrios-Paoli, Senior Vice President of the United Way of New York City, stated: "We were first introduced to *Mental Health News* two years ago and quickly realized that this was an emerging young organization that was providing essential mental health education to the community. We enrolled *Mental Health News* in our Management Assistance Program (MAP), which helps to foster the capacity and future development of young and promising organizations. This year *Mental Health News* is continuing to benefit from our guidance in the MAP Program and we felt that by providing this leadership grant, other funders from the foundation and corporate sector will join us in support of *Mental Health News*."

"With the birth of *Mental Health News* only a few short years ago, we are seeing a wonderful and innovative transformation in the way we are now able to deliver mental health education to the community," stated Siskind, who further commented: "In my 40 years in the mental health field, *Mental Health News* is the first publication to provide substantive, topical, diverse information for practitioners, consumers, funders, policy makers, and the interested community. The contributions have been non-politicized and of high quality, which focus on the highly complex nature of the mental health issues that we all struggle with at one time or another. This is a most unique and important achievement."

Mental Health News reaches over 70,000 individuals and families affected by mental illness in the tri-state region of New York.

United Way of New York City Helps Here

Westchester Committee Meets To Help Launch *"Salud Mental"* A New *Mental Health News* Publication That Will Reach Out To The Latino Community

Staff Writer
Mental Health News

What happens when you combine a great idea with a wonderful group of key community leaders? In this case, it's the launching of a new bilingual publication by *Mental Health News* called *Salud Mental* .

Recently, representatives of the Westchester mental health, Latino, and legislative community got together to help guide the development of *Salud Mental.* Prior to the Westchester committee meeting, a meeting was held for the New York City committee for *Salud Mental*. Both committees will work to further the launching of a new bilingual mental health newspaper designed to reach out to the Latino communities of both Metro New York City and Westchester County, New York.

Members of the Westchester Committee (still in formation) include: David Aquije, a seasoned editor of Latino publications; Robin Bikkal, Esq, Chair of the Hispanic Advisory Board of Westchester County; Debra Del Toro-Phillips, CSW, Director of the MHA of Westchester's Caminando Juntos Program; Gladys Perez DiVito, Hispanic Outreach Coordinator for NAMI Westchester; Ximena Francella, an advocate for the Latino community; Lee Guich, ACSW, Director of Latino Services at The Guidance Center of New Rochelle; Beth Hofstetter, representing NY State Senator Suzi Oppenheimer; Jacqueline Lacor, CSW, of The Guidance Center; Leo Leiderman, Psy.D., Director of Latino Treatment Services at the Saint Vincent Catholic Medical Center; Blanca P. Lopez, Assistant Director of Housing at Human Development Services of Westchester; Martha Lopez, Program Administrator for Hispanic Affairs for Westchester County; Congresswoman Nita Lowey; Senator Suzi Oppenheimer and Jennifer Schaffer Ph.D., Commissioner of the Westchester Department of Community Mental Health.

(first row l to r) **Beth Hofstetter, Blanca Lopez, Ximena Francella, Martha Lopez**
(rear l to r) **Dr. Leo Leiderman, David Aquije, Ira Minot, Jacqueline Lacor, Gladys Perez DiVito, Dr. Jennifer Schaffer, Debra Del Toro-Phillips**

According to Dr. Leo Leiderman, "Hispanics are the nation's youngest and fastest growing population, who unfortunately underutilize and drop out of mental health and substance abuse services more than any other population with equivalent socioeconomic problems. Our hope is that *Salud Mental* will bring vital mental health education to Latino consumers and unite Latino service providers and clinicians to the cause of providing more information about their vital Latino programs."

Mental Health News will pilot the new publication in the five boroughs of NY City, and Westchester County, with future plans to distribute *Salud Mental* to more and more communities.

According to Ira H. Minot, CSW, Founder and President of Mental Health News Education, Inc. "We are very excited about reaching out to the Latino community with our educational mission, and our hope is that every sector of the community will pitch in and help us make this a tremendous success." He further commented, "Funding for this project will be critical to its success and much of our initial efforts will be to identify individual donors, foundations, and corporate sponsors to help us bring this vital publication to the community."

Plans are already underway to launch the premier issue sometime in early winter. But first, letters and e-mails will need to go out announcing the project and enlisting support. Latino mental health, substance abuse and human service organizations will be invited to participate by writing articles about their programs and to sponsor low-cost ads to direct consumers to their services.

Both NYC and Westchester committees ask your help in building a database of service providers that we can reach out to.

Please help us spread the word about Salud Mental, and call the Mental Health News office with names of people who you think should be contacted. Please call us at (914) 948-6699 or e-mail us at mhnmail@aol.com. Your help is deeply appreciated.

In The News...At The Office Of Mental Health News

Mental Health News Is Now Reaching 4,500 NYSPA Members Throughout NYS

Staff Writer
Mental Health News

Thanks to the efforts of New York State Psychiatric Association (NYSPA) President, Barry B. Perlman, M.D., copies of *Mental Health News* are now being sent to over 4,500 psychiatrists throughout New York State.

According to Dr. Perlman, "NYSPA recognizes *Mental Health News* as a wonderfully useful publication which brings a unique perspective to the delivery of mental health education. No other publication has managed to combine clinical information, advocacy and resources in one easy-to-read format. We hope our members find this to be a publication that broadens their perspectives on psychiatry and hope that they will bring it to the attention of their patients."

Last year, NYSPA presented its prestigious *Warren Williams Award* to *Mental Health News* Founder Ira H. Minot. According to Minot, "We are delighted to have this opportunity to reach out to NYSPA members throughout New York State. It is important to have our broad-based perspective on mental health recovery and education reach the physicians that are treating people with mental illness. These are also the doctors that are heading programs, clinics and psychiatric hospitals throughout our readership. This represents an important and vital link for us."

Barry B. Perlman, M.D.

Anne G. Katz Joins Mental Health News Board Of Directors

Staff Writer
Mental Health News

Mental Health News is very pleased to announce the recent appointment of Anne G. Katz to the Board of Directors. Anne grew up in New Rochelle, New York and attended the University of Arizona where she received her Bachelors Degree in Psychology and Sociology in 1974.

Her professional career has been in banking for over twenty-five years. For many years she worked for Citibank in their Branch Banking and Private Banking Division. Currently, Ann is a Vice President and Branch Manager at North Fork Bank at the bank's new branch located at 420 Lexington Avenue in Manhattan.

A civic-minded woman, Anne has always found time to volunteer and raise funds for such groups as the March of Dimes, and served on the Women's Business and Professional Division of the Jewish Federation of Greater Monmouth County, New Jersey.

"I have followed the growth and development of *Mental Health News* since its inception in 1999, reports Katz, and upon my recent return to Westchester my first priority was to volunteer my services to the Board of Directors." Anne will serve as Board Treasurer.

In her spare time, Anne enjoys gardening, golf, scuba diving and cooking.

Anne G. Katz

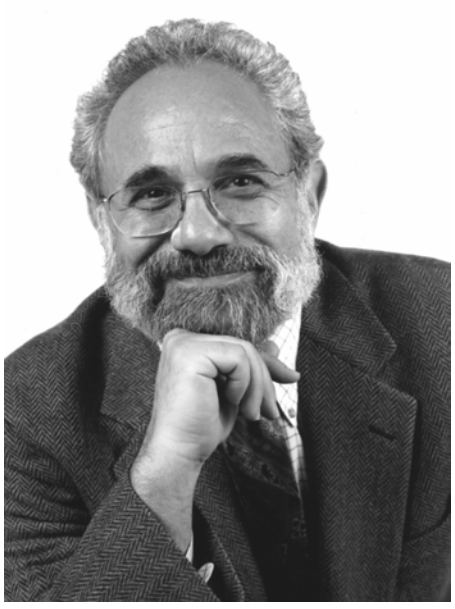
Dear Members of the Latino Mental Health & Human Service Community:
Mental Health News is Launching an Exciting new Bilingual Mental Health Publication.
We Are Building our Mailing List of Latino Organizations and Clinical Providers.
Please Contact Us Today to Express Your Interest in Participating
(914) 948-6699 or e-mail to: mhnmail@aol.com

POINT OF VIEW

POINT OF VIEW

Make A *Full* Commitment To Housing

By Michael B. Friedman, CSW



Michael B. Friedman

I first became aware of the need for housing for people with serious mental illness in the early 1970s. It was the height of deinstitutionalization in New York State. (From 1968 to 1973 the population of state hospitals dropped from 80,000 to 40,000). I worked at a psychiatric rehabilitation center on the Upper West Side of Manhattan, one of the very few in New York State at the time. The people who came to our program lived in single room occupancy hotels (SRO's), which were a major source of housing for very poor people. All of them were squalid places, and many of them were exceedingly dangerous. Muggings were a daily fact of life. Murders took place from time to time. They were dreadful places for people with mental illness to live. In truth, they were dreadful for anyone. I learned, however, that our clients preferred to live in them than in the state hospitals of the time, which they found even more dangerous, and at least equally squalid. I also learned that a huge number of patients were discharged to their families and that many were sent to adult homes, which often were as terrible then as many are now.

New York State's decision in the late 1970s to initiate a major housing program for people with serious mental illnesses brought a great deal of hope to all of us who were trying to help people who would have lived in state hospitals in another era to live decently in the community instead.

The new housing program was quite successful. It is and should be a matter of pride to New York State that roughly 25,000 housing units have been created since 1978. We've come a long way.

But there is still a vast unmet need, and people with serious mental illnesses should not have to wait another quarter century or longer to get the job to get done.

It is time for the Legislature and the governor to declare the next ten years *The Decade of Housing Reform* and to make a commitment to meet the housing needs of people with serious mental illness by 2015.

Many of us estimate that there is a need for at least 35,000 units of housing for people with serious mental illness in New York State and that the need could run as high as 70,000.

Unfortunately, it is impossible to project this housing need with any precision because New York State has not done an assessment of housing needs for people with serious mental illness since 1993.

At that time, the New York State Office of Mental Health (OMH) acknowledged a housing shortage of 20,000 community-based housing units statewide. Since then, the state has established about 9,000 additional units for adults with mental illness—a shortfall of approximately 11,000 units.

That estimate, however, did not take into account a number of factors that have become clear over the past decade, including the growth of homelessness, the abysmal conditions of adult homes, the inappropriate use of nursing homes, the number of people with mental illness in jails and prisons, the number of young adults with serious emotional disturbances discharged from foster care without adequate housing, the number of housing dislocations that take place due to the death of family members who provide housing, the large number of people with serious mental illness inappropriately living with their older parents, and the impact of population growth.

When all of these factors are taken into account, it becomes clear that OMH's 1993 estimate is way out of date.

Surely, New York State should try to meet this need as rapidly as possible, so that the current generation of people with serious mental illness who need housing can get it before they die.

What are the chances? Well, OMH now plans to develop about 5,000 additional adult units, a shortfall of at least 30,000, and perhaps as many as 65,000, units of community-based housing. At the rate of housing development over the past quarter century (about 1,000 new units per year), it could take well over another half century to meet the current need.

Isn't it obvious that the pace of housing development must be vastly increased?

In addition, the failure of funding to keep pace with inflation over the past decade has resulted in two very serious problems. First, when market rents are no longer affordable—a growing problem both in the NYC metropolitan area and in many upstate communities—people's housing is jeopardized. Second, inadequate compensation has resulted in rapid staff turnover and high staff vacancy rates.

I believe that a disaster is just waiting to happen—and the governor apparently agrees, since he did propose an infusion of $9 million in this year's budget for community residences (CRs). Unfortunately, it is not nearly enough for the CRs, and it cannot be used for "supported housing"—the most common type of community-based housing in New York State.

As I have said, I believe it is time for New York State to commit to a *Decade of Housing Reform* and to meet the housing needs of people with serious mental illness by 2015. Specifically, that will require that OMH conduct a systematic-needs assessment and issue a multi-year plan with specifics about how many, where, and when. This should be done through a broad-based planning process with oversight by an independent advisory committee. The plan should reflect a fundamental change of policy regarding the use of adult and nursing homes. In addition, because of problems developing housing sites, the state should enact a Mental Health Property Reinvestment Act, giving priority in the use of state psychiatric center property to provide community housing.

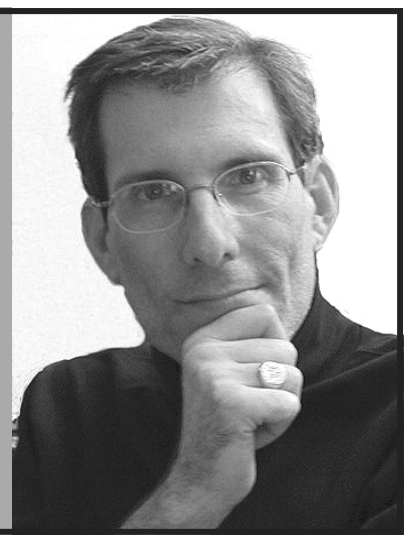
New York State also needs to take steps to protect and preserve existing housing programs by providing an infusion of funding for both community residences and supported housing far beyond the $9 million that the governor has proposed, and by establishing an annual "trend" factor (i.e., an automatic cost-of-living adjustment) to prevent further erosion and a reoccurrence of the crisis that we now face.

I think back over the past 30 years with a great deal of satisfaction about what has been accomplished. But I find it sad to think that people with serious mental illness will have to wait another 25 years or more to get the housing they deserve. The time has come for New York State to finish the job it began a quarter century ago.

Michael B. Friedman, CSW is The Director of The Center for Policy and Advocacy of The Mental Health Associations of New York City and Westchester. The opinions in this article are his own and do not necessarily reflect the positions of The Mental Health Associations.

A Voice of Sanity

A Column by Joshua Koerner
Consumer Advocate and Executive Director,
CHOICE, New Rochelle, New York



Psychiatry Endorses Prejudice

By Joshua Koerner

"A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient." That's from the Principles of Medical Ethics of the American Medical Association. It is a principle that psychiatry honors only in the breach.

Prejudice becomes deeply rooted when institutions and systems that should protect us from prejudice instead embrace it. The Supreme Court once ruled that segregation was constitutional. Politicians who pander to the lowest common denominator and our basest fears enact laws that disregard the Bill of Rights. Mental hygiene laws that condone the forced treatment of persons diagnosed with mental illness ignore the Fifth Amendment, which states, "No person shall be deprived of life, liberty, or property, without due process of law." Forced treatment, involuntary commitment, the things that happen on locked psychiatric units, are fundamental violations of due process. Due process isn't even a consideration.

But there's greater damage done than that which the individual suffers. The community knows that some politicians are craven meretricious hacks who follow the winds of public opinion. And the press, whose often distorted portrayal of mental illness certainly contributes to fear and prejudice, is itself viewed with deep suspicion. But doctors still hold some position of esteem in this country. When doctors endorse and participate in forced treatment they send out a clear message: the mentally ill are so dangerous that they don't deserve the same basic protections the rest of America enjoys. Mental patients are sub-citizens.

It isn't what the mental health system tells itself, of course. They justify forced treatment by saying it saves lives. But couldn't we save millions of lives if we involuntarily treated the obese, smokers, diabetics who don't watch their blood sugar, and everyone else whose health was at risk because they won't seek treatment on their own? And couldn't we catch many more criminals if we ignored the Bill of Rights? If we didn't need search warrants or due process of law we could arrest many more guilty people.

But for most Americans the rights are more important than lives saved. There's even the well-known expression that "better ten guilty go free than one innocent convicted." For people with mental illness, that gets turned on its head: you get locked up first and then have to prove yourself sane to get out. The mental health system, by failing to protest these laws, gives its approval to them and becomes an enforcement arm of discrimination. If the doctors believe it, it must be true.

I don't know of a single mental health practitioner who doesn't decry prejudice and discrimination against people with a diagnosis. Yet hospitals and hospital administrators and psychiatrists continue to take advantage of these cruel and discriminatory laws. To do so is an endorsement of cruelty and discrimination.

Even silence in the face of these laws is an endorsement. I have seen doctors use their positions of influence in society to literally march in the street. I've seen hospital emergency rooms and trauma centers closed for a day in support of a principle. That principle was lower insurance rates for doctors. For that they will storm the Capitol. For us they say nothing.

Psychiatry has been used as a tool of social oppression as far back as the founding of the Republic. The seal of the American Psychiatric Association is a portrait of Benjamin Rush, one of the signers of the Declaration of Independence. "Terror," he wrote, "acts powerfully upon the body, through the medium of the mind, and should be employed in the cure of madness."

Psychiatry becomes an enforcer of social norms when we give it the power of forced treatment because it defines pathology as a belief in something outside the social norm. Consider this statement from the American Psychiatric Association, issued September 2003:

"In the absence of one or more biological markers for mental disorders, these conditions are defined by a variety of concepts. These include the distress experienced and reported by the person who has the mental disorder; the level of disability associated with a particular condition; patterns of behavior; and statistical deviation from population-based norms for cognitive processes, mood regulation, or other indices of thought, emotion and behavior."

In other words, mental illness is what we say it is. Ever hear of drapetomania? It isn't diagnosed much any more. It's "an irrestrainable propensity to run away," a psychotic disorder to which slaves were prone. The treatment was amputation of the toes. If you think that's ancient history, homosexuality wasn't removed from the Diagnostic and Statistical Manual of Mental Disorders until 1974, and "ego-dystonic homosexuality" (in other words, being in the closet) wasn't removed until 1986.

If we send the modern criteria of mental illness – "distress", "deviation from social norms" – back to the 18th century, the urge of slaves to run away still fits. However, the "population-based" norms did change – slavery is no longer an acceptable behavior, and so the diagnosis vanished. What is so horribly ironic is that forced treatment itself is still the acceptable social norm; thus, when we—the psychiatrically labeled—object, our objection to treatment becomes itself evidence of illness.

Psychiatry, rather than taking a leadership role in combating prejudice, gives its medical imprimatur to hatred. Then again, perhaps we should consider ourselves fortunate that they aren't cutting off our toes to ensure our compliance with treatment.

The NAMI-NYS Corner

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

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

J. David Seay, J.D.

Housing for New Yorkers with psychiatric disabilities continues to be at the very top of the NAMI-New York State advocacy agenda. We are doing all within our power to press for the construction of more housing units – supported housing, supportive housing, and community residences. The problem is, is anyone listening? In the second year in a row with multi-billion dollar state budget deficits, what more excuses does the state need to do nothing more than token actions with regard to this plight of some of the neediest and most vulnerable New Yorkers?

Well, we are mad as hell and won't take it any more. Yes, the state is to be commended for building nearly 30,000 housing beds for persons with mental illness, and yes, that is probably more than any other state, and yes, New York spends more than any other state on mental health, blah, blah, blah. Lest shoulders be dislocated patting oneself on the back, let's get real. Despite all of the good works and housing that has been created, and that is true, there remains a staggering unmet need for more. Estimates vary from advocacy group to advocacy group – NAMI-NYS believes that we need between 40,000 and 70,000 new housing units, an admittedly wide range. But consensus is rapidly building on a number not too far from that.

The New York Campaign for Mental Health Housing Reform, an advocacy effort begun about a year ago, appears to be emerging as the preferred vehicle of choice for leading the charge for more and better mental health housing in the state. NAMI-NYS has been an active participant in this group from the start. This group's consensus is that at least 35,000 are needed over time, a number that can easily be substantiated. And that is exactly what the campaign is doing – substantiating and advancing the case for putting that number of beds into the development pipeline over a number of years. Nobody believes that this can be done overnight. But we all believe that we must start, and start now. Sadly, the Section 5.07 Plan recently issued by the Office of Mental Health has no numbers, dates or financial commitment in the housing section for what they are going to do in the future. What kind of a plan has no numbers, dollars, or timetable? But to their credit, and under Commissioner Carpinello's leadership, the plan document contains a lot more population-based data than it used to, and if that is a step towards true, needs-based planning, then it is most definitely a step in the right direction.

I quote from the campaign's case statement:

"*History:* New York State has long been a pioneer in the area of mental health. The nation's first community mental health legislation was enacted here in the mid-1950s. Many of the psychotropic drugs that help persons with mental illness recover and remain stable were developed and tested here. And New York was one of the first states to acknowledge its responsibility to house people with mental illness by investing in groundbreaking mental health housing development initiatives.

Nevertheless, New York's commitment to house people with mental illness came more than a decade after the most aggressive phase of deinstitutionalization. Subsequent development has never kept pace with the need. In 1955, New York's psychiatric center system had over 93,000 inpatient beds. By 1978, it had been reduced to about 27,000 beds. Today it has 4,200. Yet during this period, only 23,731 units of community-based housing for adults with mental illness were created.

In 1994, the New York State Office of Mental Health Comprehensive Plan acknowledged the housing shortfall, reporting the need to create 20,000 additional community-based mental health housing units statewide. Since then, the state and localities have created 10,000 units of housing. But the 1994 Plan underestimated the need for alternative housing for many people with serious mental illness, as it did not specifically address the mental health housing needs of those residing in adult homes, living with aging parents, incarcerated in jails and prisons, or aging out of the foster care system. Further, the state's assessment did not project changes in need due to population growth over the next decade. According to the Census Bureau, the adult population will increase by over 698,000 from 2005 to 2015. Approximately 1.5% of these people will meet the criteria for serious and persistent mental illness and many of these people will need housing. The estimate also assumed that there would be 2,000 more people in state psychiatric centers than are now there. Most importantly, it did not anticipate the growing severity of the shortage of all low-income housing in New York today, a shortage that has resulted in growing homelessness among many vulnerable populations.

The Problem Today: Despite over 23,000 units of specialized housing available to adults with mental illness in New York State, there remains an enormous unmet need. Existing housing stock ranges from large, licensed congregate housing models that offer 24-hour clinical care to smaller, licensed scattered-site apartments that offer Medicaid-reimbursable rehabilitation services. It also includes a number of supported housing models that offer case management and supportive services in scattered-site apartments or single residences. The vast majority of these housing units are operated by voluntary, nonprofit organizations. Just under half of the units are in New York City, many of them created under the celebrated city-state development collaboration, the New York-New York Agreement to House Homeless Mentally Ill Individuals.

All of the different models of mental health housing are in great demand, with vacancy rates of less than 2%. People with mental illness are often forced to wait years in expensive and inappropriate institutions, prisons, homeless shelters and other emergency settings before they gain entry into the housing. They are more likely to be locked out of the housing market and forced to live in sometimes grossly inappropriate settings.

The Need: The New York State Campaign for Mental Health Housing Reform has used existing data to establish preliminary estimates of the total housing need for people with mental illness in New York:

- More than 12,000 people with psychiatric disabilities are homeless statewide.
- An estimated 12,00 people with psychiatric disabilities reside in adult homes, mostly underfunded, overly large, for-profit facilities ill-equipped to offer rehabilitative services. A governor's workgroup has estimated that approximately 6,000 current adult home residents should be placed into alternative housing.
- Approximately 21,300 individuals in New York State prisons and jails, or 15% of all inmates, have serious and persistent mental illness. At least 9,000 people with psychiatric disabilities are released annually from New York jails and prisons without adequate housing or support services.
- Some 7,000 individuals live with aging parents and other ultimately untenable living situations.
- An additional 1,500 individuals with mental illness transition out of the foster care system to homelessness each year.
- Further, many individuals are estimated to live in housing that does not meet their needs, or does not allow them to achieve higher levels of independence.

Taking into account overlaps in these populations, the campaign estimates that New York State must create at least 35,000 units of housing over the next ten years.

The Solution: The New York State Campaign for Mental Health Housing Reform will be a broad-based, time-limited campaign with four related objectives:

- The development of at least 35,000 new units of various models of mental health housing in New York State over the next ten years, including the establishment of a third NY-NY Agreement to House Homeless Mentally-Ill Individuals.
- The preservation of approximately 20,000 units of housing currently available to people with mental illness in New York State – including supportive and licensed housing and well-run adult homes – by reforming oversight functions, investing in rehabilitation of the housing stock, and ensuring adequate funding for services and operations.
- The establishment of a statewide mental health housing waiting list, identifying those New Yorkers with psychiatric disabilities who have applied for but have not received supported, supportive, supervised or congregate housing.
- The creation of a comprehensive mental health housing plan. Developed in collaboration with stakeholders and local communities, the plan should include: a realistic assessment of the numbers of units needed; the design of state-of-the-art housing models; credible financing strategies for capital, operating, and service costs; as well as explicit milestones for implementation.

NAMI-NYS is proud to be a part of this coalition fighting for housing for New Yorkers with mental illness. We join with the dozens of other organizations in this effort to return New York State to its rightful role of pioneer in the area of mental health.

The NYSPA Report

Women's Mental Health: What's The Difference?

Nada Stotland, MD, MPH, Secretary
American Psychiatric Association

Men and women may be equal, but we're not identical. When it comes to mental health diagnosis and treatment, we have to take gender into account. There are psychiatric conditions, like premenstrual syndrome and postpartum depression, only women experience. There are psychiatric medications that interact with birth control pills (ask your doctor if this might affect you.) There are stresses and strains related to women's responsibilities to our families and our role in society. The American Psychiatric Association has paid attention to important gender differences in its research, its publications, its advocacy, and its activities, many of which have been championed and shared by the New York State Psychiatric Association. American Psychiatric Publishing, Inc., the largest psychiatric publisher in the world, has published a wide range of books on gender issues. You can find them at www.appi.org.

Here is a taste of the latest discoveries. Some of the newer antidepressant medications, when taken for a week before menstruation, can relieve the symptoms of women who have severe symptoms of depression limited to that 'time of the month.' Postpartum psychiatric illnesses have received a lot of publicity lately because of some terrible tragedies in which mothers killed their children. We have to distinguish between 'baby blues,' postpartum depression, and postpartum psychosis. 'Baby blues' are emotional highs and lows experienced by most women within a few days after they give birth. This condition may have gotten its name from the fact that women cry easily during this time, but they are not necessarily unhappy; they just feel things very deeply. This state goes away on its own and is nothing to worry about.

About 10% of women have clinical depression within six to twelve months after they deliver; many of these cases begin during pregnancy, but are not identified by the woman, her family, or the obstetrician. Postpartum depression can be very successfully treated with psychotherapy and/or antidepressant medication. We now have considerable evidence about the use of medication by pregnant women and nursing mothers. Some medications appear to pose little risk. It's important to remember that untreated depression poses risks for the mother, baby, and family, and to make an informed decision in consultation with a psychiatrist. Postpartum depression tends to recur in subsequent pregnancies. Although we can't prevent it, we can be prepared to begin treatment the moment symptoms appear.

Postpartum psychosis is a rare disease, occurring in fewer than 1% of new mothers, but it is a medical emergency. It begins within a few days after birth. The mother becomes agitated and confused, with delusions and hallucinations. She must have an immediate psychiatric evaluation for her own safety and that of her baby.

Women with schizophrenia and other severe psychiatric disorders are now as likely to have children as those in the general population. Caring for children while coping with a psychiatric illness is a challenge, but one that can often be met with adequate social support. When we plan psychiatric services, for example, we have to remember that child care responsibilities may make it difficult for women to get to appointments.

Sometimes you read that it is women's roles in the workplace that cause women's psychiatric problems. The evidence shows that having multiple roles is good for one's mental health - as long as those roles are supported. Having to work at a minimum wage job to support a family, without health insurance or reliable child care, does increase the risk of depression. Then having depression makes it more difficult to fulfill those responsibilities, not to mention having the energy and ingenuity to better one's position.

Women constitute just a bit over half of the new medical students in the United States, changing the face and, to some degree, the focus, of medicine. Women psychiatrists, along with men, have taken leadership roles in raising and exploring questions about gender differences. Women psychiatrists also face those universal challenges of integrating their family and professional lives. The APA supports the professional development of our women members with a Committee on Women, a Women's Caucus, a Women's Mentoring Program, a Women's Activity Center at our annual scientific meeting (the largest psychiatric meeting in the world was held in New York City this year), and a designated staffer in the national office. Many of our district branches, throughout New York and the rest of the country, sponsor Committees on Women of their own, dedicated to the well-being of women patients and women psychiatrists. A newly appointed task force is studying the relationships between gender and psychiatric diagnoses. The APA's very first woman president took office only fifteen years ago. We now have our fifth woman president, Dr. Michelle Riba. All the members of the APA and NYSPA are there to serve those who suffer from mental illnesses, men and women alike.

I would like to take this opportunity to congratulate the publisher on this excellent newspaper, which I have enjoyed for some time, and to thank NYSPA and NYSPA's President, Dr. Barry Perlman, for allowing me to participate.

Dr. Nada Stotland is Editor, with Dr. Donna Stewart, of Psychological Aspects of Women's Health Care, published by American Psychiatric Publishing, Inc., Washington, DC.

The Coalition Report

The Coalition of Voluntary Mental Health Agencies, Inc.

Co-occurring Disorders: Hope And Convergence

**By Meggan Christman,
Policy Advocate and Liaison to the Coalition's Committee on Co-occurring Disorders**

Perceiving the individual, wholly and uniquely. Individuals with Co-occurring Psychiatric and Addictive Disorders have been referred to by many labels and acronyms: CAMI; MICA; Double Trouble; Dual Diagnosis; Dual Disorders; and Dual Recovery, to name a few. We now know that none of these labels is quite accurate or sufficient. Individuals with co-occurring disorders often cross multiple service sectors, including the criminal justice system, the shelter system, the domestic violence system, the foster care system, and the public hospital system, to name a few. I am reminded of the parable about the blind men and the elephant. Each is given a different part of the elephant and asked to describe what kind of thing an elephant is. Each man gives a completely different description based on the part of the elephant they have been exposed to, whether the tail or the trunk or the legs or the ears, etc. Eventually, the dispute about the nature of the elephant comes to blows.

The rule, not the exception. Originally, it was thought that individuals with co-occurring psychiatric and addictive disorders were a minority, a small portion of individuals on each side of the proverbial fence that divided the mental health and substance abuse fields. However, according to the 1999 Surgeon General's Report, "Forty-one to 65 percent of individuals with a lifetime substance abuse disorder also have a lifetime history of at least one mental disorder, and about 51 percent of those with one or more lifetime mental disorders also have a lifetime history of at least one substance abuse disorder" (U.S. DHHS, 1999).

Barriers to service. The primary barriers to service can be broken down into three categories: 1) Systemic: There is not a single locus of responsibility. Services are fragmented. The separate bureaucracies, funding streams, and regulations for mental health and substance abuse often put the sectors in the position of competing for the same funding. 2) Provider level: Differing ideologies of treatment between the two sectors raise complications in treating both disorders simultaneously. There is an insufficient amount of cross-training available for clinicians to increase competencies in both disorders. 3) Consumer level: These individuals often require the most expensive and intensive services with the highest rates of relapse. Mental illnesses mask substance abuse issues and vice versa. There is a double stigma surrounding these individuals.

Recovery, hope and solutions. We have begun identifying the solutions, best-practices and how to collaborate to implement both. The hope for recovery is an ever-increasing reality. Providers are successfully treating these individuals every day. New York State has taken leadership in advancing better services for dual recovery. An Interagency Workgroup was formed in 1998 between the NYS Office of Mental Health (OMH) and the NYS Office of Alcoholism and Substance Abuse Services (OASAS). Out of this workgroup, the "New York Model" was defined. This model was a way to separate individuals with co-occurring disorders into four quadrants according to which of the disorders was primary. Responsibility for the care of these individuals was assigned based on their quadrant.

Government collaboration. What evolved from the interagency process was the acknowledgement by government and other stakeholders that Quadrant IV, the group of individuals with both severe substance abuse and severe mental illness, was a "no man's land." Those individuals were receiving services in hospitals, jails, and shelters. A Quadrant IV Taskforce led to a final report with recommendations on how to better serve these individuals. The idea of "no wrong door" was conceived. Individuals with co-occurring disorders should be able to present for services at any agency within either the mental health or substance abuse systems and receive concurrent and individualized treatment. This Interagency Workgroup is a successful example of collaboration across the disciplines of mental health and substance abuse, including representatives of all interested stakeholders. Yet there is still a long way to go until the vision of "no wrong door" is realized.

Evidence-based practice. The Substance Abuse and Mental Health Services Administration (SAMHSA) has endorsed Integrated Dual Diagnosis Treatment (IDDT) as one of its initial six evidence-based practices. The primary focus of IDDT is the concurrent provision of treatment for both the mental illness and the substance abuse issue by the same clinician or team of clinicians, in an individualized manner with stage-wise interventions relevant to each stage of recovery for both the mental illness and the addiction. It requires accurate screening and assessment, training of staff in dual diagnosis, motivational treatment and an agency-wide buy-in and cultural acceptance of dual diagnosis treatment. For more information and a draft of SAMHSA's Evidence-based Treatment Toolkit on IDDT, go to: www.mentalhealthpractices.org/dd.html.

Training. Although there is much debate about the appropriate use of the limited resources available to train providers in dual diagnosis, trainings are being conducted and competencies are being increased. The reasons for successful training offered thus far, and what is required in even greater dosages for continued success, is collaboration.

Meggan Christman

What we do know about effective training is that provider and consumer input are absolutely vital. Trainings designed from the top down often result in a disconnect between the theories imparted and the application to the daily provision of services. Follow-up, technical assistance, and regular refresher courses are necessary to affect practice. A partnership in New York City called the MICA Partnership consisting of: the NYS Office of Mental Health; the NYC Department of Health and Mental Hygiene, Division of Mental Hygiene; and the MHA of NYC has resulted in several training tracks for providers on dual recovery services.

In an ideal world. The current budget crisis at both the city and state levels means that enhanced rates, funding for more training, and cost of living adjustments for staff will come slowly and in small doses. Meanwhile, both substance abuse and mental health providers are faced with the immediate reality that these clients walk through their doors every day. In an ideal world, the state funds agency-wide trainings so that every clinician and front-line staff worker has competency in working with dually diagnosed individuals; enhanced rates are provided to support the additional needs of these individuals; a continuum of services is available including: housing, employment, counseling, and substance abuse services; services are tailored to each individual; and the capacity of both mental health and substance abuse services is sufficient to treat every New Yorker in need.

And, if agencies are expected to provide these services, then agency directors must be assured that they will be adequately reimbursed. They must have confidence that regulations and billing requirements will support the work, not offer hurdles to navigate. They must be offered incentives and resources to train staff and enhance the services they are currently providing.

Partnerships to transcend traditional boundaries. Meanwhile, directors and providers are infusing their agency cultures with cross-disciplinary collaboration. Recently, The Coalition's Committee on Co-occurring Disorders and the NYS Association of Alcoholism and Substance Abuse Providers (ASAP) Committee on Co-occurring Disorders have formed a joint workgroup. The providers that participate on these committees are providing leadership to those agencies that do not yet provide dual recovery services, but recognize the need to do so. They are forging partnerships and alliances to begin cross-pollination. Substance abuse counselors are visiting mental health agencies and participating in peer consultations. Mental health providers are providing on-site counseling in substance abuse programs. Providers are taking this initiative in order to demonstrate to government that they are ready, willing, and able *with support* to move in the direction of dual recovery services.

Government buy-in. There are several instances in New York State where government is making an effort to meet providers halfway. Providers and government are cooperatively developing and field-testing screening and assessment tools so that they can more accurately define the needs of the individuals they are seeing. In NYC, the Department of Health and Mental Hygiene has developed one of two upcoming Quality IMPACT Initiative projects around co-occurring disorders.

Effective treatment saves people and money. It is often said that individuals with co-occurring disorders consume the most expensive services. However, effective treatment for dually diagnosed individuals saves money. Poor, fragmented services cost money without yielding results. The problem has been acknowledged, positive steps are being made, and convergence is happening everywhere: between the mental health and substance abuse worlds and between government and other stakeholders. The key to continued improvement of the quality and capacity of services for individuals with co-occurring disorders is the continued collaboration, partnerships, communication and commitment evident in recent months. If we are willing to admit that each of us sees only a part of the elephant and that what we perceive of that part cannot be the whole picture, we will understand how vital it is to communicate, share information, work together, and develop a more complete and accurate understanding of the nature of the elephant. If we can focus on convergence, on the things we agree on, and remember that we all want the same thing, to help people live more satisfying, healthy and productive lives as members of their communities, free from substance abuse and in recovery from mental illness, then there will be an ever-increasing convergence and hope.

THE MENTAL HEALTH LAWYER

By Carolyn Reinach Wolf, Esq.

This space will be dedicated to a quarterly column dealing with issues that involve mental health and the law. We will respond to your questions, comments or concerns with current, informative, and hopefully, helpful facts and insight. The legal issues involving mental healthcare are expansive and growing increasingly complex. Whether your areas of concern are "in" or "out" patient psychiatric care, how to deal with a loved one's refusal to be treated, decision-making for an incapacitated person, information privacy or criminal law-related issues, this column is a space for you to make your thoughts known, seek information, and identify options. Because any legal action has the potential for profound impact on your life or the well-being of someone you are concerned about, this column is not meant as legal advice, but rather a platform for assisting you in making informed decisions.

As lawyers who have practiced in the field of mental health law for over fifteen years, our firm understands that entering the legal system for assistance in obtaining services or court intervention in your own or a loved one's affairs is a daunting task. However, there are many "tools" at your disposal in seeking a just result. The Mental Hygiene Law is a series of statutes created by the New York State Legislature designed to insure that individuals receiving care, and those who provide care, have a predictable legal outline of what they can and cannot do. In addition to the Mental Hygiene Law, individuals and entities may rely on New York's criminal laws, the laws that govern the provision of social services and patient privacy, and a myriad of state regulations and federal laws for guidance through the legal process, although many people perceive these laws as being confusing, intimidating, and too complex for the "average" citizen to utilize in reaching a desired resolution. In reality, the opposite is true. When used effectively, these laws can provide a safety net for those in need, giving individuals access to treatment, social services, and public benefits, as well as protection of their assets and personal medical information. Many of these laws also protect people from abuses at the hands of institutions by requiring access to judicial review of the institutions' care and treatment of patients, a patient's Bill of Rights, and regular review and licensure of these institutions.

The best place to start is by obtaining as much information as possible. Identify the problems and define your goals. For example, if your aunt, who is elderly, lives alone and is starting to neglect

Carolyn Reinach Wolf, Esq.

herself, you should identify her present and future needs. You may find that she requires the intervention of a social services agency to help connect her to treatment, a community center, or a home health aide, and this might be sufficient to address her needs for several years to come. Alternatively, you may find that her needs are more complex in that she may require a guardian to make decisions regarding her healthcare, financial assets, and Medicaid planning—or even to place her in a skilled nursing facility.

As a further example, your brother has been in acute psychiatric hospitals twice within the past thirty-six months, each time due to a failure to take his prescribed medications, resulting in a recurrence of his psychiatric symptoms. He is currently refusing treatment, now that he is back in the community. What can be done to help him survive safely outside of a hospital setting? Kendra's Law, also known as New York's Assisted Outpatient Treatment ("AOT") Law, may be the answer. AOT is a statute that allows a family member or other qualified individuals, such as a doctor or case manager, to seek a court order for outpatient services. AOT orders provide for services in the form of Intensive Case Management, Psychiatric Day Treatment, Medication Management, and Substance Abuse Testing and Treatment, and/or Supportive Housing (if applicable). The standard order initially lasts for six months and can be renewed for one-year periods after further judicial review.

Whatever the course, information is the key. The more you know about your loved one's medical and psychological needs, financial resources, and the circumstances of their daily living, the greater the likelihood that you will be able to utilize the system effectively and achieve your goal expeditiously. Once you have identified the person's needs and gathered facts, choosing a course is your next step. This may be your greatest challenge. There are innumerable local, city, and state agencies, as well as not-for-profit organizations, hospitals, out-patient clinics, nursing homes, and other service providers. There are so many choices, not to mention beaurocratic "red-tape," that you may want to retreat and give up. This is when you might want to seek the assistance of a lawyer or other individual who is trained to deal the "the system." Here, your choices are critical. You should be certain that the professional whose advice you are seeking has both academic and real-world experience. Bad advice can be costly, both in terms of a client's mental and physical health and their financial well-being. You will want to choose someone with experience in dealing with healthcare providers, governmental agencies, the courts, and of equal importance, people. Making decisions for your future needs or the needs of someone you care about can be a difficult time. Seeking advice from someone with no "bedside manner" will only make matters worse.

Once you have chosen appropriate professional help, be sure to stay involved. Your input regarding family history, the medical and social needs of the person in need of help, as well as remaining available to be an advocate, are all important tools to put at the professional's disposal. He or she will need your assistance and guidance in formulating an appropriate plan of action and in bringing that plan to fruition. Remain a proactive participant in the plan to insure it is working well for your loved one.

Life circumstances rarely remain static, and those services that were appropriate at one stage of a person's life may need to be expanded or modified to protect those interests as needs change. It is always difficult when trying to make decisions for someone you care about, but with professional assistance, hard work and a positive outlook, you can help to insure that you or your loved one gets the help that is deserved.

the NARSAD *report*

The National Alliance for Research on Schizophrenia and Depression

By Constance E. Lieber, President NARSAD

Constance E. Lieber

Sleep and the Brain: NARSAD Studies Sleep Disorders and Psychiatric Illness

Why is sleep so important? Evidence has been accumulating that at least one of the functions of mammalian sleep is to promote or allow nervous system changes. Disturbances in the sleep cycle, or circadian rhythms, can be associated with many psychiatric disorders, especially schizophrenia and mood disorders such as bipolar affective disorder and major depressive disorder. Researchers agree that a disturbance in the sleep cycle not only worsens the symptoms of psychiatric illnesses, but can also be seen as a marker of new episodes that occur following periods of remission. Much of the research done in this area by NARSAD-funded investigators is focusing on the relationship between sleep disorders and these psychiatric illnesses – from its genetic beginnings to therapeutic strategies that influence the sleep/wake cycle and improve mood, such as sleep deprivation, phototherapy (exposure to light), lithium and melatonin treatment.

Genetics

On the genetic front, Dr. Roseanne Armitage of University of Texas-Southwestern-Dallas and a recipient of a 1999 NARSAD Independent Investigator grant, is attempting to identify abnormalities in the genes that control biological rhythms in patients with major depressive disorders. Although these rhythms are inherited, many environmental factors have a strong influence. The hope is that an early identification of an abnormality can lead to early intervention to reduce the risk for developing the first episode of depression, improve the clinical course and minimize the biological risk for depression.

Several researchers are using animal models to address fundamental questions about the genetic, neurochemical and biochemical mechanisms which underlie sleep cycle disturbances and depression.

By altering the genetic marker that regulates sleep cycles in rats, Dr. Fred W. Turek, of Northwestern University and a recipient of a NARSAD Distinguished Investigator grant in 98 found that a disturbed sleep cycle compromises the animal's ability to respond to stress in a normal manner. Russell Van Gelder, M.D., Ph.D., of Washington University, a NARSAD 2002 Young Investigator grant recipient, has similarly genetically altered the "clock" of mice to study the relationship between bipolar disorder and seasonal affective disorder or "winter depression" – and abnormal circadian rhythms.

The importance of quiescence in animal development is considered to be fundamentally relevant to human health. David M. Raizen, M.D., Ph.D., of the University of Pennsylvania and recipient of a NARSAD 2003 Young Investigator grant, is also working on a genetic understanding of sleep and its regulation by identifying a quiescent state in worms so they can be used to model sleep and sleep disorders in the lab.

Sleep disturbances and schizophrenia

Sleep disturbances have been consistently observed in chronic schizophrenia and are exacerbated during psychotic relapses. The reduction of slow wave sleep (SWS) and the decreased REM sleep in schizophrenics suggest that there is an abnormal functioning of the body clock. Dr. Diane B. Boivin, of McGill University, a NARSAD Young Investigator grantee in 1997, tested whether or not that is true.

Her results show that sleep efficiency is reduced over 30% of the circadian cycle in patients with chronic schizophrenia compared to healthy subjects, and that the "window of opportunity" for deep sleep is more restricted in schizophrenia. Interestingly, there is a similar pattern in healthy elderly people. There were no significant differences in the sleep patterns between young schizophrenics and older healthy individuals.

These results suggest a neurodevelopmental theory of chronic schizophrenia. The NARSAD-funded research was the first time sleep cycles in schizophrenia had been quantified.

The study of human circadian rhythms is rather difficult and challenging since it requires around-the clock intensive physiologic monitoring. But there are those researchers who have taken on the task. Sudeep Chakravorty, M.D., of the University of Pittsburgh, a NARSAD 2002 Young Investigator grantee, is using PET and EEG (electroencephalo-graph) monitoring to study the changes in the brain during sleep and waking hours in schizophrenics.

It is believed that gamma activity revealed in the EEG of the human brain is somehow representative of cognitive integration. Therefore, an unusual gamma reading on an EEG could be seen as characteristic of some types of mental illness. Studies by Janet L. Tekell, M.D., of the University of Texas Southwestern Medical Center at Dallas, a NARSAD 2003 Young Investigator grantee, have shown that there is a positive correlation between symptoms of schizophrenia and gamma frequency power.

This work is significant because it may lead to the use of the measure of gamma activity as a neurobiologic index of the severity of schizophrenia symptoms and to measure treatment response. The more researchers know about the physiology of the disease, the more work can be done toward developing new drug treatments.

Effects of sleep disruption on other psychiatric illnesses

When the sleep/wake cycle is disrupted in healthy individuals, they may exhibit some changes in behavior, but most people can usually bounce back to their normal pattern of activities and behavior once normal sleep is resumed. This is not necessarily the case with people who suffer from bipolar depression. Results of studies done by Ellen Frank, Ph.D., of the University of Pittsburgh, revealed that disruptions in social routines that potentially affect the sleep/wake cycle could lead to onset of affective episodes in vulnerable individuals, specifically to mania. Dr. Frank was a recipient of a NARSAD Distinguishing Investigator grant in 1998.

Major depression and posttraumatic stress disorder (PTSD) are two major psychiatric conditions that have similar symptoms: sleep disturbance, diminished interest in activities, a lack of future orientation, irritability, and difficulty concentrating. Recent research with adults suggests that depression and PTSD may look the same, but may be caused by a distinctly different - and even diametrically opposed - biology.

By studying sleep disturbances in children with depression and PTSD, Carol A. Glod, Ph.D., R.N., of Northeastern University, a NARSAD 1996 Young Investigator grantee, found that their characteristics differed greatly. Children with PTSD exhibited problems both falling asleep and staying asleep, but did retain some sleep cycling. Depressed children suffered from hypersomnia, or too much sleep. In adolescents, however, depression was characterized with insomnia. Impaired sleep may lead to other problems in adolescents including poor concentration and subsequent declining school performance, daytime fatigue, and suicidal thoughts or behaviors. Future studies may try to determine whether sleep may be used as a predictive factor to identify children and adolescents who are at risk for depression, PTSD, or suicidal or violent actions.

Susan I. Wolk, M. D., of Columbia University, attempted to validate a continuity between childhood and adult depression by measuring growth hormone (GH) that is secreted during sleep.

There were no prior longitudinal studies of subjects with childhood depression that looked at the sleep patterns and neuroendocrine findings of the children and then compared them to their adult measures.

Results suggest that changes in nocturnal GH secretion may be seen in healthy adolescents who would develop depression over the 10-15 year follow-up period.

Dr. Wolk received a NARSAD Young Investigator grant in 1996.

Treatments

Several researchers are focusing on treatments for psychiatric illnesses that involve modifying the sleep cycle. For a healthy individual, sleep deprivation can have negative effects, but several studies have found that for people suffering from depression, sleep deprivation or partial sleep deprivation can have a therapeutic effect - similar to antidepressants.

By using brain imaging techniques, Camellia Pratt Clark, M.D., of the University of California -San Diego and a recipient of NARSAD Young Investigator grants in 1995 and 1998, has found that there is a marked difference in brain activity in the region associated with control of emotions between normal and depressed patients after sleep deprivation.

Sanjay Dube, M. D., of the University of Pittsburgh, a recipient of a NARSAD Young Investigator grant in 1992, is looking at why that is the case. He is studying the corollary between slow wave sleep, (which is prominent in the initial 2-3 hours of a normal sleep period, and is associated

see NARSAD on page 23

NARSAD from page 22

with a decrease in oxygen consumption and a precipitous drop in core body temperature) and an increased glucose metabolic rate. Several studies have shown reduced slow wave sleep and higher core body temperature in depression and an increased glucose metabolic rate. In depressives that means that sleep deprivation can normalize metabolism.

Meanwhile, Jamie Zeitzer, Ph.D., of Stanford University, and a NARSAD Young Investigator grant recipient in 2003, has found that hypocretin, a molecule that is critically involved in the regulation of wakefulness, may be disrupted in depressed humans and can be at least partially restored after treatment with antidepressants.

A better understanding of the antidepressant effects of sleep deprivation can lead to the development of new treatments for depression.

Meanwhile, lithium, one of the oldest and most successful mood stabilizers, has been shown to cause a lengthening of the circadian period and changes in the phase of circadian rhythms in a wide variety of organisms. Several researchers are looking at the efficacy of lithium as it relates to the sleep cycle and the implications of that.

Robert H. Lenox, M.D., of the University of Pennsylvania, is attempting to determine how lithium affects the molecular circadian clock mechanism. Preliminary data show that lithium affects the body clock on a genetic level. He received a NARSAD Distinguished Investigator grant in 2001.

Mehmet E. Dokucu, M.D., Ph.D. of Washington University, a NARSAD 2002 Young Investigator grantee, is also studying the effects of lithium on circadian rhythms and genetic signaling in an effort to identify specific molecular targets that may lead to safer alternatives to lithium in the future.

Martin P. Szuba, M. D., of the University of California-Los Angeles, a NARSAD 1990 Young Investigator grantee, is combining lithium and sleep deprivation treatment and has found that together, they can have an acute, sustained antidepressant effect.

Other studies of treatments for depression and schizophrenia involve the use of melatonin to reset the biological clock. Studies have been conducted on both people with non-seasonal major depression and people with winter depression (Seasonal Affective Disorder or SAD) This is a form of depression that typically begins in mid-autumn/early winter and goes into remission during the summer. Researchers have found that the body clocks of people with SAD are set too late or too early. Exposure to early morning bright light or evening bright light has also been found to correct this misalignment and reduce depressive symptoms. Consequently, it has been proposed that at least some forms of depression might be associated with a circadian clock that can't reset to light-dark cycles under normal circumstances.

Charles J. Weitz, M. D. Ph. D., of Harvard University, a NARSAD Independent Investigator grantee in 1999, is examining the molecular mechanism of how the circadian clock is re-set by light.

Some recent research has demonstrated that there is actually an autonomous circadian clock in the mammalian retina. More research will certainly explore that.

One of the related studies tested the notion that there is a relationship between eye disease and sleep cycles. In a clinical trial over a year, researchers found that children who were blind from optic nerve disease had a significantly higher incidence of daily napping than children blind from other causes and normal sighted children.

These results strongly suggest that input from the optic nerve to hypothalamic brain centers influence the timing of sleep and wakefulness. It is highly possible that the same pathways are also responsible for the effect of light on mood, in other words, seasonal affective disorder.

Conclusion

In psychiatric patients, sleep disorders are an important cause of a diminished quality of life and frequently lead to an over-consumption of sleep medications with unfortunate physiological and psychological side effects. Greater understanding through research of the mechanisms underlying sleep complaints in chronic schizophrenia, bipolar disorder and depression offers significant promise for designing new and appropriate treatments.

This article was prepared by Emily Hoffman, a free-lance writer and broadcaster in NYC.

It's OK To Get Caught Napping: Daytime Sleep To Compensate For Age-related Nighttime Sleep Loss

By Patricia J. Murphy, Ph.D.
Associate Professor of Psychology and Psychiatry, NewYork-Presbyterian Hospital – Weill Cornell Medical Center, Westchester Division

Patricia J. Murphy, Ph.D.

Sleep Disturbance in Aging

Up to half of individuals over age 60 report significant difficulty sleeping. This age-related sleep disturbance is more chronic and severe than the minor insomnia that almost everyone experiences occasionally. Moreover, there are certain characteristics of insomnia in older men and women that set it apart from other types of insomnia. In particular, as we get older, we may have some difficulty falling asleep initially after getting into bed, but more often, older individuals wake up frequently throughout the night, and have trouble getting back to sleep. This type of insomnia is called "sleep-maintenance insomnia." Most problematic, however, is that with aging, we tend to wake up earlier and earlier. Some older folks awaken at 3:00 or 4:00 a.m., and despite wanting to go back to sleep, are unable to, and thus are forced to terminate their night's sleep much earlier than they wish. This particular facet of sleep-maintenance insomnia is called "early morning awakening."

Such self-reported sleep problems have been verified in the laboratory. Sleep is more shallow, and fragile, in aging individuals. For example, it is much easier to awaken a 70 year old with a moderately loud tone, such as a phone ringing, than it is to awaken a 30 year old with that same noise. Also, as we age, the amount of "deep sleep" or "slow wave sleep" that is thought to be the most restorative type of sleep, shows a decline. Lab studies have confirmed that individuals over age 60 awaken twice as often as their younger counterparts, and further, take almost four times longer to get back to sleep. While bladder and prostate problems contribute to the increased frequency of awakenings, getting up to use the bathroom accounts for only about one-quarter of the relatively long awakenings that older people experience. Finally, when older people are studied in the lab, and permitted to sleep on their own schedules, they tend to fall asleep a little bit earlier (about 30 minutes) than younger study participants, but they wake up substantially earlier – about two to three hours – than younger subjects.

It is likely that there are several, perhaps interacting, causes of age-related sleep-maintenance insomnia. For example, many of the medical problems that accompany aging can negatively affect sleep. Arthritis, osteoporosis, heartburn, and heart disease increase with age, and both the symptoms of these diseases, as well as the medications used to treat them, may exacerbate sleep difficulties. Changes in the ability to withstand hot and cold temperatures influences sleep quality as well. Additionally, both men and women experience hormone changes as they age that may impact on sleep quality. The daily rhythm in the timing of sleep and wakefulness, controlled by an internal clock in the brain, is altered in aging, often resulting in earlier bedtimes and waketimes. Thus, age-associated changes in health and lifestyle may directly result in sleep disturbance, and probably combine to produce age-related sleep-maintenance difficulties.

Whatever the underlying factors, for nearly half of people over 60, the reduced sleep that accompanies aging is disruptive enough to be subjectively regarded as chronic sleep disturbance, or insomnia. Even those who do not complain, but instead, view nighttime sleep loss as a natural part of growing older, may nevertheless suffer the consequences of an inability to obtain sufficient sleep at night. The result of interrupted and/or truncated sleep is often decreased alertness, compromised waking function, and reduction in quality of life.

Fortunately, however, it is becoming clear that sleep problems are *not* an inevitable part of aging. There are several approaches to obtaining a good night's sleep and improving alertness during the daytime that have proven successful in clinical studies. Moreover, knowledge about sleep across the lifespan is growing at an impressive rate, and finding new ways to improve sleep in older individuals is a hot topic for researchers. Although there are many differing approaches to the treatment of age-related insomnia, based on what the clinician and patient believe is the underlying etiology, the goal of all treatments is the same – *to increase total sleep time and improve sleep quality, thereby enhancing quality of life and waking function.* Yet, adding significantly to nighttime sleep amounts may be beyond the capacity of a sleep system that is already operating at peak output in older individuals.

Older persons report nighttime sleep amounts that are, on average, two hours shorter than sleep amounts reported by younger people. The most successful treatments for sleep loss in older patients have resulted in maximum increases of about an hour of sleep, which still falls short of sleep amounts obtained by the young. It is possible that as we get older, the amount of sleep we *need* declines. However, the weight of evidence is that sleep need remains relatively constant throughout adult life, but the *ability* or *capacity* to get that amount of sleep decreases with age. As a result, sleep loss accumulates, and for many older individuals, this chronic sleep debt compromises daytime alertness and functioning. Although it seems difficult to further increase nighttime sleep in older people, it may be possible to increase *24-hour sleep amounts* by taking advantage of an opportunity to sleep during the daytime hours. The information below focuses on this seemingly simple, yet often overlooked, strategy for making up for nighttime sleep loss that accompanies aging.

Napping as Compensation for Nighttime Sleep Loss in Aging

It is generally thought that humans are *monophasic* – that is, that sleep occurs about once per day, in a consolidated 7 to 8 hour bout. However, if humans are truly monophasic, then we are different from every other animal on earth (and in the sky) whose sleep behavior has been studied. Some animals are extremely *polyphasic* – cats, for example, take catnaps all day and all night long. Cockroaches are even more polyphasic: while they are definitely less active during the day than the nighttime hours, they nonetheless obtain almost 3 hours of "sleep" per night. They remain active for 30 to 45 minutes at a time, then sleep for 15 minutes or so.

The assumption that humans are built to sleep in one 8-hour long episode has been challenged by studies in which humans were not, *a priori*, treated as different from other animals. When hamsters, mice, or rats are studied in the laboratory, their rest activity patterns are measured around the clock. They are typically placed in a cage, with ample food and water for a few days, and the floor of the cage is wired to measure when they walk around (wakefulness), and to record also when they are motionless (asleep).

Until quite recently, the study of human sleep was limited almost exclusively to the hours between about 10 PM until 8 AM the next morning. However, when humans are instead studied like hamsters, mice, and rats – when they are put into a comfortable room with ample food and water, and not much else to do – they sleep and eat like other animals! They often exhibit a relatively long sleep period during the nighttime hours and one or more sleep periods during the day. The pattern of sleep times under these experimental conditions is actually quite predictable. There is a biological tendency to sleep as our daily rhythm of body temperature is on the decline, and to wake up when body temperature begins its daily rise in the morning hours.

There is a second time during the day at which people tend to get sleepy, and take shorter sleep bouts if they are permitted to. As you might predict, the time of day at which many people experience sleepiness is the middle of the afternoon. Researchers have found that napping is likely to occur just before the time that the body temperature rhythm reaches its highest point of the day – in the mid - to late afternoon. Thus, like cats and cockroaches, humans also have a biological propensity for taking naps. It is doubtful that napping is a vestigial behavior, one that humans have evolved to no longer need. On the contrary, it is more likely, based on recent studies, that humans do not obtain adequate sleep during the nighttime hours, and might benefit from taking advantage of the robust biological tendency to nap in the afternoon.

The mere suggestion that ambitious, industrious Americans should consider embracing a siesta culture is no doubt preposterous to some. But scientific evidence indicates that taking a nap can actually enhance waking performance, perhaps for several hours, or potentially days, after a good nap. "Prophylactic" naps, taken before a person knows he or she will have to remain awake for an extended time period, such as before a night shift, do indeed help to promote alertness. Other studies have shown that taking a short nap during a long period of sleep deprivation, such as that experienced by hospital residents on 36-hour shifts, can be both refreshing and restorative.

Some sleep researchers might argue that daytime naps can interfere with the nighttime sleep that follows the nap. In fact, there is very little empirical evidence that napping has *any* effect on the subsequent night's sleep. Taking an afternoon nap may make the time it takes to get to sleep at night slightly longer, but most studies have reported that taking a nap does not change the timing, amount, or depth of nighttime sleep. Rather, getting even a 20 minute nap during the daytime has been shown to improve daytime mood and functioning.

Older individuals with sleep maintenance difficulties might particularly benefit from daytime napping. As mentioned, older individuals consistently report obtaining, on average, 2 hours less sleep per night than young subjects. Even following treatment for sleep problems, it appears that the maximum capacity for nighttime sleep is reduced in aging. Many older people simply can't get enough sleep at night. An easy-to-implement, non-drug treatment for nighttime sleep loss, and its resulting effects on waking function and mood, might be a daily napping regimen.

see Napping on page 48

NewYork-Presbyterian Psychiatry

NewYork Weill Cornell Medical Center

Columbia Presbyterian Medical Center

The Westchester Division

Columbia Weill Cornell Psychiatry of NewYork-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 NewYork-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.nyppsychiatry.org

NewYork-Presbyterian
The University Hospitals of Columbia and Cornell

Columbia Psychiatry		Affiliate	Weill Cornell Psychiatry	
Columbia Presbyterian Medical Center 622 West 168th Street New York, NY 10032 212-305-6001	**The Allen Pavilion** 5141 Broadway New York, NY 10034 212-305-6001	**New York State Psychiatric Institute** 1051 Riverside Drive New York, NY 10032 212-543-5000	**The Payne Whitney Clinic** 525 East 68th Street New York, NY 10021 888-694-5700	**The Westchester Division** 21 Bloomingdale Road White Plains, NY 10605 888-694-5700

Consortium from page 12

disability is permanent, their housing assistance should not be time limited. A time limited voucher could force people with disabilities back into nursing homes, institutions and other restrictive settings, and homeless shelters. Congress would no longer have the authority - as it has for the past seven years -- to target Section 8 vouchers for people with disabilities who have lost housing due to elderly-only policies. Over 50,000 people with currently funded disability vouchers would be at-risk. Over the long term, the Administration's budget projections for 2005-2009 clearly show further erosion in voucher funding – putting more people with disabilities at-risk of losing their Section 8 assistance. By 2009, Section 8 expenditures would be more than $4.6 billion below what the Congressional Budget Office estimates would be needed to maintain the program's current level of funding. The Center for Budget and Policy Priorities (CBPP) projects that cuts of this magnitude would mean that 600,000 vouchers – or 30 percent of the vouchers currently authorized – would be eliminated.

People with Disabilities Need Section 8 Vouchers

People with disabilities have the highest level of unmet need for housing assistance of any group eligible for federally subsidized housing. The CCD Housing Task Force estimates that more than 3 million people with disabilities receiving SSI do not currently receive any housing assistance from HUD. The current Section 8 program is literally a "lifeline" for people with disabilities who rely on SSI, as well as other low income people with disabilities who simply cannot afford the cost of rental housing. Section 8 Vouchers are needed by people with disabilities who have been negatively affected by the loss of housing opportunities because of federal "elderly only" housing policies. Over 500,000 units of HUD public and assisted housing have "elderly only" policies, and more units are being designated "elderly only" every day.

The Administration's Flawed Rationale

The Administration's proposal and their statements defending it are seriously flawed. The CCD Housing Task Force urges Members of Congress to treat this proposal with the same degree of skepticism and concern as it treated last year's Housing Assistance for Needy Families (HANF) proposal. One senior HUD official's public statement, that the current program's income-targeting requirements should be eliminated because they are not needed, can be rebutted by the fact that over 3 million people with disabilities below 30 percent of median income still do not receive federal housing assistance. HUD officials state that converting the current voucher program to a block grant is needed to control the programs "upward spiral in costs over the past two years". This statement is also misleading.

HUD's failure to produce accurate data and projections on Section 8 program costs cannot be used to imply that Section 8 program spending is "out of control". The rising costs in the Section 8 program during the past few years are due in part to improved PHA voucher utilization -- as urged by the Congress -- and leasing of new vouchers authorized from 1999-2002. Other cost factors include the escalating rental market of the late 1990s (which has now stabilized) and higher subsidy levels needed by households who have recently lost employment. CBPP's analysis projects that spending for the voucher program for FY 2005 will grow by only 1.6 percent, which is lower than the rate of inflation.

Conclusion

The current Section 8 Housing Choice Voucher program is the most important federal housing resource to address the housing needs of those with low incomes. We believe that Congress should maintain its responsibility to protect people with disabilities who receive or need Section 8 assistance. The CCD Housing Task Force urges Congress to fully fund the Section 8 voucher program in FY 2005, which means a $600 million increase over FY 2004 appropriation levels.

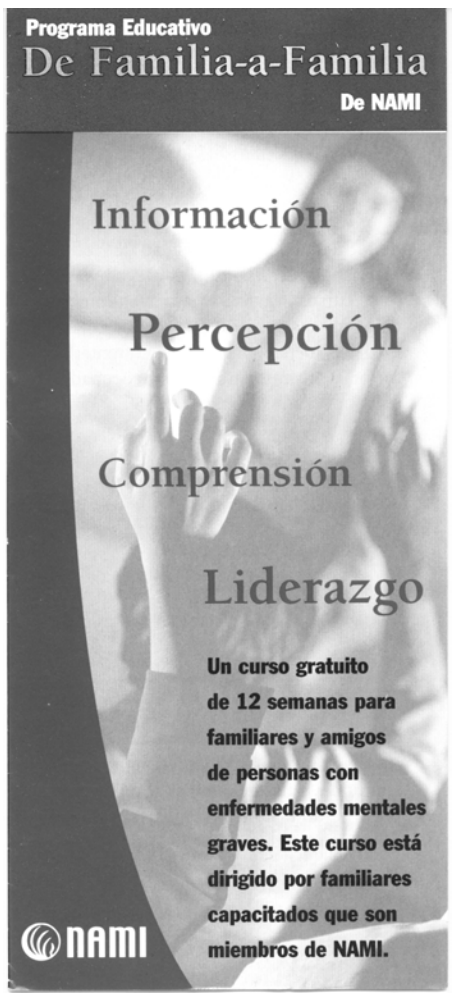
We also urge Congress to reject the Administration's Flexible Voucher Program proposal. This proposal is nothing more than another attempt by the Administration to achieve what they could not achieve in Congress last year, when bipartisan opposition to the HANF block grant proposal ensured its failure. We believe that Congress should continue to have the direct authority to ensure adequate funding for the program and to make decisions on how the Section 8 program is utilized.

HUD's role in administering the Section 8 program and monitoring the use of vouchers by PHAs is critically important. HUD should be held responsible for devoting the necessary resources to carry out these responsibilities successfully. Many of the current problems with the Section 8 program can be attributed to HUD's mis-management– including long-standing mismanagement of over 50,000 vouchers targeted to people with disabilities. Most importantly, the Section 8 program should continue to be targeted to addressing the most critical housing needs in our country today – those of extremely low-income people including people with disabilities.

CCD Housing Task Force: American Association of People with Disabilities, American Association on Mental Retardation, American Network of Community Options and Resources, Association of University Centers on Disabilities, Bazelon Center for Mental Health Law, Brain Injury Association of America, Easter Seals, Epilepsy Foundation, International Association of Psychosocial Rehabilitation Services, National Alliance for the Mentally Ill, National Alliance to End Homelessness, National Association of Protection and Advocacy Systems, National Council for Community Behavioral Healthcare, National Mental Health Association, Paralyzed Veterans of America, Spina Bifida Association of America, The Arc of the United States, United Cerebral Palsy, United Spinal Association (formerly Eastern Paralyzed Veterans Association)

NAMI Offers New Family-To-Family Course In Spanish

The National Alliance for the Mentally Ill (NAMI)
Westchester County, New York



Family educators of NAMI in the suburban county of Westchester, New York have announced a new Spanish NAMI Family-to-Family Education Program which will begin this spring.

This program is sponsored by NAMI Westchester as part of a nationwide initiative to train family members as teachers of its education program. The result of a recent scientific evaluation of the effectiveness of this program, conducted by Lisa Dixon, M.D., at the University of Maryland School of Medicine and the VA, showed that course participants gained a greater understanding of mental illness, coped much better, worried less, and felt newly empowered to advocate for better treatment and service for their relative. Many family members describe the course as life changing.

Family-to-Family presently has over 2,500 NAMI members teaching in 44 states, the District of Colombia, 2 Canadian provinces, and in Mexico. There are over 80,000 graduates.

The Family-to-Family Education Program is a priority commitment of NAMI of Westchester. Besides assisting families in desperate need, this program has brought in many new members and produced new leaders.

The course is specifically for relatives of people with bipolar disorder, major depression, schizophrenia and schizoaffective disorder, co-occurring brain disorders, and addictive disorders.

The curriculum, which covers 12 classes, focuses on schizophrenia, bipolar disorder, clinical depression, panic disorder, and obsessive-compulsive disorder. The course includes sessions on the latest medications and treatments, effective communication skills, problem-solving techniques, and how to advocate with the system. Classes offer an opportunity to share with other families in a confidential setting. All materials are furnished at no cost to participants.

NAMI Westchester's first Spanish Family-to-Family was held on May 3rd at St. Mary's Church, 23 High Street, Mount Vernon, New York, from 6:30 to 9:00 PM.

There is no charge for the course. Registration is required. Anyone interested can call Ann Loretan or Gladys Perez Di Vito at (914) 592-5458.

Nightmare Or Night Terror?

By Zvi S. Weisstuch, M.D.
Inpatient Child and Adolescent Unit
Mount Sinai Medical Center

Sleep disorders are divided into four broad categories in the DSM-IV-TR: (1) primary sleep disorders (dyssomnias and parasomnias); (2) sleep disorder related to another mental disorder; (3) sleep disorder due to a general medical condition, and (4) substance-induced sleep disorder. This discussion focuses on the primary sleep disorders, dyssomnias and parasomnias.

The **dyssomnias** are disturbances in the amount or timing of sleep whether insufficient, inefficient, or excessive. Dyssomnias are further divided into the intrinsic, extrinsic, and circadian rhythm dyssomnias. The intrinsic dyssomnias originate from causes within the body and consist of obstructive sleep apnea syndrome and narcolepsy, which is the only dyssomnia of rapid-eye-movement (REM) sleep. The extrinsic dyssomnias are due to external factors and are termed primary insomnias in DSM-IV-TR. They are defined as disorders of initiating and maintaining sleep. The circadian rhythm dyssomnias occur because of inappropriate timing of sleep within the 24-hour day. They are due to prolonged periods of sleep deprivation or persistent irregularities in sleep hygiene, which inevitably lead to delayed sleep phase syndrome (DSPS) or a disruption of the biologic clock.

The **parasomnias** are abnormal behaviors or physiologic events that occur during sleep and intrude on ongoing sleep. The parasomnias are subdivided into (1) arousal disorders (sleep/night terror disorder, sleep-walking disorder, and confusional arousals); (2) sleep-wake transition disorders (sleep-talking, nocturnal leg cramps, rhythmic movement disorder {head-banging, sleep starts, body-rocking}); (3) REM parasomnias (nightmares and REM sleep behavior disorder); and (4) miscellaneous parasomnias (sleep bruxism, sleep enuresis).

Sleep terror attacks occur with a sudden autonomic sympathetic system discharge, such as screaming, crying out, palpitations, irregular respiration, and diaphoresis. The attacks last from 30 seconds to 10 minutes, and it is difficult to arouse patients because they are typically not reactive to external stimuli. When awakened, the patient shows mental confusion and disorientation; retrograde amnesia for the episode is characteristic. The attacks occur in the first 1 to 2 hours after sleep onset, which is the time of transition from non-REM (NREM) stage IV sleep to REM sleep. Sleep attacks are most commonly associated with partial arousals from stage III or IV NREM sleep.

Occurrences of sleep terror attacks are sporadic and thus difficult to predict. They are more frequent in children between the ages of 2 and 6 years old and have an estimated prevalence of between 3% and 7% in this population. They are more likely to occur during periods of illness, stress or sleep deprivation, but they can also occur without any obvious associated stress. People with one form of parasomnia are also more likely to manifest symptoms of another form (e.g., somnambulism / sleep-walking), and a family history of parasomnias is common.

The main differential diagnosis for sleep terror attacks is nightmares. In comparison with sleep terror tacks, nightmares are frightening arousals from REM sleep associated with dream reports that are anxiety-laden. Nightmares predominate during the second half of the night during REM sleep. Stress, especially traumatic experiences, increases the frequency and severity of nightmares. In comparison to sleep terrors, nightmares are usually recalled in the morning.

The differential diagnosis also includes temporal lobe epilepsy that occurs at night, as manifested by hallucinations, incomplete arousals, fear and automatic behaviors. Suspicions of seizure activity when awake, a large degree of autonomic activation, and enuresis during the episode warrant an electroencephalogram (EEG).

Sleep terror attacks, nightmares and primary sleep disorders in children are treated with behavioral and supportive methods. An understanding of the underlying anxiety or major life stressor and the provision of parental support, reassurance, and encouragement for the child are imperative for alleviating sleep disorders. Angry threats, ridicule, and punitive measures should be avoided. The focus of treatment is on reducing stress and fatigue (due to association of sleep deprivation with sleep terrors). Benzodiazepines and tricyclic antidepressants have also been used in the treatment of sleep terrors because they suppress stages 3 and 4 of the sleep cycle. There are no studies, however, to confirm their efficacy.

Dr. Weisstuch is Clinical Instructor of Psychiatry and Pediatrics at Mount Sinai School of Medicine and Attending Psychiatrist of the Inpatient Child and Adolescent Unit at Mount Sinai Medical Center in New York City.

The Mental Health News

New York City Section

What Are Sleep Centers And Sleep Studies?

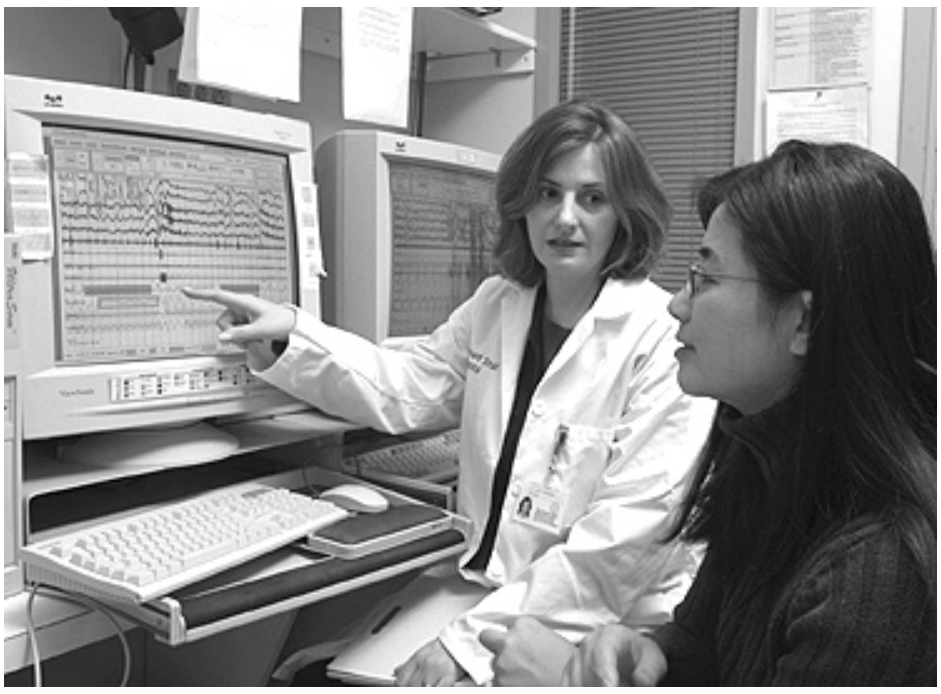
By Stasia J. Wieber, M.D.
Director, Center for Sleep Medicine
Mount Sinai Medical Center

A center for sleep medicine usually assists in the diagnosis and treatment of a multitude of sleep disorders. Sleep studies are often used to aid in the diagnosis and treatment of sleep disorders. The best centers offer a coordinated approach to the management of a variety of sleep disorders and related conditions.

Mount Sinai's Center for Sleep Medicine is undergoing a multi-disciplinary expansion. Our program is a full-service program that specializes in the comprehensive, compassionate, personalized care of adults and children with sleep disorders. This is the first truly multi-disciplinary sleep center in New York City. We have board-certified sleep physicians that are also board certified in pulmonary, neurology and pediatrics.

Patients are either self-referred or referred by their physicians. Some patients have undergone evaluation and treatment elsewhere and are still not sleeping well and are desperate to sleep well again. The most difficult cases are those that have not slept well for a long time. We find that a multi-disciplinary approach often works in that scenario.

The most common complaints are excessive daytime somnolence, snoring, and fatigue. The most common diagnosis in our center is the Obstructive Sleep Apnea Syndrome (OSA). OSA affects at least 2% of women and 4% of men aged 30 to 60. Signs and symptoms of OSA result from disruption of normal sleep. There are frequent arousals and the inability to achieve or maintain deep stages of sleep. This may lead to excessive daytime sleepiness, non-refreshing sleep, irritability, decreased memory, erectile dysfunction (impotence), and depression.



Dr. Wieber (left) discusses a patient with Chief Technician Yu Ding

Approximately 20 million Americans suffer from this disorder, characterized by the muscles of the back of the mouth and the throat relaxing too much during sleep. This relaxation causes a collapse of the airway, leading to a complete (apnea) or partial (hypopnea) blockage. Each time there is collapse, the oxygen level may fall, causing the heart to work harder. When left untreated, this disorder can lead to hypertension, heart failure, and stroke. Sleep is not restful and patients often complain of daytime sleepiness. Unfortunately, OSA is associated with an increased mortality due to motor vehicle and industrial accidents.

Most patients usually begin their care with an initial consultation. This consultation includes a medical and surgical history and physical examination. In some cases, the diagnosis and treatment plan can be completed in a single visit. If OSA is suspected, or other diseases such as narcolepsy, the evaluation requires a sleep study (typically over one or two nights). Overnight studies are called *nocturnal polysomnograms* (NPSG). NPSGs begin before the normal bedtime and are completed by 8 a.m. Most patients do not miss work the next day. In rare instances, daytime studies are recommended.

What is a sleep study (NPSG)?

NPSG's utilizes state-of-the-art monitoring equipment that converts the body's electrical impulses into a graphical representation that determines what is happening during sleep. The procedure is painless and noninvasive. Patients come to the sleep lab several hours before their usual bedtime. The patient will answer several questions about the events of their day and then the technician will begin the "hook-up." The "hook-up" isn't painful and takes only about thirty minutes. The technician will place small sensors called electrodes on the scalp, face, chin, chest, legs, and fingers. The electrodes and a conducting gel transmit biological signals from the skin to the equipment.

The most commonly asked question is, "Do you really expect me to sleep with all of the electrodes on?" Surprisingly, most people have little difficulty going to sleep wearing all the wires and sensors. After the "hook-up," the patient is permitted to go back to the room and relax before the test begins.

see Sleep Studies on page 48

HHS Awards $81 Million For Five-Year Health Screening Of World Trade Center Rescue And Recovery Workers

Staff Writer
Mental Health News

Health and Human Services (HHS) Secretary Tommy G. Thompson recently announced the awarding of eight grants to fund an $81 million, five-year health screening program of New York City firefighters and other workers and volunteers who provided rescue, recovery, and restoration services at the World Trade Center disaster site

The grants will allow the recipients to conduct three free standardized clinical examinations for each eligible individual over the next five years.

"Today's action will further assess the health of the brave men and women who worked day and night in the rescue and recovery at Ground Zero," HHS Secretary Tommy G. Thompson said.

"These grants will assure that the health screening of the World Trade Center rescue and recovery workers will continue without interruption."

HHS awarded the grants to the New York City Fire Department, the Long Island Occupational and Environmental Health Center, the Mt. Sinai School of Medicine, the New York University School of Medicine, the City University of New York's Queens College, and the University of Medicine and Dentistry of New Jersey's Robert Wood Johnson Medical School.

Of the more than 40,000 workers and volunteers who were present at Ground Zero, all of the approximately 11,000 New York City firefighters and about 11,000 other rescue workers have already received initial examinations through previous funding from HHS. These additional free, long-term examinations will help employers and public health professionals identify symptoms, injuries, or conditions that may indicate long-term illness as a result of the World Trade Center rescue and recovery operations, so that interventions can be pursued.

HHS also awarded grants to the New York City Fire Department and the Mt. Sinai School of Medicine, New York, N.Y., to develop data and to establish coordinating data centers. This will assure good, ongoing coordination between the various clinical sites that will perform the examinations. This will also support the development of databases of information that will help determine the ongoing needs and priorities of the health-screening program.

The Centers for Disease Control and Prevention's (CDC) National Institute for Occupational Safety and Health (NIOSH) will administer the grants.

the mental health association of new york city, inc.

MHA Of NYC Celebrates Mental Health Month: Teens Invited To "Get The Balance"

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

Giselle Stolper

During the month of May the mental health community nationwide commemorated Mental Health Awareness Month. The month is dedicated to educating the public about the symptoms of mental illness, and to underscore importance of maintaining their mental health.

The purpose and importance of this commemorative time is best summarized by the Proclamation that Mayor Bloomberg issued to acknowledge Mental Health Awareness Month in New York City. We gratefully accepted this proclamation from Dr. Lloyd Sederer, Executive Deputy Commission for Mental Hygiene of the New York City Department of Health and Mental Hygiene. Dr. Sederer issued the proclamation on the mayor's behalf at the Picnic for Parity, held Wednesday May 5 in Bryant Park.

The MHA of NYC Launches New Campaign

During Mental Health Awareness Month the MHA of NYC took the opportunity to launch a new mental health campaign: *Mind. Body. Get the Balance.* The goal of the *Get the Balance* campaign is to remind young and old alike that taking care of ourselves mentally is as important as staying fit physically. If adults or kids feel "out of balance," we encourage them to call 1-800-LIFENET, the 24/7 confidential crisis, information and referral hotline operated by the MHA of NYC.

The campaign initially targets children and teens. In order to encourage them to *Get the Balance*, the campaign includes mental health screenings at city schools, special outreach through community organizations, celebrity appearances and other awareness efforts.

Our timing for this campaign seemed critical as the statistics about the state of our teens' mental health are daunting. In 2001, the Centers for Disease Control and Prevention (CDC) found that 7.8 percent of New York City high school students, in grades 9 through 12, having attempted suicide in the 12 months prior to the survey. Another 10.6 percent made a suicide plan, and 15 percent seriously considered suicide. New York City's statistics put us at 12th in the nation for rates of attempted suicide among teens, leading us to conclude this is a nationwide crisis.

The Department of Health and Mental Hygiene estimates that in the year 2000, 13 percent of NYC youth, ages 9-17 had an anxiety disorder, 6.2 percent suffered from depression, 10.3 percent had a disruptive behavior disorder, and two percent had a substance abuse disorder. In addition, some children are believed to be experiencing social and/or emotional problems as an a result of the 9/11 attacks.

If we convey our message properly, we will have promoted the importance of early detection of an emotional problem, when treatment has a better chance for success. Look for *Get the Balance* multiple language buttons and postcards at health fairs, in-school screenings and other special events *(shown on next page)*. The campaign will also be expanded to reach children's parents and other adults throughout 2004-2005.

Get the Balance also ties to our advocacy efforts as we continue to fight for parity legislation in support of Timothy's Law – balancing mental health treatment benefits with those offered for physical care. The MHA of NYC is dedicated to supporting New Yorkers who suffer with mental illness to sustain their health and to lead satisfying lives, just as those with physical disabilities do. That, combined with raising awareness about the symptoms of mental illness and the importance of mental health screenings, will help keep our community mentally fit, balanced in mind and body.

For more information about our *Get the Balance* campaign or for buttons or postcards to distribute to consumers or at events please contact us at helpdesk@mhaofnyc.org.

Proclamation of Mental Health Month by Mayor Michael R. Bloomberg

Office of the Mayor, City of New York:

Whereas: Most of us know someone – a family member, a friend, or simply an acquaintance – who has struggled with some form of mental illness. This is not surprising, considering that more than a million New Yorkers currently have a mental disorder. Mental illness affects people regardless of age, gender, race, ethnicity, religion or economic status, causing pain and hardship not only for those affected, but also for their loved ones.

Whereas: Every May, the Mental Health Association of New York City and its partners observe Mental Health Month to raise awareness and understanding of mental health and illness. People who have mental illnesses can recover and lead productive lives, and early detection and treatment of a mental illness, especially among children, can help improve prospects of recovery. By promoting healthy social and emotional development among young children, we can help assure school readiness and give children a greater chance for lifelong success.

Whereas: To that end, the Mental Health Association of New York City is sponsoring *Get the Balance*, a program offering free mental health screenings for children and teenagers in schools across the city. More than 7 million American children and adolescents suffer mental disorders, but only 20 percent receive the services they need. This initiative, taking place on May 4, emphasizes the importance of early detection and seeks to ease the stigma associated with mental illness.

Whereas: Untreated and mistreated mental illnesses and addictive disorders cost American families, businesses and government hundreds of billions of dollars each year. Community-based services that respond to individual and family needs are cost-effective and beneficial to consumers and the community. During Mental Health Month, people throughout our city come together to battle mental illness, armed with knowledge, compassion, and the desire for a healthier, happier New York.

Now therefore I, Michael R. Bloomberg, Mayor of the City of New York, in recognition of the contributions of the Mental Health Association of New York City to the health and well-being of New Yorkers, do hereby proclaim May 2004 in the City of New York as Mental Health Month.

Michael R. Bloomberg, Mayor

Giselle Stolper and Dr. Lloyd Sederer receive Proclamation from NYC Mayor Michael Bloomberg

GET THE BALANCE

Feel off-balance? If you feel out of control, overwhelmed, or stop caring about family, friends, or anything — you're out of balance.

If you or someone you know needs to get the balance, call **1-800-LIFENET**. It's free, personal, and all calls are completely confidential.

Talk about your thoughts and feelings instead of covering them up. Take care of yourself better. We'll provide resources and referrals — for you, a friend, or a family member.

Getting the balance means realizing your full potential and leading a healthier, happier life.

Get the Balance. Be strong in mind and body.

Call: 1-800-LIFENET (1-800-543-3638)
Spanish LifeNet: 1-877-AYUDESE (1-877-298-3373)
Asian LifeNet: 1-877-990-8585
www.mhaofnyc.org

the mental health association of new york city, inc.

心康體健，心理安康一線牽 1-877-990-8585

MIND · BODY · GET THE BALANCE · 1-800-LIFENET ·

MENTE Y CUERPO EN BALANCE · 1-877-AYUDESE ·

GET THE BALANCE

When your mind and body are balanced, you're strong. When you're strong you know how to enjoy the good days, get over the bad ones, and make things happen.

Are you and your friends balanced?
- **Do you wish you could just forget your problems?**
- **Do you have secrets you don't share with anyone?**
- **Do you take care of your body?**
- **Is there someone you know who is hurting themselves physically, or with drugs and alcohol?**

A sure sign of being off-balance is when someone feels out of control, overwhelmed, or stops caring about family, friends, or anything.

If you think you or one of your friends might be out of balance, call **1-800-LIFENET**. Talk about your thoughts and feelings instead of covering them up. Share your problems. We'll help. Your call is free and totally confidential.

Call: 1-800-LIFENET (1-800-543-3638)
Spanish LifeNet: 1-877-AYUDESE (1-877-298-3373)
Asian LifeNet: 1-877-990-8585
www.mhaofnyc.org

the mental health association of new york city, inc.

Neurological Sleep Disorders

By Gabriele M. Barthlen, M.D.
Assistant Professor, Neurology
Director, Sleep Center Neurology
Mount Sinai Medical Center

Sleep disorders are very common in neurology: prevalence ranges from 0.05% for narcolepsy to 10% for restless legs syndrome (RLS). On the other hand, many neurological conditions, especially the degenerative diseases such as Parkinson's disease or dementia, are associated with a high percentage of sleep disturbance. Sleep onset and sleep maintenance insomnia has been shown to occur in up to 80% of Parkinson's disease patients, and is the most frequently cited direct cause for nursing home placement, as the caregiver becomes too exhausted.

This article will focus on the clinical features and currently available treatment options of narcolepsy, restless legs syndrome, periodic limb movements (PLMS) in sleep, REM behavior disorder, and sleep disorders in neurodegenerative conditions such as Parkinson's disease, dementia, and neuromuscular disorders (e.g., amyotrophic lateral sclerosis, or Lou Gehrig's disease).

Narcolepsy

Narcolepsy has its onset most often in the second decade, but is often not diagnosed until ten years later. It has been matched to chromosome 6, HLA locus DQB1*0602, most often in combination with HLA DR15. There is a profound decrease in the hypocretin levels of the cerebrospinal fluid. Clinical features include:

- excessive sleepiness
- cataplexy
- sleep paralysis
- hallucinations

Excessive sleepiness: Patients have unwanted sleep episodes in conditions not usually associated with sleep, such as while talking to someone, during an examination, while eating, or driving. They typically sleep for about 20 minutes, and wake up refreshed. Sleep episodes may occur several times a day, and can be used therapeutically when taken as a scheduled nap. Amphetamines are effective in treating sleepiness, but have the potential for abuse and tolerance. Modafinil (Provigil) is a newer wake-promoting agent with fewer side effects, but less potency. Dosage ranges from 100 mg to 400 mg, given in divided doses upon arising and at noon time.

Cataplexy: Cataplexy consists of sudden loss of muscle tone triggered by emotion, usually laughter. Patients may become completely paralyzed, except for the respiratory and extraocular muscles. They remain fully awake; deep tendon reflexes are absent. When mild, there may only be ptosis, or a buckling of the knees. Episodes last for a few minutes and recovery is complete. Differential diagnosis is syncope, akinetic seizure, and transient ischaemic attacks. Traditionally, antidepressant medications have been used to treat cataplexy. Treatment now consists of nocturnal administration of sodium oxybate (Xyrem), which has been approved by the Food and Drug Administration (FDA) for treatment of narcolepsy with cataplexy. Dosages range from 3 grams to 9 grams per night.

Sleep paralysis: Sleep paralysis occurs at the onset of sleep, and consists of a transient inability to move, lasting one to several minutes. It can occur in isolation; about one-third of the general population has experienced sleep paralysis at least once during their lifetime. Episodes often occur in combination with hallucinations, and can be very frightening.

Hallucinations: Hallucinations in narcolepsy are usually visual, but may be tactile, kinetic, or auditory. They occur at sleep onset (called hypnogogic hallucinations) or upon awakening (hypnopompic), usually in conjunction with sleep paralysis.

Associated features: Patients with narcolepsy also suffer from sleep disruption, and have an increased incidence of sleep apnea syndrome and periodic limb movements in sleep.

Restless legs syndrome and Periodic limb movements in sleep

Patients with restless legs syndrome (RLS) experience a very uncomfortable sensation in their legs, usually in their calves, when at rest. These sensations have been hard to describe by the patient, who may use phrases such as "Seltzer running through their legs," "worms crawling," or "electricity." Symptoms are usually worse in the evening, especially when laying in bed. They are alleviated by movement, such as walking around, or stretching. Restless legs often result in sleep onset insomnia. A familial component is present in at least one-third of RLS patients. Almost all patients with RLS will exhibit periodic limb movements in sleep (PLMS) at night. These are muscle contractions recorded over the anterior tibialis muscles, lasting 0.5 to 5 seconds each, occurring in regular intervals of between 5 and 90 seconds. When associated with an electrocortical arousal, PLMS can result in sleep maintenance insomnia.

Conditions that may underlie RLS are: anemia, uremia, use of antidepressants, as well as overindulgence of caffeinated beverages. Addressing those conditions will help improve RLS/PLMS.

Preferred pharmacological treatment consists of low-dose administration of dopamine agonists, such as pramipexole (Mirapex), in dosages of 0.125 mg up to 1.5 mg. Ropinirole (Requip) is given at dosages between 0.5 mg and 6 mgs. Levodopa/carbidopa (Sinemet) should be administered as the CR preparation to assure coverage through the night. In more refractory cases, opioids, such as codeine 15 mg to 120 mg per night, have been successful. Benzodiazepines, such as clonazepam (Clonopin), in doses of .5mg to 4mg, can also be used.

REM behavior disorder

Under physiological conditions, rapid eye movement sleep (REM sleep) is characterized by muscle atonia (paralysis) generated through active inhibition of the alpha motor neurons. Patients with REM behavior disorder (RBD) will act out their dreams, as they lack muscle atonia. Kicking, punching, fighting, running out of bed during attempted dream enactment often correlate with the patient's dream content. Serious injuries to self or bed partner have been observed. RBD is estimated to have a prevalence of 0.5%, occurs almost exclusively in older men, and has been associated with neuro-degenerative disorders. About one-third of RBD patients also have, or will develop, Parkinson's disease (PD); conversely, about one-third of PD patients have features of RBD. Clonazepam, in doses of 0.5 mg to 1 mg, is highly effective in the treatment of RBD, with little evidence of tolerance or abuse.

Sleep in Parkinson's disease

Patients with Parkinson's disease suffer from severe sleep onset and sleep maintenance insomnia, which may be due to the intrinsic degenerative nature of the disease, the persisting bradykinesia, or due to concomitant organic sleep pathology such as PLMS in sleep, REM behavior disorder, or sleep apnea syndrome. The latter is thought to be due to dyskinetic movements of the upper airway muscles. Treatment of these possible concomitant sleep disorders, which need diagnostic evaluation in a sleep center, can help alleviate the sleep disturbance. Whereas high evening doses of dopaminergic medication can aggravate sleep disruption, low doses can have sedating properties. Nonpharmacological measures such as following general sleep hygiene rules, having a urinal or a commode at the bedside, or employing satin bed sheets and satin pajamas (to facilitate turning over in bed) can be of great value.

Sleep in Dementia

Demented patients suffer from impairment of the "internal clock," a cell group in the suprachiasmatic nucleus that acts as a "Zeitgeber" and regulates proper sleep-wake functioning. Degeneration of the suprachiasmatic nucleus has been found in Alzheimer's disease. Neurotransmitters involved in sleep-wake regulation, such as the serotonergic system, and the adrenergic system, are dysfunctional as well. Patients have an elevated percentage of the light sleep stages one and two, and often have no slow wave sleep. The well-known picture of "sundowning" consists of wake intrusions at night and sleep intrusions during the day, resulting in a random, chaotic sleep-wake pattern. Treatment is difficult, and often limited to behavioral measures, such as regular daytime activity, disallowance of naps, and providing a quiet and dark bedroom. These conditions are often not met in nursing homes, where the washing of patients starts in the early morning hours, cleaning teams come in, and the bedrooms are often kept in a dim light.

Sleep in Neuromuscular Disorders

Neuromuscular disorders are found in childhood, such as the muscular dystrophies, and in later adulthood, such as amyotrophic lateral sclerosis (Lou Gehrig's disease). In those patients, respiratory muscles are weak, resulting in awake hypoventilation, which worsens at night. Because the upper-airway dilator muscles are weak, patients with neuromuscular disorders are also prone to obstructive sleep apnea syndrome, a condition resulting from partial or complete closure of the upper airway. Patients exhibit breathing pauses, with concomitant oxygen desaturations, and electrocortical arousals, leading to severe sleep disruption and often excessive daytime sleepiness. Treatment consists of non-invasive ventilation, such as intermittent positive pressure ventilation (IPPV), nasal continuous positive pressure ventilation (nCPAP), or bi-level continuous positive pressure ventilation (BiPAP). More invasive measures, such as tracheotomy need very careful consideration.

Mental Health News
Metro-New York Leadership Committee

Common Sleep Disorders And Improving Sleep Habits

By Chris Keane, FNP
Director of Nursing
Institute for Community Living

When you are asked to describe how you spend most of your time, do you quickly list your most frequent daytime activities and prioritize them based on the number of hours spent pursuing them? Are there any particular tasks that you routinely pursue from seven to eight hours at a time? Answering yes to the second question could qualify you for being the employee of the year or speak to the fact that you spend your biggest blocks of time trying to sleep and recuperate from the challenges of the day. Although sleep is a much-experienced entity, it is not necessarily well known scientifically.

What is sleep?

Sleep is a state marked by lessened consciousness, lessened movement of the skeletal muscles, and slowed-down metabolism. Beyond knowing these hallmarks, the physiological need for a certain amount of sleep is open to much debate. The reason for any amount of sleep is not truly known. Scientific researchers know that certain body systems benefit from sleep, but the exact reason for the need to sleep remains veiled. The National Academy of Sciences offers some insight into the need for sleep. We do know that during sleep many of the body's major organs and regulatory systems continue to work actively. Some parts of the brain actually increase their activity dramatically, and the body produces more of certain hormones.

Sleep, like diet and exercise, is important for our minds and bodies to function normally. In fact, sleep appears to be required for survival. It has been shown that lab animals (rats) deprived of sleep die within two to three weeks, a period similar to death due to starvation.

So how much sleep does a person need. The answer varies from one individual to the next. Nevertheless, most experts agree that it should be enough to feel alert during the next day. Typically, 7 to 9 hours (varies from person to person, and by age) of good quality sleep is appropriate.

Disturbances to sleep come in many forms and can be triggered by stress, physical illness, medication regimens, and a variety of other factors. According to the National Institutes of Health, insomnia affects more than 70 million Americans. Direct costs of insomnia, which include dollars spent on insomnia treatment, healthcare services, hospital and nursing home care, are estimated at nearly $14 billion annually. Indirect costs such as work loss, property damage from accidents and transportation to and from healthcare providers, are estimated to be $28 billion.

Insomnia is an experience of inadequate or poor quality sleep as characterized by one or more of the following sleep complaints: difficulty initiating sleep; difficulty maintaining sleep; or waking too early in the morning. Although most forms of sleep disorder are thought of as insomnia, or "no sleep" problems, it is also possible to have too much sleep (hypersomnia) and suffer the consequences to your equilibrium. A review of some common sleep disturbances and some of the causes will help to clarify the potential corrective measures. The resources available at Sleepnet (www.sleepnet.com) were used to compile this review of disorders.

Three basic types of Insomnia

Transient insomnia is a lack of sleep where the overall problematic sleep has a duration of only a few nights. Short-term insomnia may persist for two to four weeks worth of poor sleep. When insomnia moves into a more chronic state it said to be characterized by a poor sleep habit that happens most nights and can last for a month or longer.

Transient and short-term insomnia generally occur in people who are temporarily experiencing one or more of the following: increased stress, environmental noise, extreme temperatures change in the surrounding environment, sleep/wake schedule problems such as those due to jet lag, or medication side effects.

Chronic insomnia is more complex and often results from a combination of factors, including underlying physical or mental disorders. One of the most common causes of chronic insomnia is depression. Other underlying causes include arthritis, kidney disease, heart failure, asthma, sleep apnea, restless legs syndrome, Parkinson's disease, and hyperthyroidism. However, chronic insomnia may also be due to behavioral factors, including the misuse of caffeine, alcohol, or other substances; disrupted sleep/wake cycles as may occur with shift work or other nighttime activity schedules; and chronic stress.

In addition, the following behaviors have been shown to perpetuate insomnia in some people:

- Poor sleep hygiene in general
- Expecting to have difficulty sleeping and worrying about it
- Ingesting excessive amounts of caffeine
- Drinking alcohol before bedtime
- Smoking cigarettes before bedtime
- Excessive napping in the afternoon or evening
- Irregular or continually disrupted sleep/wake schedules

Difficulty sleeping at night is only one of the symptoms. Daytime symptoms can include sleepiness, anxiety, impaired concentration or memory, and irritability.

Treatment for insomnia

Transient and short-term insomnia may not require treatment since episodes last only a few days at a time. For example, if insomnia is due to a temporary change in the sleep/wake schedule, as with jet lag, the person's biological clock will often get back to normal on its own. However, for some people who experience daytime sleepiness and impaired performance because of transient insomnia, the use of short-acting sleeping pills may improve sleep and next-day alertness. As with all drugs, there are potential side effects. The use of over-the-counter sleep medicines is not usually recommended for the treatment of insomnia.

Treatment for chronic insomnia requires a few distinct steps. First, diagnosing, and treating any underlying medical or psychological problems. Next, action should be taken to Identify behaviors that may worsen insomnia and take subsequent actions towards stopping (or reducing) them. As a final measure, consider the possibly of using sleeping pills, although the long-term use of sleeping pills for chronic insomnia is controversial.

An individual taking any sleeping pill should be under the supervision of a physician or other health care provider to closely evaluate effectiveness and minimize side effects. In general, these drugs are prescribed at the lowest dose and for the shortest duration needed to relieve the sleep-related symptoms. For some of these medicines, the dose must be gradually lowered as the medicine is discontinued because, if stopped abruptly, it can cause insomnia to occur again for a night or two.

Trying behavioral techniques to improve sleep

Relaxation Therapy. There are specific and effective techniques that can reduce or eliminate anxiety and body tension. As a result, the person's mind is able to stop "racing," the muscles can relax, and restful sleep can occur. It usually takes much practice to learn these techniques and to achieve effective relaxation.

Sleep Restriction. Some people suffering from insomnia spend too much time in bed unsuccessfully trying to sleep. They may benefit from a sleep restriction program that at first allows only a few hours of sleep during the night. Gradually the time is increased until a more normal night's sleep is achieved.

Reconditioning. Another treatment that may help some people with insomnia is to recondition them to associate the bed and bedtime with sleep. For most people, this means not using their beds for any activities other than sleep and sex (some experts even say using the bed for sex call cause performance anxiety which could lead to insomnia). As part of the reconditioning process, the person is usually advised to go to bed only when sleepy. If unable to fall asleep, the person is told to get up, stay up until sleepy, and then return to bed. Throughout this process, the person should avoid naps, wake up, and go to bed at the same time each day. Eventually the person's body will be conditioned to associate the bed and bedtime with sleep.

Bright Light. If you are having trouble getting to sleep early enough at night it will help to wake up at the same time every morning and try to get as much bright light in the morning as possible. This will help reset the internal clock to an earlier time at night for sleep. If you are having trouble staying awake in the evening and waking up too early in the morning then try to get bright light in the evening. This will help rest the internal clock to go to sleep later and wake up later. You may want to avoid early morning light using this method until you have stabilized your sleeping pattern.

If insomnia is affecting the quality of life, talking to your physician is advised. The subject will not usually be brought up unless you bring it up. For chromic insomnia, a sleep specialist may be needed.

Sleep habits for a good night's rest

- Stay away from caffeine, nicotine, and alcohol, particularly later in the day.
- Have a light snack (but avoid eating a large meal) shortly before bedtime.
- Go to bed and get up at the same times each day, even on weekends.
- Get regular exercise early in the day.
- Keep your bedroom cool, dark, and quiet. A fan or soft music can help disguise distracting bedtime noise.
- Use your bed for only sleep and sex.
- Before bedtime, do muscle-relaxing exercises or take a warm bath.
- Do not take sleeping pills unless your doctor prescribes them.
- Avoid daytime naps, unless they last less than 1 hour and are taken before 3 PM.
- Try counting sheep or counting backward, which can lull some people to sleep.
- If you lie in bed awake for more than 30 minutes, get up, go to a different room and read or watch television, and return to bed when you feel sleepy.

Many times, there is a physical irregularity to the disruption of sleep. Most frequently, people complain of excessive snoring, or a significant other will be sure to make that complaint on their behalf. Snoring can be a sign of sleep apnea.

Sleep Apnea: the Basics

Sleep Apnea is a disorder of breathing during sleep. Typically, it is accompanied by loud snoring. Apnea during sleep consists of brief periods throughout

see Common on page 49

Institute for Community Living, Inc.

...a rehabilitation and support network

Medicaid Service Coordination Opening Doors - Building Futures

Medicaid Service Coordination (MSC) is a Medicaid State Plan service provided by the Office of Mental Retardation and Developmental Disabilities (OMRDD) which assists persons with developmental disabilities and mental retardation in gaining access to necessary services and supports appropriate to the needs of the individual. MSC promotes the concepts of choice, individualized services, supports and consumer satisfaction.

The Service Coordinator will assist with:

- Day Habilitation program (traditional or Day Habilitation without walls)
- Supported Employment
- Healthcare Services
- Physical and Occupational Therapy
- Employment
- Speech Therapy
- Housing opportunities
- Family Support Services
- Crisis Intervention
- and more...

Contacts and Referrals:

Kate Gottlieb, Director of Medicaid Service Coordination
Phone: 917-816-0115

How To Be Secure In An Insecure World

By Dr. Brenda Shoshanna

Most of us believe that our happiness and security are dependent upon our relationships, work, income, and the external events that take place in our lives. When things are going well, there is a sense of well-being and safety. We sleep well at night, wake up feeling refreshed, and have the sense that the world can be managed—that we are in control. However, this kind of security is fleeting, not grounded in the deepest truth. As people and events are constantly changing, we are often edgy about what's coming down the road.

We then spend our precious time and energy trying to manage and control ourselves, others, the whole world. This craze to control takes many forms; it turns into addictions, compulsions, or catastrophic thinking. It leads to strange, unhappy relationships, and produces anxiety that never seems to dissolve. No matter how much we attempt to plan and organize, the larger force of life itself often has its own ideas. Our life then soon becomes an endless struggle, rather than a source of joy.

A deeper question then arises—if not I, then who or what is in control? How can I feel secure in an insecure world? Where can I place my trust?

These questions have been asked and answered for centuries and different responses have been made, both from the world of psychology and spirituality. Particularly when we live in a world full of upheaval, the answer to these questions needs to be known.

The answer is actually simple. It lies in our deep need to develop Authentic Faith; faith in life, oneself, or a higher power—the kind of faith that becomes our flesh and bones. Hand-me-down beliefs, structures, words, habits, and behaviors no longer fill the bill. As the old Zen saying goes, *"Painted cakes do not satisfy hunger."* We urgently crave the real thing.

Authentic Faith is not based upon hearsay or old worn out habits. It allows us to release stress, stay centered, and develop a new source of support and worth. Authentic Faith restores our original strength to us, opens new ways of responding, and shows where our real treasure lies. As we become able to live from this basis, our life takes a completely different turn.

There is a process involved in developing this faith. We have to start by unlearning much of what we've based our lives upon. There are steps to be taken. They are directed to letting go of that which is in the way of our intrinsic balance and good will. Different individuals will warm to different parts of the process. That is fine. Each step when done completely can take a person just where they need to be. Some basic, initial principles and steps will be offered here.

To begin, rather than racing forward, we stop and turn around. Some call this returning to our original nature. We describe this step as returning home.

Returning Home

Rather than continue our frantic search for pleasure, wealth, love, well-being in the external world, this step suggests that we return home to ourselves. We take back our attention from all events and people and return it to who, what, and where *we* are at this moment. As we do this a centeredness, balance and simplicity takes the place of the upheaval we live with most of the time.

This step is based upon the principle that difficulties we encounter do not arise from that which is going on outside of us, but from the way we react and respond. As we return home and we become aware of these reactions, we receive a strong glimpse of where our true security lies.

Returning home can include times of walking, meditation, centering, focussing, or journaling. All of these have the common denominator of placing our attention back upon ourselves, our breath, feelings, thoughts, sensations - of becoming acquainted with who we truly

Dr. Brenda Shoshanna

are; making friends, becoming intimate. This not only restores our energy, but significantly reduces the endless spin of catastrophic thinking most of us engage in. As we do this we notice it is the catastrophic thinking itself that makes us uneasy, that creates scenarios we react to as though they have already taken place.

Unless we can recognize and control this thinking and know who we are, true faith is impossible. Otherwise we are often grasping at straws to calm the storm within.

Letting Go Of False Expectations

Our lack of trust in life, God, ourselves is often fueled by the disappointments we suffer over and over again. When our hopes, dreams and expectations are not met, insecurity arises, not knowing where to turn. We may not see however, that many of these dashed expectations which cause us so much pain are simply fantasies, dreams, hopes and demands we have placed upon the world. They are all self created. We've dreamt them up, or they have been dreamt up by others and put on our shoulders. Often they have little or nothing to do with what is real—about ourselves, other people, or the world we live in.

These false expectations must be made conscious and released, day by day. As we do this and are able to see and accept the world as it is, we find a new basis for living in it. Much anger and stress dissolves easily. We find who we are, where we belong, and where our true security lay. Many then become amazed at how light, joyous and at ease they feel—and at beauty and goodness that has always been available to them, day by day.

Removing Masks And Games

We wear a mask to greet the masks of others and then wonder why we feel so alone. Though we feel masks provide security, the opposite is true. These masks hide our sense of inadequacy and shame. They keep us separate and unknown, unable to let the light of true warmth and friendship in. Not only does this cause loneliness, it takes our original power and strength away.

In the process of developing Authentic Faith, little by little, we take off our masks. As we risk being and accepting who we are, a miraculous thing happens—our sense of fear and unworthiness vanishes, and our natural inner balance, security and wisdom appear.

"The world is a womb, not a tomb, a place where everything is engendered and brought to life."

Henry Miller

Dr. Brenda Shoshanna is author of Zen Miracles (Finding Peace in an Insane World), Wiley, and Zen and the Art of Falling in Love, (Simon and Schuster), among other books. Dr. Shoshanna offers talks and workshops on Authentic Faith (Opening The Doors To Unshakeable Strength) for mental health professionals, clergy, associations, and individuals. She is a psychologist, relationship expert, and speaker practicing in Manhattan: www.brendashoshanna.com.

Fall 2004 Cover Story Theme: "Cultural Diversity in Mental Health"
Deadline August 1st

Winter 2005 Cover Story Theme: "Womens Issues in Mental Health"
Deadline Nov 1st

Commentary On Insomnia

Since 350 B.C., when Aristotle wrote his epithet on sleeplessness, the scientific community has discussed insomnia. Over the past forty years, research on sleep using polysomnography has led to a large body of knowledge about sleep-wake manifestations, mechanisms, functions, and abnormalities, and led to the development of the clinical discipline of sleep medicine. The rapid expansion of this field has accumulated the diagnosis, treatment, and prevention of a spectrum of sleep disorders.

Insomnia is recognized as the most common sleep disorder in industrialized nations. Transient insomnia is virtually a universal experience. However, for approximately 35% of Americans, insomnia is chronic, with 15% experiencing moderate to severe disorders. The adverse consequences of insomnia are numerous, and include perceived decrease quality of life, poor daytime functioning, fatigue-related accidents, and physical and psychiatric morbidity. Although the scope of the problem is large, less than 5% of insomniacs seek medical treatment. Unfortunately, in the primary care setting, insomnia is often unrecognized and untreated by primary care providers. As a graduate student, I researched the barriers to accurate diagnosis and treatment of insomnia in the primary care setting. This article explores some of my findings.

Patients rarely make an office visit to their primary care provider to discuss poor sleep. However, sleep disturbances are associated with medical, neurological, and psychiatric disorders, which often are the chief complaint. Thus, the primary care office is an ideal setting for the recognition and assessment of insomnia and other sleep disorders. Despite this, many studies have found that primary care providers rarely inquire about sleep. There are several factors contributing to this phenomenon. First, a number of studies indicate that primary care providers lack adequate knowledge of sleep disorders, secondary to insufficient education of sleep medicine during their training. This lack of instruction on sleep and sleep disorders has been documented in medical schools and undergraduate and graduate nursing programs. Many programs provide less than three hours of didactic instruction on sleep disorders.

Effective management of sleep disorders not only requires accurate diagnosis, but also appropriate treatment. Despite recommendations from the American Academy of Sleep Medicine to attempt non-pharmacologic treatment prior to initiating drug therapy, many studies indicate that hypnotic therapy is the most frequent intervention used by primary care providers. In several studies, inappropriately large quantities of hypnotics and anxiolytics were prescribed for treatment of insomnia without adequate follow up.

The consequences of insomnia include daytime fatigue, drowsiness, impairment of performance, mood changes, and difficulty with concentration. Chronic insomnia can cause psychosocial, occupational, and other health problems. The health benefits of accurate screening and effective treatment cannot be minimized. A brief sleep history incorporated into the routine review of systems during health examinations can detect sleep disorders, and may additionally reveal comorbid psychiatric and medical disorders.

The primary care providers that I interviewed as part of my graduate research thesis identified time constraints as the primary barrier to adequate assessment of sleep disorders. Many providers have 30 to 45 minutes for an initial evaluation and 15 minutes for a follow up visit. Several of the providers reported ignoring sleep issues because there simply is "not enough time."

Clinicians' and patients' attitudes about insomnia also create barriers for treatment. Many clinicians described various degrees of pessimism when describing their treatment of insomnia. Several clinicians described feeling unsuccessful at managing sleep disorders. Patients' perceptions and expectations also shape treatment. Our culture promotes a quick fix. Often patients report wanting a solution now and prefer pharmacologic treatment to a trial of sleep hygiene measures.

Insomniacs that do not seek professional treatment often self medicate with over-the-counter sleep aids or alcohol. Too frequently in my work, I encounter patients who relapse with substances or spiral into depression after an episode of insomnia. I have ceased being surprised by patients' reports of taking Tylenol PM "for years."

Whether a primary or secondary disorder, acute or chronic, insomnia can have devastating effects in a patient's quality of life. All clinicians, in all specialties, need to be cognizant of the pervasiveness and seriousness of this disorder and ask the simple question, "how are you sleeping?"

Emily Byrne, APRN

"Salud Mental"
Our Exciting New Bilingual Publication
Will Premier This Coming Fall
Call Us Today To Express Your Interest

Sleep from page 9

western industrialized societies has created so much sleep deprivation that what is really abnormal sleepiness is now almost the norm.

Many studies make it clear that sleep deprivation is dangerous. Sleep-deprived people who are tested by using a driving simulator or by performing a hand-eye coordination task perform as badly as or worse than those who are intoxicated. Sleep deprivation also magnifies alcohol's effects on the body, so a fatigued person who drinks will become much more impaired than someone who is well-rested. Driver fatigue is responsible for an estimated 100,000 motor vehicle accidents and 1500 deaths each year, according to the National Highway Traffic Safety Administration. Since drowsiness is the brain's last step before falling asleep, driving while drowsy can – and often does – lead to disaster. Caffeine and other stimulants cannot overcome the effects of severe sleep deprivation. The National Sleep Foundation says that if you have trouble keeping your eyes focused, if you can't stop yawning, or if you can't remember driving the last few miles, you are probably too drowsy to drive safely.

What Does Sleep Do For Us?

Although scientists are still trying to learn exactly why people need sleep, animal studies show that sleep is necessary for survival. For example, while rats normally live for two to three years, those deprived of REM sleep survive only about 5 weeks on average, and rats deprived of all sleep stages live only about 3 weeks. Sleep-deprived rats also develop abnormally low body temperatures and sores on their tail and paws. The sores may develop because the rats' immune systems become impaired. Some studies suggest that sleep deprivation affects the immune system in detrimental ways.

Sleep appears necessary for our nervous systems to work properly. Too little sleep leaves us drowsy and unable to concentrate the next day. It also leads to impaired memory and physical performance and reduced ability to carry out math calculations. If sleep deprivation continues, hallucinations and mood swings may develop. Some experts believe sleep gives neurons used while we are awake a chance to shut down and repair themselves. Without sleep, neurons may become so depleted in energy or so polluted with byproducts of normal cellular activities that they begin to malfunction. Sleep also may give the brain a chance to exercise important neuronal connections that might otherwise deteriorate from lack of activity.

Deep sleep coincides with the release of growth hormone in children and young adults. Many of the body's cells also show increased production and reduced breakdown of proteins during deep sleep. Since proteins are the building blocks needed for cell growth and for repair of damage from factors like stress and ultraviolet rays, deep sleep may truly be "beauty sleep." Activity in parts of the brain that control emotions, decision-making processes, and social interactions is drastically reduced during deep sleep, suggesting that this type of sleep may help people maintain optimal emotional and social functioning while they are awake. A study in rats also showed that certain nerve-signaling patterns which the rats generated during the day were repeated during deep sleep. This pattern repetition may help encode memories and improve learning.

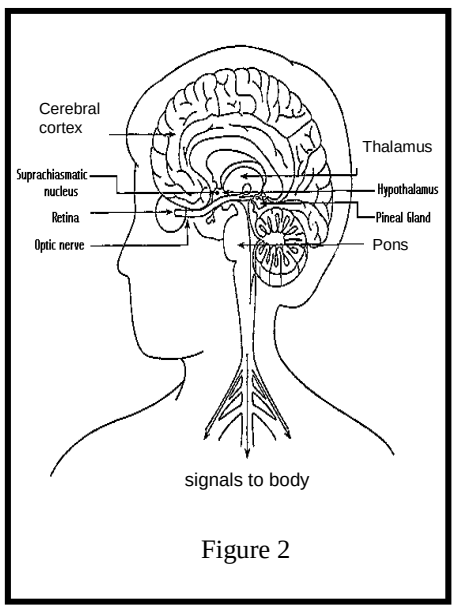


Figure 2

Dreaming and REM Sleep

We typically spend more than 2 hours each night dreaming. Scientists do not know much about how or why we dream. Sigmund Freud, who greatly influenced the field of psychology, believed dreaming was a "safety valve" for unconscious desires. Only after 1953, when researchers first described REM in sleeping infants, did scientists begin to carefully study sleep and dreaming. They soon realized that the strange, illogical experiences we call dreams almost always occur during REM sleep. While most mammals and birds show signs of REM sleep, reptiles and other cold-blooded animals do not.

REM sleep begins with signals from an area at the base of the brain called the pons (see figure 2). These signals travel to a brain region called the thalamus, which relays them to the cerebral cortex — the outer layer of the brain that is responsible for learning, thinking, and organizing information. The pons also sends signals that shut off neurons in the spinal cord, causing temporary paralysis of the limb muscles. If something interferes with this paralysis, people will begin to physically "act out" their dreams — a rare, dangerous problem called REM sleep behavior disorder. A person dreaming about a ball game, for example, may run headlong into furniture or blindly strike someone sleeping nearby while trying to catch a ball in the dream.

REM sleep stimulates the brain regions used in learning. This may be important for normal brain development during infancy, which would explain why infants spend much more time in REM sleep than adults. Like deep sleep, REM sleep is associated with increased production of proteins. One study found that REM sleep affects learning of certain mental skills. People taught a skill and then deprived of non-REM sleep could recall what they had learned after sleeping, while people deprived of REM sleep could not.

Some scientists believe dreams are the cortex's attempt to find meaning in the random signals that it receives during REM sleep. The cortex is the part of the brain that interprets and organizes information from the environment during consciousness. It may be that, given random signals from the pons during REM sleep, the cortex tries to interpret these signals as well, creating a "story" out of fragmented brain activity.

Sleep and Circadian Rhythms

Circadian rhythms are regular changes in mental and physical characteristics that occur in the course of a day (circadian is Latin for "around a day"). Most circadian rhythms are controlled by the body's biological "clock." This clock, called the suprachiasmatic nucleus or SCN (see Figure 2), is actually a pair of pinhead-sized brain structures that together contain about 20,000 neurons. The SCN rests in a part of the brain called the hypothalamus, just above the point where the optic nerves cross. Light that reaches photoreceptors in the retina (a tissue at the back of the eye) creates signals that travel along the optic nerve to the SCN.

Signals from the SCN travel to several brain regions, including the pineal gland, which responds to light-induced signals by switching off production of the hormone melatonin. The body's level of melatonin normally increases after darkness falls, making people feel drowsy. The SCN also governs functions that are synchronized with the sleep/wake cycle, including body temperature, hormone secretion, urine production, and changes in blood pressure.

By depriving people of light and other external time cues, scientists have learned that most people's biological clocks work on a 25-hour cycle rather than a 24-hour one. But because sunlight or other bright lights can reset the SCN, our biological cycles normally follow the 24-hour cycle of the sun, rather than our innate cycle. Circadian rhythms can be affected to some degree by almost any kind of external time cue, such as the beeping of your alarm clock, the clatter of a garbage truck, or the timing of your meals. Scientists call external time cues zeitgebers (German for "time givers").

When travelers pass from one time zone to another, they suffer from disrupted circadian rhythms, an uncomfortable feeling known as jet lag. For instance, if you travel from California to New York, you "lose" 3 hours according to your body's clock. You will feel tired when the alarm rings at 8 a.m. the next morning because, according to your body's clock, it is still 5 a.m. It usually takes several days for your body's cycles to adjust to the new time.

To reduce the effects of jet lag, some doctors try to manipulate the biological clock with a technique called light therapy. They expose people to special lights, many times brighter than ordinary household light, for several hours near the time the subjects want to wake up. This helps them reset their biological clocks and adjust to a new time zone.

Symptoms much like jet lag are common in people who work nights or who perform shift work. Because these people's work schedules are at odds with powerful sleep-regulating cues like sunlight, they often become uncontrollably drowsy during work, and they may suffer insomnia or other problems when they try to sleep. Shift workers have an increased risk of heart problems, digestive disturbances, and emotional and mental problems, all of which may be related to their sleeping problems. The number and severity of workplace accidents also tend to increase during the night shift. Major industrial accidents attributed partly to errors made by fatigued night-shift workers include the Exxon Valdez oil spill and the Three Mile Island and Chernobyl nuclear power plant accidents. One study also found that medical interns working on the night shift are twice as likely as others to misinterpret hospital test records, which could endanger their patients. It may be possible to reduce shift-related fatigue by using bright lights in the workplace, minimizing shift changes, and taking scheduled naps.

Many people with total blindness experience life-long sleeping problems because their retinas are unable to detect light. These people have a kind of permanent jet lag and periodic insomnia because their circadian rhythms follow their innate cycle rather than a 24-hour one. Daily supplements of melatonin may improve night-time sleep for such patients. However, since the high doses of melatonin found in most supplements can build up in the body, long-term use of this substance may create new problems. Because the potential side effects of melatonin supplements are still largely unknown, most experts discourage melatonin use by the general public.

Sleep and Disease

Sleep and sleep-related problems play a role in a large number of human disorders and affect almost every field of medicine. For example, problems like stroke and asthma attacks tend to occur more frequently during the night and early morning, perhaps due to changes in hormones, heart rate, and other characteristics associated with sleep. Sleep also affects some kinds of epilepsy in complex ways. REM sleep seems to help prevent seizures that begin in one part of the brain from spreading to other brain regions, while deep sleep may promote the spread of these seizures. Sleep deprivation also triggers seizures in people with some types of epilepsy.

Neurons that control sleep interact closely with the immune system. As anyone who has had the flu knows, infectious diseases tend to make us feel sleepy. This probably happens because cytokines, chemicals our immune systems produce while fighting an infection, are powerful sleep-inducing chemicals. Sleep may help the body conserve energy and other resources that the immune system needs to mount an attack.

see Sleep on page 44

Mental Health News

Fairfield County Section

Danbury BRIDGEPORT **Stamford** Ridgefield Norwalk

Raising The Bar On Quality By Addressing Health Disparities

By Arthur C. Evans, Jr., Ph.D.
Deputy Commissioner, Connecticut Department of Mental Health and Addiction Services—DMHAS

Commissioner Kirk has said that quality should be the defining characteristic of the DMHAS health care system. As we continue to strive for this goal, we are identifying systematic variations in service delivery that effect quality. Several national organizations like the President's New Freedom Commission have highlighted health disparities as a priority that we must address in our systems of care.

Health disparities are systematic differences in health care practices and patterns of utilization that are related to race, culture, or gender and are not due to a health condition. [1]

So, for example, you have a health disparity when a woman and a man each tell their doctors, "I have a crushing feeling on the chest, shortness of breath and dizziness," and he gets evaluated for a heart attack, while she gets sent home with Valium.

Arthur C. Evans, Jr., Ph.D.

Just as health disparities can be found in general medicine, we also have them in behavioral health. Thus, for example, Vijay Ganju and Lucille Schacht found that Whites with schizophrenia were more likely to receive the "new generation" (and more effective) antipsychotic medications than African-Americans or Latinos. Many of the differences noted in scientific literature persist, even when factors like socioeconomic status and health care access are taken into account. Like other states, Connecticut must address health disparities.

This is why we have established the DMHAS Health Disparities Initiative with academic partners from Yale University and the University of Connecticut. Building on the cultural competency work led Jose Ortiz and the DMHAS Office of Multicultural Affairs, our goal is to systematically review data to identify health disparities and implement strategies to reduce and eliminate them. An important aspect of this effort involves using a conceptual model to guide how we improve access to care, treatment engagement and retention, service delivery, and community supports.

The reasons for health disparities are often subtle and complex, but we know they can be eliminated. For example, providing vocational supports has resulted in more paid jobs and has helped remove racial differences in the employment status of DMHAS mental health consumers. Likewise, we have been able to significantly reduce differences in access to care using programs like the Latino Outreach Initiative. Connecticut is fortunate because we have been working on improving cultural competency for the past seven years and have developed strategies that we know are effective. We will work to expand on these efforts as we pursue our goal of building a recovery-oriented system of care.

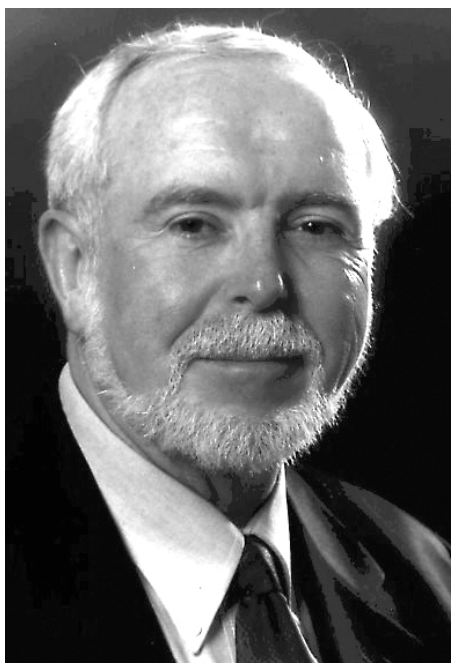
As long as health disparities exist, we will continue to address these issues to ensure that everyone receiving DMHAS services gets the best possible quality of care.

To find out more about the Health Disparities Initiative in Connectcut, log onto the DMHAS website: www.dmhas.state.ct.us/disparities.htm. Your e-mail comments are welcome at: Arthur.evans@po.state.ct.us.

1. Ganju V & Schacht LM (2002, May). NRI Behavioral Healthcare Performance Measurement System Public Report: Use of New Generation Antipsychotic Medications in State Hospitals. Alexandria, VA: National Assoc. of State Mental Health Program Directors Research Institute.

"Thank You for Your Life"

Thomas A. Kirk, Jr., Ph.D.
Commissioner, DMHAS
Connecticut Department of Mental Health and Addiction Services



Thomas A. Kirk, Jr., Ph.D.

The above quote was the closing comment at a recent annual meeting of a DMHAS-funded private nonprofit agency. It was voiced by John, a member of the agency's board. He used the word "your" to refer to the staff in attendance, some being honored for years of service. My recollection is that their tenure extended from 5 to 20 years and their titles ranged from van driver to director of an outpatient care program.

John preceded his comment with a description of his own life, which included alcoholism. He now has a few dozen years of sobriety, a family life with a wife and children, as well as several grandchildren, and retirement from a business career. His message? Without the lives of staff such as those in the audience, his own life would not be what it is today. There are many, many persons such as John in Connecticut.

"Thank you for your life!" is an accolade that fits thousands of private nonprofit and state staff within the DMHAS Healthcare System. There are an estimated 3,000

see Life on page 41

Sleep Schedules: The Consequences Of Insufficient Sleep In Adolescents

By Edward B. O'Malley, Ph.D., Director, and Daniel Cuzzone, Research Assistant, The Sleep Disorders Center at Norwalk Hospital

The National Institutes of Health (NIH) have identified adolescents and young adults (ages 12 to 25 years) as a population at high risk for problem sleepiness based on "evidence that the prevalence of problem sleepiness is high and increasing with particularly serious consequences." (NIH, 1997) (The other high-risk population identified is shift workers.) The most troubling consequences of sleepiness are injuries and deaths related to lapses in attention and delayed response times at critical moments, such as while driving. Drowsiness or fatigue has been identified as a principle cause in at least 100,000 police-reported traffic crashes each year, killing more than 1,500 Americans (4 percent of all traffic crash fatalities) and injuring another 71,000, according to the National Highway Traffic Safety Administration (NHTSA, 1994).

Sleep is, in essence, food for the brain, and insufficient sleep can be harmful, even life-threatening. When hungry for sleep, the brain becomes relentless in its quest to satisfy its need and will cause feelings of "sleepiness," decreased levels of alertness or concentration, and, in many cases, unanticipated sleep. Excessive sleepiness is also associated with reduced short-term memory and learning ability, negative mood, inconsistent performance, poor productivity, and loss of some forms of behavioral control (NIH, 1997).

Researchers have identified several changes in sleep patterns, sleep/wake systems, and circadian timing systems associated with puberty. (Carskadon, 1999) These changes contribute to excessive sleepiness that has a negative impact on daytime functioning in adolescents, including increasing their risk of injury. Key physiological, behavioral and psychosocial changes in sleep patterns and needs that are associated with puberty include:

- Adolescents require at least as much sleep as they did as preadolescents.
- To function at peak levels, adolescents require, in general, 9.25 hours of sleep each night.
- Adolescents' sleep patterns undergo a phase delay; that is, a tendency toward later times, for both sleeping and waking.
- Studies show the typical high school student's natural time to fall asleep is 11:00 p.m. or later.
- Many U.S. adolescents do not get enough sleep, especially during the week.
- 13 year olds average total sleep time during the school week: 7 hours, 42 minutes.
- 19 year olds average total sleep time during the school week: 7 hours, 4 minutes.
- Only 15 percent of adolescents reported sleeping 8.5 or more hours on school nights.
- 26 percent of students reported typically sleeping 6.5 hours or less each school night.
- Irregular sleep schedules—including significant sleep discrepancies between weekdays and weekends—can contribute to a shift in sleep phase (i.e., tendency toward morning or evening), trouble falling asleep or awakening, and fragmented (poor quality) sleep.
- 13 to 19 year olds have been shown to sleep about 1 hour, 50 minutes more on weekends.
- 18 year olds averaged more than two hours more sleep on the weekends.
- 91 percent of the surveyed high school students reported going to sleep after 11:00 p.m. on weekends, and 40 percent went to bed that late on school nights.

Consequences of Poor Sleep

Data on children, adolescents, and adults confirm that sleep loss and sleep difficulties can have serious detrimental effects. Although research specifically on adolescents and young adults is relatively new and limited, studies and clinical observations have shown that insufficient sleep in adolescents and young adults is linked to:

Increased risk of unintentional injuries and death. As noted, drowsiness or fatigue has been identified as a principle cause in at least 100,000 traffic crashes each year. In addition, about 1 million, (or one-sixth), of traffic crashes in the United States are believed to be attributable to lapses in the driver's attention; sleep loss and fatigue significantly increase the chances of such lapses occurring. A North Carolina state study found that drivers aged 25 or younger cause more than one-half (55 percent) of fall-asleep crashes.

The same symptoms of sleepiness that contribute to traffic crashes can also play a role in non-traffic injuries, such as those associated with handling hazardous equipment in the workplace or in the home. Furthermore, adolescents who have not received sufficient sleep and who consume even small amounts of alcohol are at greater risk of injury than those who are not lacking sleep, because sleep loss has been shown to heighten the effects of alcohol (Roehrs, et al, 1994).

Low grades and poor school performance. High school students who describe themselves as having academic problems and who are earning C's or below in school report getting less sleep, having later bedtimes, and have more irregular sleep schedules than students

Edward B. O'Malley, Ph.D.

reporting higher grades (Note: A causal relationship has not yet been established.) (Wolfson and Carskadon, 1998).

Negative moods (e.g., anger, sadness and fear), difficulty controlling emotions, and behavior problems. In one study, female high school students who went to sleep on the weekend two or more hours later than their typical weeknight bedtime reported feeling more depressed than those who did not stay up late on the weekends. (Wolfson and Carskadon, 1998)

Sleep loss may be associated with:

- Decreased ability to control, inhibit, or change emotional responses.
- Inability to stay focused on a task, impulsivity, difficulty "sitting still."
- Problems completing tasks, resemble behaviors common also in attention deficit hyperactivity disorder.
- A 1995 study of students in transition from junior high to senior high school found that conduct/aggressive behaviors were highly associated with shorter sleep times and later sleep start time.
- Increased likelihood of stimulant use (including caffeine and nicotine), alcohol and similar substances.

Insufficient sleep accumulates into a sleep debt that can ultimately be relieved only through additional sleep.

Changing Sleep Habits

Perhaps the most significant behavioral change that adolescents can make—and that their parents can encourage them to make—is to establish and maintain a consistent sleep/wake schedule. This is a good practice for people at all ages, but may be especially important for adolescents.

Sleep Tips for Adolescents

- Sleep is food for the brain: get enough of it, and get it when you need it. Even mild sleepiness can hurt your performance—from taking school exams to playing sports or video games. Lack of sleep can make you look tired and feel depressed, irritable, and angry.
- Keep consistency in mind: establish a regular bedtime and waketime schedule, and maintain it during weekends and school (or work) vacations. Don't stray from your schedule frequently, and never do so for two or more consecutive nights. If you must go off schedule, avoid delaying your bedtime by more than one hour, awaken the next day within two hours of your regular schedule, and, if you are sleepy during the day, take an early afternoon nap.
- Learn how much sleep you need to function at your best. You should awaken refreshed, not tired. Most adolescents need between 8.5 and 9.25 hours of sleep each night. Know when you need to get up in the morning, then calculate when you need to go to sleep to get at least 8.5 hours of sleep a night.
- Get into bright light as soon as possible in the morning, but avoid it in the evening. The light helps to signal to the brain when it should wake up and when it should prepare to sleep.
- Understand your circadian rhythm. Then you can try to maximize your schedule throughout the day according to your internal clock. For example, to compensate for your "slump (sleepy) times," participate in stimulating activities or classes that are interactive, and avoid lecture classes or potentially unsafe activities, including driving.
- After lunch (or after noon), stay away from coffee, colas with caffeine, and nicotine, which are all stimulants. Also avoid alcohol, which disrupts sleep.
- Relax before going to bed. Avoid heavy reading, studying, and computer games within one hour of going to bed. Don't fall asleep with the television on—flickering light and stimulating content can inhibit restful sleep. If you work during the week, try to avoid working night hours. If you work until 9:30 pm, for example, you will need to plan time to "chill out" before going to sleep.

Become a sleep-smart trendsetter

- Be a bed head, not a dead head. Understand the dangers of insufficient sleep—and avoid them! Encourage your friends to do the same. Ask others how much sleep they've had lately before you let them drive you somewhere. Remember: friends don't let friends drive drowsy.

see Schedules on page 45

Life from page 39

plus staff in the few hundred private nonprofit agencies DMHAS funds to provide prevention, treatment, and recovery services. Another 3,000-plus state staff carry out direct care, support and administrative duties within DMHAS' accredited state hospitals, care centers, and administrative offices throughout Connecticut.

Mental illness and substance use disorders are serious health care conditions. They are medical illnesses. Yet, is anyone being immunized to prevent or cure these disorders? No, and a vaccine does not appear likely any time soon. Meanwhile, state and private staff skillfully apply research, medication, treatment, health promotion, and recovery strategies to help thousands of people in Connecticut's 169 communities. As with any number of chronic health care conditions, the strategies may not cure the illness, but they are very effective. They can and do help people to manage their health so that they can have lives separate from the illness. Prevention staff are also playing a large part in that we now know risk and protective factors that point to the need for early intervention and decrease the risk of these disorders. Administrative staff effectively carries out infrastructure and business functions essential to the care system, despite the fact they rarely have the opportunity and reward of seeing the faces of individuals and families helped by our health care structure.

Connecticut's behavioral health care system needs both its state and private nonprofit partners. The reality is that significant human resource, fiscal, and healthcare demands are challenging the system to a greater degree than in the past. Shortages in trained staff are all too common. The cultural diversity of our workforce needs attention. Fiscal margins are slim. Hospital ER's are too often the first point of healthcare contact. These issues are testing the administrative, service and quality focus of state and private sector partners. Some units, agencies and boards of directors are skillfully meeting the challenges. Others are having difficulty doing so, sometimes due to factors beyond their control.

"Thank you for your life!" We do not say that enough to the state and private partners that comprise the DMHAS Healthcare System. Their lives help to promote the health and recovery of thousands of others each year. On behalf of these lives, we who are in private or state leadership, policy, staff and management positions must all find ways to meet the human resource, fiscal and healthcare demands challenging our system. Lives depend on it. See www.dmhas.state.ct.us for previous "Messages from the Office of the Commissioner." Comments are welcome at Thomas.Kirk@po.state.ct.us..

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

HALL-BROOKE
BEHAVIORAL HEALTH SERVICES

Exceptional Care for Mind, Body, and Sprit.

Main Campus

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

The Center at Bridgeport

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

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

Member: St.Vincent's Health Services ASCENSION HEALTH

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

Sleep from page 38

Sleeping problems occur in almost all people with mental disorders, including those with depression and schizophrenia. People with depression, for example, often awaken in the early hours of the morning and find themselves unable to get back to sleep. The amount of sleep a person gets also strongly influences the symptoms of mental disorders. Sleep deprivation is an effective therapy for people with certain types of depression, while it can actually cause depression in other people. Extreme sleep deprivation can lead to a seemingly psychotic state of paranoia and hallucinations in otherwise healthy people, and disrupted sleep can trigger episodes of mania (agitation and hyperactivity) in people with manic depression.

Sleeping problems are common in many other disorders as well, including Alzheimer's disease, stroke, cancer, and head injury. These sleeping problems may arise from changes in the brain regions and neurotransmitters that control sleep, or from the drugs used to control symptoms of other disorders. In patients who are hospitalized or who receive round-the-clock care, treatment schedules or hospital routines also may disrupt sleep. The old joke about a patient being awakened by a nurse so he could take a sleeping pill contains a grain of truth. Once sleeping problems develop, they can add to a person's impairment and cause confusion, frustration, or depression. Patients who are unable to sleep also notice pain more and may increase their requests for pain medication. Better management of sleeping problems in people who have other disorders could improve these patients' health and quality of life.

Sleep Disorders

At least 40 million Americans each year suffer from chronic, long-term sleep disorders each year, and an additional 20 million experience occasional sleeping problems. These disorders and the resulting sleep deprivation interfere with work, driving, and social activities. They also account for an estimated $16 billion in medical costs each year, while the indirect costs due to lost productivity and other factors are probably much greater. Doctors have described more than 70 sleep disorders, most of which can be managed effectively once they are correctly diagnosed. The most common sleep disorders include insomnia, sleep apnea, restless legs syndrome, and narcolepsy.

Insomnia

Almost everyone occasionally suffers from short-term insomnia. This problem can result from stress, jet lag, diet, or many other factors. Insomnia almost always affects job performance and well-being the next day. About 60 million Americans a year have insomnia frequently or for extended periods of time, which leads to even more serious sleep deficits. Insomnia tends to increase with age and affects about 40 percent of women and 30 percent of men. It is often the major disabling symptom of an underlying medical disorder.

For short-term insomnia, doctors may prescribe sleeping pills. Most sleeping pills stop working after several weeks of nightly use, however, and long-term use can actually interfere with good sleep. Mild insomnia often can be prevented or cured by practicing good sleep habits (see "Tips for a Good Night's Sleep"). For more serious cases of insomnia, researchers are experimenting with light therapy and other ways to alter circadian cycles.

Sleep Apnea

Sleep apnea is a disorder of interrupted breathing during sleep. It usually occurs in association with fat buildup or loss of muscle tone with aging. These changes allow the windpipe to collapse during breathing when muscles relax during sleep. This problem, called obstructive sleep apnea, is usually associated with loud snoring (though not everyone who snores has this disorder). Sleep apnea also can occur if the neurons that control breathing malfunction during sleep.

During an episode of obstructive apnea, the person's effort to inhale air creates suction that collapses the windpipe. This blocks the air flow for 10 seconds to a minute while the sleeping person struggles to breathe. When the person's blood oxygen level falls, the brain responds by awakening the person enough to tighten the upper airway muscles and open the windpipe. The person may snort or gasp, then resume snoring. This cycle may be repeated hundreds of times a night. The frequent awakenings that sleep apnea patients experience leave them continually sleepy and may lead to personality changes such as irritability or depression. Sleep apnea also deprives the person of oxygen, which can lead to morning headaches, a loss of interest in sex, or a decline in mental functioning. It also is linked to high blood pressure, irregular heartbeats, and an increased risk of heart attacks and stroke. Patients with severe, untreated sleep apnea are two to three times more likely to have automobile accidents than the general population. In some high-risk individuals, sleep apnea may even lead to sudden death from respiratory arrest during sleep.

An estimated 18 million Americans have sleep apnea. However, few of them have had the problem diagnosed. Patients with the typical features of sleep apnea, such as loud snoring, obesity, and excessive daytime sleepiness, should be referred to a specialized sleep center that can perform a test called polysomnography. This test records the patient's brain waves, heartbeat, and breathing during an entire night. If sleep apnea is diagnosed, several treatments are available. Mild sleep apnea frequently can be overcome through weight loss or by preventing the person from sleeping on his or her back. Other people may need special devices or surgery to correct the obstruction. People with sleep apnea should never take sedatives or sleeping pills, which can prevent them from awakening enough to breathe.

see Sleep on page 47

Schedules from page 40

- Brag about your bedtime. Tell your friends how good you feel after getting more than 8 hours of sleep!
- Do you study with a buddy? If you're getting together after school, tell your pal you need to catch a nap first, or take a nap break if needed. (Taking a nap in the evening may make it harder for you to sleep at night, however.)
- Steer clear of raves and say no to all-nighters. Staying up late can cause chaos in your sleep patterns and your ability to be alert the next day ... and beyond. Remember, the best thing you can do to prepare for a test is to get plenty of sleep. All nighters or late-night study sessions might seem to give you more time to cram for your exam, but they are also likely to drain your brainpower.

At the Norwalk Hospital Sleep Disorders Center, physicians are on the leading edge of current medical science. The sleep laboratory conducts internationally recognized research protocols using the hospital's state-of-the-art technology. Recent research projects include participation in an international study of a new medication for sleep apnea, devising new methods to treat insomnia and evaluating sleep deprivation in residency training programs and in adolescents.

The Norwalk Hospital Sleeps Disorders Center offers a fully comprehensive program to help people with sleep disorders. The center clinicians apply recent research findings in neuroscience and pulmonary medicine together with clinical expertise in behavioral therapy to diagnose and treat sleep disorders while focusing on educational programs aimed at the prevention of sleep problems.

Patients may sleep overnight at the Sleep Center in a quiet, comfortable hotel-like private room while sophisticated instruments measure brain waves, eye movements, breathing and other physiological parameters with digital video recording for analysis as well. Daytime testing and therapies include neurofeedback, relaxation training and other cognitive-behavioral techniques designed to reduce stress and anxiety surounding sleep issues in insomnia patients.

For information on the Norwalk Hospital Sleep Disorders Center, call (203) 855-3632.

ER's from page 11

departments because they have nowhere else to turn," said Michael Faenza, President and CEO, NMHA. "Nobody wins when this happens."

"The increase in people with mental illness in emergency rooms is rapidly becoming a national crisis," said Michael Fitzpatrick, MSW, Acting Executive Director, NAMI. "Solutions require that policymakers understand the negative effects of these budget cuts on the community."

Methodology

In March 2004, The American College of Emergency Physicians fielded the Psychiatric Emergencies Survey in partnership with APA, NMHA and NAMI. The intent of this study was to research potential effects that recent trends in access to care for psychiatric patients have on emergency department environments. This survey was conducted entirely online; survey invitation URLs were printed and disseminated through the March edition of the ACEP member newsletter, reaching an approximate 12,000 active members. Between March 5 and March 23, 353 members accessed and provided responses to this survey. All responses reported in our data are for the 340 of those with enough experience to provide an informed perspective: those that had been providing direct patient care in an emergency department since 2002.

The active emergency physicians who responded to the survey come from all regions of the U.S. including 47 states and Puerto Rico, as well a broad variety of hospital settings: teaching and non-teaching hospitals; hospitals that serve predominantly urban, suburban, rural, and mixed suburban/rural and urban/suburban populations. The patterns of response displayed in this report are remarkably similar for physicians in each of these hospital settings.

ACEP is a national medical specialty society representing emergency medicine with more than 23,000 members. ACEP is committed to improving the quality of emergency care through continuing education, research, and public education. For more information, visit the ACEP website at www.acep.org.

The American Psychiatric Association is a national medical specialty society, founded in 1844, whose 35,000 physician members specialize in the diagnosis, treatment and prevention of mental illnesses. For more information, visit the APA website at www.psych.org.

The National Alliance for the Mentally Ill is a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illness. NAMI works to achieve equitable services and treatment for more than 15 million Americans living with severe mental illness, and their families. For more information, visit the NAMI website at www.nami.org.

The National Mental Health Association is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. NMHA works to improve the mental health of all Americans through advocacy, education, research, and service. For more information, visit the NMHA website at www.nmha.org.

Help Is Just A Phone Call Away

Staff Writer
Mental Health News

Self-help groups can be beneficial to someone who is suffering with a problem, whether physical or emotional. When life deals hard blows, it can be comforting and helpful to meet with others who are facing similar challenges.

The Westchester Self-Help Clearinghouse, a non-sectarian program of Westchester Jewish Community Services, offers more than 280 mutual-support groups which are listed in the 14th edition of the Directory of Self-Help Groups in Westchester County for 2003-2004. A comprehensive guide to the various mutual support groups that meet throughout the county, the Directory is an excellent resource for people who seek support groups for a myriad of difficult life situations.

Copies of the directory are available at the Clearinghouse Office, 141 North Central Avenue, Hartsdale, NY, for $15 per copy or three for $40. To obtain an Order Form for The Directory or for further information about the Clearinghouse or a specific group, please call Lenore Rosenbaum at 914-949-7699, extension 319 or go to www.wjcs.com.

Westchester County New York Depression and Bipolar Support Alliance

WDBSA is a consumer facilitated mutual support group which meets every first and third Wednesday of the month

Join us from 7:00 to 9:00 pm White Plains Hospital in the board room on the main floor. For further information, please contact Liz at 914-476-4720

Carpinello from page 1

- business continuity; and
- a new public mental health role for New York State, including culturally relevant public awareness campaigns about topics including suicide prevention, eating disorders, and building resiliency, and co-morbid physical health risks, (e.g., diabetes; cardiac/cardiovascular disorders; respiratory disorders).

"I envision a future filled with hope and opportunity for New Yorkers with mental illness, and I look forward to continuing my partnerships with the thousands of consumers and stakeholders I have come to know as we work together toward that goal," said Dr. Carpinello. "We have the opportunity to help parents achieve what they want most for their children—to have them home, happy, successful in school, with friends. We have the opportunity to ensure that adults with mental illness can live and work in the community. And we have the opportunity to further break the walls of stigma that surround us."

"I am optimistic because I know that recovery occurs, it is real, and we can make it a reality for many."

Dr. Carpinello is a registered nurse and holds bachelor's and master's degrees in nursing from Russell Sage College, and a Ph.D. in education from the State University of New York in Albany. She is a member of Sigma Theta Tau International Honor Society of Nursing, and in 1997 received the Presidential Award for meritorious and dedicated service to advancing effectiveness of public resources available to recovering people of New York State, from the New York Association of Psychiatric Rehabilitation Services. Most recently she received the Outstanding Leadership Award from the Mental Health Empowerment Project for outstanding leadership in the development of consumer-focused evidence-based practices.

A resident of Rensselaer County, Dr. Carpinello is married to Anthony J. Carpinello, New York State Supreme Court Justice, Appellate Court. They have two children, James, an actor who resides in Los Angeles, and Amy, a dancer who resides in New York.

Sleep from page 44

Restless Legs Syndrome

Restless legs syndrome (RLS), a familial disorder causing unpleasant crawling, prickling, or tingling sensations in the legs and feet and an urge to move them for relief, is emerging as one of the most common sleep disorders, especially among older people.

This disorder, which affects as many as 12 million Americans, leads to constant leg movement during the day and insomnia at night. Severe RLS is most common in elderly people, though symptoms may develop at any age. In some cases, it may be linked to other conditions such as anemia, pregnancy, or diabetes.

Many RLS patients also have a disorder known as periodic limb movement disorder or PLMD, which causes repetitive jerking movements of the limbs, especially the legs. These movements occur every 20 to 40 seconds and cause repeated awakening and severely fragmented sleep. In one study, RLS and PLMD accounted for a third of the insomnia seen in patients older than age 60.

RLS and PLMD often can be relieved by drugs that affect the neurotransmitter dopamine, suggesting that dopamine abnormalities underlie these disorders' symptoms. Learning how these disorders occur may lead to better therapies in the future.

Narcolepsy

Narcolepsy affects an estimated 250,000 Americans. People with narcolepsy have frequent "sleep attacks" at various times of the day, even if they have had a normal amount of night-time sleep. These attacks last from several seconds to more than 30 minutes. People with narcolepsy also may experience cataplexy (loss of muscle control during emotional situations), hallucinations, temporary paralysis when they awaken, and disrupted night-time sleep. These symptoms seem to be features of REM sleep that appear during waking, which suggests that narcolepsy is a disorder of sleep regulation. The symptoms of narcolepsy typically appear during adolescence, though it often takes years to obtain a correct diagnosis. The disorder (or at least a predisposition to it) is usually hereditary, but it occasionally is linked to brain damage from a head injury or neurological disease.

Once narcolepsy is diagnosed, stimulants, antidepressants, or other drugs can help control the symptoms and prevent the embarrassing and dangerous effects of falling asleep at improper times. Naps at certain times of the day also may reduce the excessive daytime sleepiness.

In 1999, a research team working with canine models identified a gene that causes narcolepsy—a breakthrough that brings a cure for this disabling condition within reach. The gene, hypocretin receptor 2, codes for a protein that allows brain cells to receive instructions from other cells. The defective versions of the gene encode proteins that cannot recognize these messages, perhaps cutting the cells off from messages that promote wakefulness. The researchers know that the same gene exists in humans, and they are currently searching for defective versions in people with narcolepsy.

The Future

Sleep research is expanding and attracting more and more attention from scientists. Researchers now know that sleep is an active and dynamic state that greatly influences our waking hours, and they realize that we must understand sleep to fully understand the brain. Innovative techniques, such as brain imaging, can now help researchers understand how different brain regions function during sleep and how different activities and disorders affect sleep. Understanding the factors that affect sleep in health and disease also may lead to revolutionary new therapies for sleep disorders and to ways of overcoming jet lag and the problems associated with shift work. We can expect these and many other benefits from research that will allow us to truly understand sleep's impact on our lives.

Tips for a Good Night's Sleep:

Adapted from "When You Can't Sleep: The ABCs of ZZZs," by the National Sleep Foundation.

· Set a schedule: Go to bed at a set time each night and get up at the same time each morning. Disrupting this schedule may lead to insomnia. "Sleeping in" on weekends also makes it harder to wake up early on Monday morning because it re-sets your sleep cycles for a later awakening.

· Exercise: Try to exercise 20 to 30 minutes a day. Daily exercise often helps people sleep, although a workout soon before bedtime may interfere with sleep. For maximum benefit, try to get your exercise about 5 to 6 hours before going to bed.

· Avoid caffeine, nicotine, and alcohol: Avoid drinks that contain caffeine, which acts as a stimulant and keeps people awake. Sources of caffeine include coffee, chocolate, soft drinks, non-herbal teas, diet drugs, and some pain relievers. Smokers tend to sleep very lightly and often wake up in the early morning due to nicotine withdrawal. Alcohol robs people of deep sleep and REM sleep and keeps them in the lighter stages of sleep.

· Relax before bed: A warm bath, reading, or another relaxing routine can make it easier to fall sleep. You can train yourself to associate certain restful activities with sleep and make them part of your bedtime ritual.

· Sleep until sunlight: If possible, wake up with the sun, or use very bright lights in the morning. Sunlight helps the body's internal biological clock reset itself each day. Sleep experts recommend exposure to an hour of morning sunlight for people having problems falling asleep.

· Don't lie in bed awake: If you can't get to sleep, don't just lie in bed. Do something else, like reading, watching television, or listening to music, until you feel tired. The anxiety of being unable to fall asleep can actually contribute to insomnia.

· Control your room temperature: Maintain a comfortable temperature in the bedroom. Extreme temperatures may disrupt sleep or prevent you from falling asleep.

· See a doctor if your sleeping problem continues: If you have trouble falling asleep night after night, or if you always feel tired the next day, then you may have a sleep disorder and should see a physician. Your primary care physician may be able to help you; if not, you can probably find a sleep specialist at a major hospital near you. Most sleep disorders can be treated effectively, so you can finally get that good night's sleep you need.

Sleep Studies from page 29

During this time, the tech may be hooking up another patient or performing calibrations on the equipment. The test will probably begin around the normal bedtime.

What is measured?

Although the parameters measured may change for different types of diagnostic evaluations, usually we monitor eye movement (or electro-oculography, EOG), brain waves (or electroencephalography, EEG), chin movement and snoring (or electromyography, EMG), respiration (using piezoelectric bands around the chest and abdomen and nasal-oral airflow), heart rate and rhythm (electrocardiogram), leg movements (EMG), oxygen levels in the blood (pulsoximetry), and continuous audiovisual monitoring. A Manual of Standardized Terminology, Techniques and Scoring System for Sleep Stages in Human Subjects 2 was published in 1968 by Rechstaffen and Kales, and discussed staging NPSGs at length.

Monitoring the eye movements (EOG) will allow the clinician to define REM sleep (see below). The EOG gauges the electrical field generated by the eye that acts as a dipole. The retina is negatively charged and the cornea is positively charged. Eye movements change the size and direction of the dipole. The Rechstaffen and Kales Manual recommend that an EOG use two channels. One electrode is placed one-centimeter superior and laterally outside the eye and referenced to another electrode at the ear or mastoid bone (behind the ear). A second electrode is placed one-centimeter inferior and lateral to the outside of the other eye. This electrode should be referenced to the same ear or mastoid as the first eye electrode. Placement in this manner will allow recognition of horizontal and vertical eye movement.

The EEG measures the changes in the electrocerebral voltage throughout the night. EEG electrodes are placed Although the specific number and location of the electrodes has not been standardized for polysomnography, placement is based according to the International 10/20 System of electrode placement.[3] The cortex of the brain elicits excitatory and inhibitory post-synaptic potentials (or charges), which change the voltage of the extra-cellular space. The cells have a summed electrical discharge that is measured at the scalp where the electrode is placed. These potentials will define the stages of sleep. If one suspects nocturnal seizures, the monitoring can be extended to assist this evaluation.

The EMG measures the depolarization of muscle fibers that occurs after the transmission of nerve impulses across the neuromuscular junctions. EEG, EMG and EOG define REM (rapid eye movement sleep) sleep. REM sleep is the stage where most of the vivid dreams occur. Low-voltage EEG and an EMG that reveals muscle atonia with occasional bursts of phasic muscle activity characterize REM sleep. The muscle atonia that occurs during REM sleep is thought to have a protective function. People who are having vivid dreams should not be able to "act out" their dreams. EMG allows the diagnosis of other sleep disorders, such as REM Behavior Disorder. In this disorder REM atonia is absent. Those afflicted with this disorder often kick, punch, and strike-out during their dreams.

Breathing and heart abnormalities and oxygen aberrations may be detected during the night. These abnormalities are often associated with OSA. When the OSA is treated, these abnormalities often resolve. The most commonly prescribed treatment for OSA utilizes a device to aid the patient's breathing while sleeping.

This device is called Positive Pressure Ventilation (PPV also referred to as CPAP or BiPAP). The patient sleeps with a nasal or facial mask. Velcro straps around the patient's head secure the mask. The mask is connected by a tube to a small air compressor about the size of a shoebox. The compressor at the bedside pushes air into the mask to keep the airway open. All patients require a different amount of pressure to keep the airway open. This essentially "splints" the airway open and keeps it from collapsing. It is most comfortable to use the lowest possible pressure to eliminate the sleep apnea. Because every patient requires a different pressure, to determine the optimum pressure, it is necessary to titrate the pressure during a NPSG. Sometimes this requires two NPSGs: one to diagnose OSA and one to treat OSA.

What is a day-sleep study?

There are two types of daytime studies that are performed. The more common type was first described in the 1970's by Carksadon and Dement and is called the multi-sleep latency test (MSLT) 4. The MSLT is the standard test performed to document sleepiness. Most patients do not need an MSLT, but in some diseases, like narcolepsy, the test may be critical to make the diagnosis. The MSLT is performed immediately after the NPSG. The patient is given four or five nap-opportunities at two-hour intervals. The patient is instructed to take a nap while lying in bed. During this study EEG, EOG and chin EMG and EKG is monitored. Respiration is not evaluated, as it was assessed in the previous night.

The mean time for sleep latency (MSL) for the naps and REM sleep during naps is determined. If the MSL is less than five minutes the patient is severely sleepy. If the MSL is between five and ten minutes the patient is moderately sleepy. If the patient is not sleep deprived and the MSL is less than ten minutes with two episodes of REM during the nap opportunities they may have another sleep disorder called "narcolepsy".

The maintenance of wakefulness test (MWT) is a variation of the MSLT. In this test the patient is instructed not to take a nap, but to resist the urge to fall asleep and stay awake, while sitting in a chair. Like the MSLT during this study EEG, EOG, chin EMG and EKG is monitored. This test is used to evaluate tendency to stay awake, especially after a therapeutic interventions. An example of clinical application would be if a truck driver has a disorder that causes excessive daytime somnolence (like OSA). His employer may require a MWT after PPV therapy in order to make sure that he is not a safety risk on the road.

Monitoring sleep can be done in the daytime or at night-time. Different tests offer different information. NPSG determines a number of disorders including OSA. The MSLT is the standard test that measures sleepiness. The MWT is rarely used in clinical medicine, but is helpful to determine the ability to stay awake.

References:

1. Young T, Palta M, Dempsey J, Skatrud J, Weber S, Badr S. The occurrence of sleep-disordered breathing among middle-aged adults. N Engl J Med 1993;328:1230–1235

2. Rechstaffen A, Kales A.A. A Manual of Standardized Terminology, Techniques scoring System for Sleep Stages in Human Subjects. Washington, DC: US Government Printing Office, 1968.

3.Jasper, H.H. The Ten/Twenty Electode system if the International Federation. Electroencephalogr Clin Neurophysiol 1958: 10: 371.

4.Carskadon MA, dement W. The multisleep latency test: what does it measure?

Napping from page 24

In that vein, several research groups are currently examining the effects of taking a daily nap on nighttime sleep and on daytime functioning in the elderly. Many questions remain about the possible consequences and potential benefits of a napping strategy in older individuals. Certainly, some people claim to be unable to nap, and may even be averse to sleeping during the daytime. Is there anything unique about such individuals? Do they already obtain enough sleep at night? Also, many older individuals would find it terribly inconvenient to nap every afternoon, as it would interfere with their daytime activities. For a napping regimen to be successful, patients must be willing to comply with the treatment approach.

Unknown as of yet is what the frequency of napping should be (once per day four times per week?), whether the timing of the nap matters (morning, afternoon, evening?), or what the optimal duration of a nap would be (10 minutes, 40 minutes, 2 hours?). Does nap timing and duration need to be tailored to the individual? Does the type of sleep obtained in the nap (only light Stage 2 sleep, deep slow wave sleep, rapid eye movement sleep?) have any effect on post-nap sleepiness or functioning? Will some people experience negative consequences of napping, such as residual post-nap grogginess, or poorer nighttime sleep following a nap?

Although it seems almost too simple to be a viable treatment for sleep problems in aging, the few studies that have investigated daytime sleep strategies have shown encouraging results. At the very least, none of these nap studies have demonstrated significant side effects or risks of napping to supplement nighttime sleep. For older individuals, whose nighttime sleep system may already be maxed out, self-treatment with a daytime nap may be prove to be an effective tactic.

A disclaimer for implementing daytime naps to compensate for nighttime sleep loss is necessary: as described, many medical problems that increase with aging can result in fatigue and poorer daytime alertness. Further, the prevalence of several serious sleep disorders, including sleep apnea, periodic limb movements in sleep, REM behavior disorder, and restless legs syndrome, increase with age. Therefore, if a person is experiencing sleep difficulties, or insomnia of any type, that lasts for more than a few days, consultation with a doctor is strongly recommended.

This article started with the fact that up to half of individuals over age 60 report significant difficulty sleeping. But that is *only* half, after all. There is a substantial proportion of older individuals who report absolutely no difficulty sleeping. Getting a good night's (and perhaps a good day's) sleep is an important and obtainable goal.

Common from page 34

the night in which breathing stops. People with sleep apnea do not get enough oxygen during sleep. There are two major types of sleep apnea.

Obstructive Sleep Apnea is the most common type and is due to an obstruction in the throat during sleep. Bed partners notice pauses approx. 10 to 60 seconds between loud snores. The narrowing of the upper airway can be a result of several factors including inherent physical characteristics, excess weight, and alcohol consumption before sleep. Central Sleep Apnea is caused by a delay in the signal form the brain to breath. With both obstructive and central apnea, you must wake up briefly to breathe, sometimes hundreds of times during the night. Usually there is no memory of these brief awakenings.

The most common symptoms of sleep apnea include: loud snoring, waking up non refreshed and having trouble staying awake during the day, waking up with headaches, waking up during the night (sometimes with the sensation of choking) and waking up in a sweat. Seeing a specialist for sleep testing should be discussed with your primary health care provider to determine the cause of sleep apnea.

A host of conditions to consider

The following is a listing of other sleep disturbances that prevent optimal daytime functioning. Individuals should seek out specific health care in instances that sound all too familiar. As with all disorders, appropriate diagnosis is the preferred way to determine helpful strategies in alleviating troublesome symptoms.

Narcolepsy. Some people, no matter how much they sleep, continue to experience an irresistible need to sleep. People with narcolepsy can fall asleep while at work, talking, and driving a car for example. These "sleep attacks" can last from 30 seconds to more than 30 minutes. They may also experience periods of cataplexy (loss of muscle tone) ranging from a slight buckling at the knees to a complete, "rag doll" limpness throughout the body.

Restless Legs. Restless legs syndrome (RLS) is a discomfort in the legs that is relieved by moving or stimulating the legs. This feeling is difficult to describe and commonly referred to as a crawling, tingling, or prickling sensation. Certain medications have been found useful in decreasing symptoms.

Periodic Limb Movements. One variation of RLS is Periodic Limb Movements in Sleep (PLMS). PLMS are characterized by leg movements or jerks that typically occur every 20 to 40 seconds during sleep. PLMS causes sleep to be disrupted. These movements are typically reported by the bed partner. The movements fragment sleep leaving the person with excessive daytime sleepiness.

Sleepwalking. Sleepwalking (Somnambulism) is a series of complex behaviors that are initiated during slow wave sleep and result in walking during sleep. The onset typically occurs in prepubertal children.

Sleep Terrors. Sleep Terrors are characterized by a sudden arousal from slow wave sleep with a piercing scream or cry, accompanied by autonomic (controlled by the part of the nervous system that regulates motor functions of the heart, lungs, etc.) and behavioral manifestations of intense fear. Also known as Pavor Nocturnus, Incubus, severe autonomic discharge, or a night terror. The episodes usually occur within the first third of the night and partial or total amnesia occurs for the events during the episode.

Some people have episodes of sleep terror that may occur less than once per month, and do not result in harm to the patient or others. While some people experience episodes less than once per week, and do not result in harm to the patient or others. In its severest form, the episodes occur almost nightly, or are associated with physical injury to the person or others. Consult a sleep specialist if you are concerned.

Sleep Bruxism. Sleep Bruxism is a stereotyped movement disorder characterized by grinding or clenching of the teeth during sleep. The disorder has also been identified as nocturnal bruxism, nocturnal tooth grinding, and nocturnal tooth clenching.

Fibromyalgia. Fibromyalgia is a disorder involving chronic pain in your muscles, ligaments, and tendons. Fibromyalgia is also known as Fibromyositis, rheumatic pain modulation disorder, or Fibrositis Syndrome. Symptoms include unrefreshing sleep, muscular pain, and firm, tender zones that are found within the muscles, particularly those of the neck and shoulders.

Hypersomnia. Hypersomnia is excessive sleepiness. It is an excessively deep or prolonged major sleep period. It may be associated with difficulty in awakening. It is believed to be caused by the central nervous system and can be associated with a normal or prolonged major sleep episode and excessive sleepiness consisting of prolonged (1-2 hours) sleep episodes of non-REM sleep.

Symptoms include long sleep periods, excessive sleepiness, or excessively deep sleep. Onset is typically before age twenty-five years old.

The consequencesof sleep deprivation

Motor vehicle accidents and work accident rates are severely increased in the presence of sleep deprivation. Further, daytime work productivity is known to be adversely affected. If this becomes a chronic problem, sleep deprivation can cause difficulties with social relationships because of irritability; as well as some significant medical problems. Accidents are most likely to happen in the early to mid afternoon and in the very early morning hours. These are the times when everyone is least alert.

Conclusion

Although a large number of possible conditions are represented here, it is important to realize that functional difficulties during our sleep periods can become dramatically accented during our waking lives. Most of the conditions noted may have potential negative health impacts and should be dealt with accordingly.

A sure way to lose a night of sleep is to spend a night worrying about what tomorrow could bring. Making efforts to improve sleep habits now is free, intellectually productive, and it can potentially improve every waking moment that you have.

So think on a few of these issues today, but let them go for tonight when it is time to recharge. Your body will thank you in the morning.

Related Internet Resources:

www.sleepfoundation.org *The National Sleep Foundation*

www.nationalacademies.org *The National Academy of Sciences*

Mental Health News Message: You may be feeling hopeless right now... Please realize that these feelings may simply be your illness talking - and with the right help these present feelings can be made to pass.

Never give up hope. There is a caring mental health community nearby that stands ready to help you get through this difficult time.

Ira H. Minot, Founder & Publisher

Subscribe

Yes! I want to receive each Quarterly issue by Mail

- ☐ Consumer/Survivor/Ex-Patient ($15/year)
- ☐ Student ($25/year) School/Program _____
- ☐ Individual/Family ($35/year)
- ☐ Group - 50 Copies Each Issue ($250/year)

Order a Gift Subscription for A Friend - Give a Gift of Hope

Name & Title: _____

Address: _____

_____ Zip: _____

Phone: _____ E-mail: _____

Include your Check Payable to:
Mental Health News Education, Inc.

cut out this coupon and mail it with your check to:

Mental Health News
65 Waller Avenue
White Plains, NY 10605
(914) 948-6699

Advertise

*** 25% Savings - Book 3 Get 1 Free!!**

- ☐ Business Card - 4 issues ($320)
- ☐ Eighth Page (1 issue $300 - 4 issues* $900)
- ☐ Quarter Page (1 issue $500 - 4 issues* $1,500)
- ☐ Half Page (1 issue $750 - 4 issues* $2,250)
- ☐ Full Page (1 issue $1,000 - 4 issues* $3,000)
- ☐ Inside Cover Pages (please call)
- ☐ Back Cover Page (please call)
- ☐ Supplement Section (please call)

Name & Title: _____

Address: _____

_____ Zip: _____

Phone: _____ E-mail: _____

Include your Check Payable to:
Mental Health News Education, Inc.

cut out this coupon and mail it with your check to:

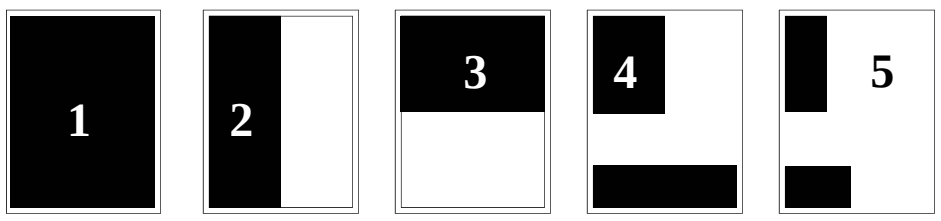
Mental Health News
65 Waller Avenue
White Plains, NY 10605
(914) 948-6699

Communicate Your Message to Our 70,000 Readers

Promote Programs & Services — *Expand Your Private Practice* — *Advertise Job Openings*
Conduct Reader Reply Surveys — *Boost Your Fundraising Campaign* — *Recruit Volunteers*

Deadline Calendar & Ad Size Specifications

Deadline	Release Date
August 1, 2004	October 2004 (fall issue)
November 1, 2004	January 2005 (winter issue)
February 1, 2005	April 2005 (spring issue)
May 1, 2005	July 2005 (summer issue)



Full Page $1,000 — Half Vertical $750 — Half Horizontal $750 — Quarter V & H $500 — Eighth V & H $300

Ad Size Chart

	Width	Height
Full Page (1)	10.10”	12.65”
Half Vertical (2)	4.95”	12.65”
Half Horizontal (3)	10.10”	6.28”
Quarter Vertical (4)	4.95”	6.28”
Quarter Horizontal (4)	10.10”	3.09”
Eighth Vertical (5)	2.43”	6.28”
Eighth Horizontal (5)	4.95”	3.09”

CALL US TO PUT IT ALL TOGETHER.

Anxiety · Stress · Mood Swings
Changes in Relationships · Lack of Energy
Eating Disorders · Hopelessness · Irritability
Substance Abuse · Sleeplessness · Problems at Work

If you're suffering from emotional stress or have any of the above symptoms prompted by a medical problem, we can help. From toddlers to seniors, the Behavioral Health Center at Westchester is uniquely qualified with a comprehensive range of behavioral health services. If you need counseling, therapy or medication, help is just a phone call away.

To put it all together, simply call 914-493-7088

BHC

Behavioral Health Center

70 Years of Caring in Times of Crisis

WESTCHESTER MEDICAL CENTER
WORLD-CLASS MEDICINE THAT'S NOT A WORLD AWAY.

Valhalla, New York 10595 ▪ (914) 493-7000 ▪ Fax (914) 493-7607 ▪ www.wcmc.com

MENTAL HEALTH NEWS

recovery from mental illness is possible but it takes a community of support

Mental Health News provides a vital link to that community of support and helps to open the door to recovery

learn how Mental Health News can help provide mental health education to your community...it's easy and affordable

call us today at: (914) 948-6699