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FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE

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Recovery and The Consumer Movement

His Battle with Depression Opened a Door to Helping Others

A Mental Health News Interview with Award-Winning Actor Joe “Joey Pants” Pantoliano

Staff Writer
Mental Health News

Joe Pantoliano is one of today's best character actors. He has more than 100 film, TV and stage credits, including *The Fugitive*, *Risky Business*, *Memento*, *The Matrix*, and his Emmy-winning role as Ralph Cifaretto in HBO's *The Sopranos*. One of his most recent films *Canvas*, tells the story about how one family copes with schizophrenia.

Mental Health News recently sat down with Joe Pantoliano to learn about his battle with depression and how it has inspired him to help others. Joe has taken a bad time in his life and turned it into a nation-wide project for increasing mental health awareness and a fight against the harmful effects of stigma towards people with mental illness. This is truly a fitting cover story for this issue's theme *Recovery and The Consumer Movement*. With the launch of his website, *No Kidding Me Too* (www.nkm2.org), and a new documentary that is geared towards helping kids talk about their emotional difficulties before they turn into more serious problems, Joe's new found mission of increasing mental health awareness and speaking out about the harmful effects of stigma is helping many. We are indeed grateful to have had this opportunity to speak candidly with him.

Ira Minot: Joe, thanks so much for meeting with us. We know a little about your story and your battle with mental illness. Was it depression?

Joe Pantoliano: Yes, I was told I suffered from clinical depression.

Ira: I know that very well, having gone through the same thing.

Joe: Did your dad or mom have it also?

Ira: No, not that I knew of. The fact was, growing up in the 1950's and 60's, our family (as did many) rarely spoke openly about emotional difficulties, heaven forbid depression or any form of mental illness. And by the way, you and I were both born in 1951 and we're both 57 years old.



Joe Pantoliano

Joe: At least I'm not depressed that I'm older than you! (laughter)

Ira: Can you tell us what it was like when you first felt that there was something wrong and that your emotional state had changed? How did this all begin?

Joe: Over the years talking to people and reflecting on my past I realized that, even as a child, I always had bad feelings about myself and the world around me. To counter these bad feelings I thought that if I could accomplish things in my life, I could make those feelings go away. I knew it wasn't a good feeling and often joked that when I was six years old I may not have been drinking but I felt like I needed a drink to make those feelings go away.

Ira: What were those childhood feelings like?

Joe: I felt different. I felt isolated. I felt alone. I felt ashamed. As a child, I also had some reading and learning disabilities that people in those days didn't identify or understand as they do now. I was labeled lazy – not stupid – lazy. I was told that if I just worked harder I could catch up.

At an early age I felt that if I could become a successful actor, if I had money, if I had status, if I had fame, that these things would allow those bad feelings to go away. That's where my journey began.

It was a long journey of acquiring all the things that I felt would prove that I was truly successful. Years later, when I finally realized that I had achieved all of my wildest dreams, I still felt empty inside. I always thought of myself as a chocolate Easter Bunny. In other words, I looked great on the outside but was hollow on the inside.

Ira: As you pursued your career, was there a major event or did you suffer a breakdown at some point?

Joe: It wasn't a major event. Wait, I take that back. When I was starting work on the movie *Canvas* with Marcia Gay Harden in 2006, the heartbreaking story stirred up many memories of my mother, and I found myself having difficulty dealing with people around me. I was right and everybody was wrong. It was then that I had a falling-out with a very good professional friend of mine. We were best friends and she needed my help. Instead of helping her, I was judgmental with her and hurt her very much. Afterwards, she felt that we could no longer be friends. Also, another dear friend of mine had unexpectedly and tragically taken his own life. I was devastated.

In a short period of time I had experienced two tremendous losses in my life. These two heartfelt losses made me realize that my life had no meaning. Even though I had a loving wife, four children, and success beyond my wildest dreams I couldn't figure out why these good things in my life couldn't make these bad feelings go away.

When I finally was at the end of my rope and was so despondent that I wanted to die, I had an appointment with my family doctor to check my cholesterol. When I told him how badly my emotional state was, he immediately referred me to a psychiatrist. When I explained to the psychiatrist what was going on, he said, "You have something that can be taken care of. It's called clinical depression."

When he said that it wasn't my fault, and that my terrible state of mind was caused by what science now knows is caused by a chemical imbalance in the brain, I literally felt as though I had hit the lottery.

Ira: It must have seemed like an amazing discovery to learn this, being in your 50's, having suffered for so many years, and just now learning that these bad feelings weren't your fault.

Joe: Before I went public about my brain dis-ease, I first discussed what I had learned with my wife and my kids. I then told my sister. When I told my sister, she was so ashamed that she didn't tell me that she had been diagnosed with the same thing three years earlier. Both my sister and I then realized that our mother had been depressed all those many years ago, and that's why we had gotten it too. We just thought that our mom was "Italian American" and that her behavior was cultural rather than any form of a disease.

Ira: I went through the same discovery following my first breakdown in my late 30's. I couldn't hide that I was seriously ill, and it was only then that I learned from members of my family that we had other extended family members that had suffered with depression and that a cousin of mine had tragically committed suicide. As we discussed earlier, these tragic family difficulties were always smoothed over and were never really confronted with any sense of reality to what actually happened at the time and over the years.

Had I known that we had a family history and that I might be predisposed to depression, I might have addressed it sooner and with more conviction and possibly could have avoided losing ten years of my life to my own battle with depression.

Joe: Same in our family. It was a heart attack, it was a stroke.

Ira: When you met with your psychiatrist, did he put you on medications right away?

see Helping Others on page 18

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Table of Contents

Recovery and The Consumer Movement

- 1 Mental Health News Interview with Joey Pantoliano
- 6 Quality Life Promotes Recovery
- 6 About My Recovery
- 7 Getting Honest with Myself
- 8 Peer Run Services Playing Pivotal Roles
- 8 Finding My Voice
- 9 Clothes Make the Man
- 11 Transformation Towards Recovery Based Services
- 16 How Our Programs Are Making a Difference
- 18 Home Health Care in Harmony with Consumer Movement
- 20 Stigma and Recovery: New Approaches to Old Challenges
- 23 Mental Illness: Myths and Facts
- 24 Eight Links to Recovery
- 24 The Truth and Nothing But the Truth
- 25 Successful Consumers Make Successful Providers
- 25 About Therapy
- 27 Wellness Self Management
- 28 A Journey to Employment
- 30 One Provider’s Perspective on Change
- 32 Self-Empowerment In An Adult Home
- 32 Helping My Fellow Consumers In Their Recovery
- 33 Baltic Street Shows the Power of Peer Support
- 34 Cultural Competence and Recovery
- 35 Recovery: A Participant in Life

Columns

- 4 From the Publisher: A Recovery Success Story
- 12 Point of View: Recovery in Long-term Care
- 13 The NYSPA Report: The New Federal Parity Law
- 14 The Economics of Recovery: A Consumer Advocate
- 15 The Mental Health Lawyer: Timothy’s Law

Other Articles of Interest

- 16 Teens At High Risk for Suicide Attempts
- 24 Luncheon Honors Pantoliano
- 25 Peninsula Counseling’s New Home

Mental Health News Upcoming Theme and Deadline Calendar

- Fall 2009 Issue:
“The Economy’s Impact on People and Community Services ”
Deadline: August 1, 2009
- Winter 2010 Issue:
“Understanding and Treating Schizophrenia”
Deadline: November 1, 2009
- Spring 2010 Issue:
“Understanding Generalized Anxiety Disorder”
Deadline: February 1, 2010
- Summer 2010 Issue:
“Understanding and Addressing the Needs of Caregivers”
Deadline: May 1, 2010

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From the Publisher

From the Depths of Despair to a Mission of Advocacy

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

I sensed that I was flat on my back in a moving vehicle, but not much more. My sleeve was being rolled up and I felt a familiar pumping up pressure on my upper arm. Someone was taking my vital signs. From the cold gurney, I heard the rear doors of the ambulance open and a warm blast of air surround me as I was moved down a long corridor. Looking up through glazed eyes, I could see green tiled walls and bright florescent lights above me. "One, two, three, lift." I was now on a softer bed, drifting in and out of consciousness. "You have to drink this," someone was saying as they held a tall plastic cup to my lips, filled with a tasteless ink-black liquid. I later learned that the charcoal drink was given to me to absorb the toxic soup that was in my stomach after I had taken a handful of pills. I am six-foot six. I have very big hands.

The year was 1996 and I had survived my third suicide attempt. I was now on the psych unit of New York Hospital, Westchester. I had just returned from waiting on line with the other patients during "morning meds." My doctor entered my room to give me some sobering news on a subject that I knew all too well: "You have a form of serious clinical depression that has not responded to medications over the past several years. If this continues much longer you are headed for a state hospital."

The notion of ending up in a state hospital gave me a sense of sheer terror—but then my ten-year illness had destroyed everything I had once taken for granted in my life anyway. I was running out of time and knew my in-patient insurance benefits would be exhausted after this latest hospitalization. I was homeless, destitute and still hopelessly depressed, with nowhere else to go. "We'd like you to consider ECT (electroconvulsive therapy)," my doctor added. "It's the only thing that hasn't been tried to help you."

"What are we waiting for?" I pleaded, "Let's do it already!" I knew very well what ECT was. I had nothing to lose.

Looking back on the ten years of my illness, I kept wondering how this could have happened to me? I was the youngest of five children who grew up in an affluent New York City suburb. I had always been a happy, energetic and caring young man who chose to help others at an early age. I earned my Bachelors Degree in Psychology at the University of Arizona. I returned to New York and worked with patients suffering from severe mental illness at the very same New York Hospital in Westchester. Determined to find a career helping others, I completed my Graduate MSW Degree at NYU, started a family and pursued a career in philanthropy, raising funds for human services causes.

Sadly, during my early thirties my mother had lost a courageous three-year battle with cancer, and my own personal life had been severely disrupted by a



Ira H. Minot, LMSW

failed marriage and the separation from my then seven year old son. Shortly thereafter, I began to experience symptoms of severe anxiety and panic—feelings of such terror and despair that I had never in my life felt before. The year was 1986. I was given a prescription for 100 Valium by a psychiatrist who had never seen me before my calling for an appointment.

Because I had spent years studying about mental illness in college and graduate school, the realization that this was happening to me was quite frightening and bewildering. I was completely at a loss about what to do about it. The Valium did nothing for my symptoms, and as the days passed, I had feelings of such hopelessness and depression that I thought I didn't deserve to live. I took an overdose of the Valium and was brought to Saint Francis Hospital in Poughkeepsie, New York where I was living at the time. I was given a diagnosis of severe reactive depression, which is not uncommon following the death of a parent, a divorce, and their disruption to one's emotional state. I stayed in the hospital for a few days and was sent home with some new medications.

Because I had my current fundraising position to worry about, I proceeded with the conviction that this was simply a passing "blip" on the time-line of my life that would be over in short order. I was not about to let this get the best of me and never imagined that this episode might be an early warning of an imminent and severe mental illness. That "blip" lasted for ten years.

Despite my efforts to put on a brave face to my depression, the attitudes and comments from people around me were just as difficult to cope with. People would say, "Snap out of it," and "You're just being lazy." These comments seemed unbelievably cruel and unhelpful things to be saying to me at this difficult time in my life. My response was, "Do you think I really want to feel like this?" Nobody understood my inner pain. Perhaps if I had been in a wheel chair they would not have been so insensitive.

I was embarrassed and ashamed of my condition which was an additional tragedy

to endure on top of my illness. I was learning about stigma towards people with mental illness, and I received a full dose of it from friends, family and employers alike. I had no clue about caring for my illness. Nobody seemed to have a handbook to give me containing the proper direction to take. With a quickly acquired dislike for their side-effects and an uninformed regard for staying on the myriad of medications that were being thrown at me every six months, I continued on a downward spiral. I was watching as my life was being destroyed before my eyes. I was placed in outpatient treatment programs with only short periods of wellness and longer and more pronounced periods of devastating depression.

Looking back, it was just before I entered the Graduate MSW program at NYU that I worked at New York Hospital in Westchester. Now, twenty years later, I was hopelessly ill and a patient at the very same hospital. While working there as a young psychiatric aide, one of our duties was to escort patients to the ECT lab and monitor their vital signs during the procedure. I had seen it work miracles on patients who were deemed hopeless in treatment. I was now on the very same ECT lab table hoping the procedure would save my own life. How unbelievable and ironic. Thankfully, in my case, the full three-week course of ECT treatments I received broke the chains of my depression and brought me back to life.

Some months later with my depression lifting, I tried to make sense of my ten-year battle. I knew there were mistakes I (and others) had made in my care and treatment. I became angry that my life had been put in such peril and realized that I was lucky to be alive. My own lack of mental health education caused me to take chances with starting and stopping the medications I was being given during my illness. More disturbingly, the treatment teams that cared for me during my illness never made me aware of the other valuable and vital resources within the mental health community that had been available to me during my ten-year illness.

I was never told that there was a resource-rich Mental Health Association (MHA) in the community, or that there was a group called NAMI (The National Alliance for Mental Illness) that provides education and support for family members. I was never told there were consumer-driven drop-in centers and club-houses that were run by people with mental illness to help others who struggled with the same psychiatric illnesses. I would have truly benefited by knowing about and participating in such programs.

Had the people who treated me over the years not been trained to understand the need for a community-wide approach to a person's mental health recovery? Maybe I was just too valuable a commodity to them, and they were afraid they would lose me to another service provider? I hate to think that that might have been the reason.

I realized that there was a critical gap in the recovery model of our mental health system. There were no readily-

available and up-to-date sources of information and education on the nature of mental illnesses, treatment options, coping strategies, community resources and support systems that could be regularly sent directly to those who need it most. Sadly, outside of the few hours a day that patients are involved in treatment, nobody had found a way to reach them where they live. It is sad to think that patients are going home to a lonely apartment where they are isolated and highly vulnerable, as I had been. In addition, most families are at a loss as to what to do and where to go for help for their loved ones.

I knew this was wrong and set out to change the way people learn about mental illness and our mental health community. I imagined that this lack of mental health education probably existed in communities near and far, and that the community would welcome a solution. I was right.

I became committed to helping the mental health community fill this need and created a quarterly newspaper called *Mental Health News*. Since the fall of 1999, *Mental Health News* has grown to be an award-winning publication which today has a nationwide readership of over 160,000 consumers, families, treatment professionals and service providers.

This fall we premiered a new publication called *Autism Spectrum News* to provide vital evidence-based news, information and resources to the rapidly growing autism community. The community responded, and now *Autism Spectrum News* has quickly become a must-read for families, consumers, treatment professionals and service providers throughout the autism community.

As a nonprofit organization, we ship thousands of copies of both quarterly newspapers to clinics, hospitals, and mental health and autism agencies throughout the metropolitan New York region and across the country. We have websites that provide free reading of each issue of *Mental Health News* (www.mhnews.org) and *Autism Spectrum News* (www.mhnews-autism.org).

Our mission is to break down barriers to treatment, to end stigma, to advocate for increased funding for research and community treatment, and to provide a roadmap to services in the community. We must continually fight for more positive legislation towards people with mental illness and autism spectrum disorders. The task is large but not insurmountable.

And me? I guess you could say that I have gone from the depths of despair to a mission of advocacy. Incredibly, my life is fuller now than it ever was before my illness began. I take great rewards from knowing that we are providing a means to help people find their way through the difficult maze of mental illness and autism spectrum disorders, and that we are succeeding in our mission to give our mental health and autism community the recognition they deserve.

Good luck in your recovery and always remember to never give up—no matter what difficulties you may face.

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1. National Institute of Mental Health. Available at: <http://www.nimh.nih.gov/healthinformation/statisticsmenu.cfm>. Accessed March 24, 2008.

Quality Life Promotes Recovery

By Jeffrey V. Perry, CPRP, MSM
Supervisor of Bridger 1 Program
Baltic Street - AEH

What may have been lost and left out in discussions on mental health treatment has been the importance of “a quality of life” as a tool of mental health treatment. What I have become aware of is the need for consumers to live at a standard that is not separate from what he/she sees as preferred by most or anyone who is being treated by another person. There are core necessities and responsibilities that anyone who performs a service must be aware of. Care is a double-edged sword with one side that focuses on that treatment (clinical or otherwise) and the other side as the care for human life. The second side, the care side is often times ignored as lesser and as unimportant in regards to the treatment side. It has become commonplace that professionalism is assumed void of caring that expedites it with concerns of perfect treatments. As we use this double-edged sword of care, one side can exert painful consequences and the other is allowed to be indifferent to the subject or recipient of services. Bad treatment, “is also a knife” with two sides that can scar ones life, whether it is a mistake done, or unintended malady of a system.



Jeffrey V. Perry, CPRP, MSM

In mental health this has been an arsenal of confounded treatments i.e., care that was laced with good-bad intentions, whether it was subtle name-calling or the handcuffs to the beds that past consumers endured. There are still many inhumane treatments that most people would not agree are inhumane until it were them in a lock ward. But I regress! My assertion is that “a quality of life” is important to mental health care!

I understand that there have been many discussions on what treatment or no treatment should be. Most advocates for consumer rights have a key list of minimal requirement that the mental health system should adhere to. Among them is the advanced directive. I would like to look at what an advanced directive brings to light about treatment. In my understanding, the advanced directive suggests preferences for services, people, places, and things that a consumer wants in place to promote their quicker recovery. The choices that a consumer makes in advance tell those treating him/her what could upset them physically, emotionally, or problems with past medications that they took. It could be used by a treatment professional like a medical bracelet tells a doctor what a patient is allergic to, i.e., penicillin, peanuts, and etc. It is completed during a point when a consumer is in a preferred state of recovery, long before a crisis, hopefully. Secondly, the advanced directive can also tell the treating person (s) a lot about that consumer, as an individual; what he or she likes in music, food, recreation, and, of course, personal contact. Just because I would write on my advanced directive that I like steak may not mean I will get a steak dinner, but it will tell someone that I eat red meat. Of course, an advanced directive will not get me everything and all things that the mental health system has to offer, but you will understand more about what choices I would make if we do need

to know. I strongly believe that we need to know!

If there is preferred treatment, then it suggests that there is a human element to our being. This person wishes something more than to be man-handled, but needs acknowledgement, fulfillment, and wants to participate in the show, he/she being the star. How and why we are not given “the star treatment?” Because there is a room full of stars and no one is better than the next. I cannot but wonder what would happen if everyone’s needs were fulfilled. What if I am the quiet one or the loud mouth one? What if there is a group, should I have to go? Nevertheless, a crisis situation is just that and any additional information could be helpful. So, can preferred or good treatment have value on an everyday basis? Will it mean that a consumer will be ready for discharge sooner or even that their behavior will be better? There are no guarantees, just like there is no magic pill that rids us all of an illness. We may have to return to the lab until we come up with the next miracle drug. But, in the meantime, I still have a human agenda, yes “Agenda,” that I must see to everyday. First on my list is to have a good day, where I eat, drink, care about others and care for myself. If I do not get that much out of a day, then, I am one day behind. Just like when I run out of medication it is a matter of time before I notice

see Quality Life on page 35

About My Recovery

By Linda Weintraub

Hi, my name is Linda Weintraub and my history with mental illness is similar to many others who suffer from mental illness. I've been diagnosed with major depression, and generalized anxiety, with former manic behavior. It started as far back as I can recall; stuttering until age 11, feeling self conscious, not as good as everyone else. I had post-partum depression following my two births and was close to being agoraphobic. Yet I managed to go on, bearing much discomfort - without any tools to help myself. In my twenties and thirties, I joined a group therapy session and private counseling, yet did not feel much better. Life was hard for me.

Fifteen years ago, in my mid-forties, I had a nervous breakdown. That is when my world became a horrible nightmare. From the moment I awoke, until the escape of sleep came, fear consumed my every thought. I was afraid that I would be found out as a failure. I could not bear to talk to anyone, except to my precious young daughters. I stopped reading, going shopping, listening to music, and going out to dinner with my husband; all of the activities which I had so much enjoyed. I lost 25 pounds from an already small frame. My heart was always racing; I just wanted to hide, sometimes resorting to the

closets, for some sort of safety...safety from what? I felt like a zombie; already dead, yet moving mechanically, with no purpose. I often thought of suicide to ease the pain. After 4 months of this torture, I went to my general practitioner, searching for an organic disease. After many medical tests, nothing was found. I was finally told to see a psychiatrist. That doctor was not sympathetic and just told me to live with the depression. I then moved on to a psycho pharmacologist. This doctor gave me the correct diagnosis, and with much trial and error, he found a winning formula of medications to help me cope with my symptoms.

I did have setbacks, which then made me even more terrified, thinking that I was going to have to be admitted to the hospital. After a few relapses, a friend (who later became my daughters' Mother-in-law) told me about a self-help, mental health organization known as Recovery International (RI). I was more than willing to try anything for some relief. RI has been helping those with mental illness, regardless of diagnosis, for over seventy years. Through weekly meetings, which are free, run by lay persons trained in the RI method (which is known as cognitive behavioral therapy), I learned to manage my fears and temper at being ill. It took time and ruthless determination. Eventually I began to use the tools which I've seen demonstrated at the meetings. I learned how to change my life-long habit

of holding onto my negative thoughts. And I came to understand that habits can be changed. I could, if I cared to, reject those thoughts, accept them as strangers in my brain signaling danger (where there is none), and begin to replace them with secure thoughts. With much practice (try/fail, try/fail, then try and SUCCEED!!!), I was able to regain my self-respect and self-reliance.

There are over 600 meetings nationally as well as internationally. For more information about Recovery International, please visit their website at www.recovery-inc.org (as well as lowselfhelpsystems.org). You can also call their headquarters, toll free at 1-866-221-0302 for a meeting and contact person near you.

Another part of my recovery is working with the National Alliance for Mental Illness (NAMI) in one of their many programs known as “In Our Own Voice” (IOOV). This program is designed to be presented in hospitals, dual-diagnosis centers, law enforcement agencies, and businesses, to both consumers and health care professionals and HR services. The goal is to teach the audience that people suffering from mental illness are not as many imagine, running around wildly with underwear on their heads or as killers. A person suffering from mental illness could be your next door neighbor, your child’s teacher, the dance instructor or even your financial advisor. We educate the public about

who we are and how we have been able to recover and have an average life. Our mission is to eradicate stigma and to recognize that mental illness is a disease of the brain, not a person’s shortcoming or weakness. NAMI IOOV presenters tell their stories, in pairs, within a specific format which includes our personal bio (with nothing about the illness- showing that we are like everyone else), our darkest days, our acceptance of the illness, treatment, coping skills, and lastly, our successes/hopes and dreams. This is done alternating with a DVD of mental health consumers. Although the presentations are not easy to give and can bring back bad memories to mind, it is so worth it, especially when I see someone in the audience nodding, with identification, and/or smiling. Perhaps now, for the very first time, people viewing these presentations believe that recovery is possible. This helps me feel better about myself and helps reduce my feelings about my own stigma. I now know and truly believe that I am not responsible for the illness, it is either fate appointed or environmental, yet I am responsible to get well. To learn more about NAMI and its wonderful programs for families, adolescents, speaking engagements, as well as updated legislation for those with serious mental illnesses, please visit their website at www.nami.org. Their programs and resources are free to those who are in need.

Getting Honest with Myself

By Rachel Berkowitz
Former Wellspring Resident

When I arrived at Wellspring in February of 2008 I had already been to four inpatient treatment centers and two outpatient programs in the last year and a half for drug and alcohol abuse. It was clear to me and my family that I was in no better shape than when I had begun treatment in December 2006. If anything, I seemed to be doing worse. We were at a loss; although my parents were willing to help me in any way they could, it appeared that drug and alcohol treatment was not doing the trick and, in the end, I would need to figure out how to help myself.

Before I go forward though, I am going to go back. I was born and raised in New York City where I attended prestigious private schools from Pre-Kindergarten through twelfth grade. I am the only child of two wonderfully loving parents who always supported and cared for me. I did extremely well in school, was well-behaved and never got into much trouble. I played team sports, rode horses, and had good friends. Growing up, I did not want for anything. Nothing in my background would make anyone think I would grow up to abuse drugs and alcohol - but I did.

Like most others, my using started out slow and increased in frequency, amount,



Rachel Berkowitz

and type over time. In my Freshman year of high school I drank beer occasionally. By the end of my senior year I was binge drinking every Friday and Saturday and occasional weekday nights and had begun using other drugs. It was very important to me that I be considered a fun person and a hard partier in high school. I was always looking for the next exciting place to go or person to meet. Rarely was I content with where I was in the moment. Fortunately, school was always very important to me and I never let my grades

slip below A minuses. I applied early decision to my first choice college and was accepted into the 2010 class at the University of Pennsylvania.

In September of 2006 I started college. Up until then, my partying and using had been somewhat under control due to the rules enforced by my parents. I always had a curfew and knew that if I showed up at home blatantly drunk I would be in trouble. While living at home I had controlled myself for my parents - I had never done so for myself. When I arrived at college, I had no concept of how to take care of myself - how to set my own boundaries or realize my own limits. My first week of college, I only made it back to my own dorm room one night. I could never let the party end and by day seven I was completely burnt out.

Still, however, I insisted on keeping my grades up. On one hand this was a very fortunate thing for me to do, but on the other hand it allowed me to fall even further into my addiction as I could always tell myself that as long as my grades were good I was okay. In November I started doing harder drugs and developed a double life. None of my friends knew exactly what I was doing. I spent a lot of my time and energy developing and maintaining lies - different ones for different groups of people. Even beyond the lies I was telling other people were the lies I was telling myself. I convinced myself that I was having fun, that I was happy, that I was enjoy-

ing the life I had made for myself at college. But the friends I had made were just people who drank and used the same way that I did. They were not people I wanted to see when I was sober during the day, and I was constantly terrified that they would somehow get to know the real me, the one who existed outside of our night-life, and they would not like her. To be honest, I didn't know if I liked her, or even if I knew who she was.

Over Thanksgiving break I was arrested in New York. I was with a group of friends and we all decided to laugh the whole thing off, but having to call your parents to come pick you up at the twentieth precinct is not a funny thing. I came home again for winter break, and brought my new habits home with me. On December 22nd, I came home drunk at eight in the evening intending to change and go back out for the night. My father told me I was too drunk, and tried to stop me from leaving the house. I felt trapped; I had to remove anything that got in the way of my partying, and so I attacked my father. My parents knew something was wrong. I had never been violent or aggressive before in my life, and so they told me they were going to drug test me.

I knew that I was caught, so I agreed to go to a treatment center for thirty days. I figured it would appease my parents and the friends who had started to unravel all

see Getting Honest on page 34

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Peer Run Services Playing Pivotal Roles In Promoting Health, Recovery and Full Citizenship

By Harvey Rosenthal
Executive Director, NYAPRS

In the words of one of our greatest peer support leaders Shery Mead, "In peer support we come together with the intention of changing our patterns, getting out of 'stuck' places, building relationships that are respectful, mutually responsible and potentially mutually transforming. We validate each other for our 'personhood' rather than our 'patienthood'... [We] see each other's behavior through the lens of personal experience rather than through the lens of illness."

Judi Chamberlin's seminal 1978 book about "Patient-Controlled Alternatives to the Mental Health System" galvanized the self-help and advocacy movement and led to the rise of peer support, whose key elements include:

- Sharing, validating and normalizing similar experiences
- Building empathy, sharing opportunities for connection and knowledge
- Building honest mutually responsible relationships
- Based on the intention to change patterns and get unstuck
- Full respect for each person's unique process of change
- Willingness to challenge each other

Peer support offers people an alternative to traditional treatment relationships which peers have often found pathologizing, dis-



Harvey Rosenthal

tancing and alienating, judgemental and/or artificial, culturally unaware and/or insensitive, controlling and/or rescuing, infantilizing and disempowering.

Too often, people's "story" is defined and mirrored back by our system as a "snapshot of me at my worst moment" and one that neither promotes hope, dignity and full citizenship or healing and spirituality.

Peer support has been seen as a different way of forming relationships and sharing power. It offers a new way of thinking about help and helping that is open to new ways of thinking about our experiences and ourselves. In peer support, we teach

and learn from each other, we challenge our status quo and move towards what we want, in an atmosphere of full respect for the individual process of change.

At its purest, peer support is about the quality and integrity of relationship, often unconnected with service models. Peer support values do, however, drive the nature of peer-run services like:

- Peer Drop-in centers: A safe haven for peers to combat isolation and loneliness, meet others and participate in social, educational and vocational activities.
- Peer Crisis Diversion services: Warm, home-like environments where peers can learn to manage stress and find compassion and understanding from a trained peer staff, as well as learn new skills to cope and prevent relapse, such as Mary Ellen Copeland's Wellness Recovery Action Planning (WRAP).
- Peer Advocacy services: Helps peers become more aware of mental health policies and issues, and encourages them to become more involved in planning and delivering mental health services and developing mental health policy.
- Peer Employment supports: Helps peers obtain and keep jobs.
- Peer Bridger services: Helps ease the transition from the hospital into community life and to significantly decrease people's need for readmission.

NYAPRS has helped pioneer the Peer Bridger model: Over the past decade, our trained peer bridgers have helped over 1,000 individuals to successfully transition from 6 NYS state hospitals to well supported lives in recovery in home communities. Our motto has been, "*We support each other to get out of the hospital, stay out of the hospital, and get the hospital out of us.*"

Peers are poised to play yet another major role in emerging new responses to help those with complex medical, mental health and substance abuse conditions.

A 2006 report by the National Association of State Mental Hygiene Program Directors concluded that, "Persons with serious mental illness are now dying 25 years earlier than the general population," and that, "Their increased morbidity and mortality are largely due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care."

In 2008, the NYS Department of Health found that 20% of NYS Medicaid beneficiaries account for 75% of the program's expenditures and that those individuals shared multiple medically complicated conditions for which they currently received fragmented, uncoordinated and duplicative care. A significant number were found to have "chronic conditions" including psychiatric disabilities and substance abuse disorders.

see *Peer Run Services* on page 36

Finding My Voice

By Peter Ashenden, President and CEO
Depression & Bipolar Support Alliance

I was one of those folks who couldn't decide what they wanted to be when they grew up. I knew that I wanted to do something that would give back to the community, but I couldn't seem to find my voice. Never in a million years did I think that, one day, I'd be helping those living with mood disorders find *their* voice and leading a national organization like the Depression and Bipolar Support Alliance (DBSA). But it has been a long, hard road, both professionally and personally.

After I graduated from high school in New York State, I found myself working in the human services field, in the office of MRDD (Mental Retardation and Developmental Disabilities), providing direct care to individuals with severe handicaps. For a young man with barely two decades of life experience, this work was rewarding but also very challenging emotionally. The same was true in my personal life. I married at 19 and was still very young when my wife left; making me a single dad to two wonderful children I loved very much. During that period, in my late 20s—around the same time that I received

my MBA—I also received a diagnosis of depression, an illness that haunted me for many more years and one that I manage successfully today.

Being diagnosed made me feel like a lesser person, a 2nd class citizen. And it was devastating to my relationships, work, and social life. It drove me to the brink of suicide (more than once), medication addiction, and the humiliation and inhumanity of psychiatric hospitalization. For years, I was *very* resistant to keeping up with any kind of treatment for my depression - this resistance, and a disabling accident at work, only intensified my struggle with the illness. A turning point came, though, when I attended my first support group meeting. I was at home one night with my kids when the doorbell rang. My kids were taught not to open the door to strangers, but that evening, for some reason, my daughter answered the door. The man there on the porch was a member of a local support group and had come to invite me to the next meeting - starting soon that same night.

Somehow, this stranger convinced me to go. I went to the meeting, but I sat on the periphery of the group just listening, not saying a word. I continued to go, week after week, and continued to be a silent observer. Some time later, after a meeting,

one of the participants invited me along for coffee with some of the others. I was more comfortable in this relaxed, social setting, and I joined in the conversation. That night of coffee and chit-chat encouraged me, and I found myself joining in the discussion at the next of what would be many support group meetings.

My support group experience helped me find my voice, and that helped lead me to what I wanted to be "when I grew up." Now in my 50s, I can look back and see the parallels between that journey and my journey to recovery. Professionally, I stayed in the human services field. In 1993, I joined the staff of PEOPLE, Inc., a nonprofit organization in New York State dedicated to helping those with special needs live more meaningful and independent lives. There, I found a safe environment with folks that had lived with and experienced mental illness and were willing to share their voices of strength and hope for recovery. And it was there, almost 10 years after I was diagnosed, that I acknowledged my depression and disclosed that I was a consumer of mental health services. In my 40s, I finally made a decision that the consumer movement was the right track, professionally, for me. And for the last 15 years or so, I've worked to impact the service system in

organizations that support those with mental illness.

From PEOPLE, I went to work with Mental Health America of Dutchess County, New York, and in 1995, the state-wide Mental Health Empowerment Project (MHEP) where the mission was (and still is) to develop and strengthen self-help and recovery activities for consumers. There, I was thrilled (and honestly, a little surprised) to be offered the leadership role. I did all I could to change the ways consumers received services...and to help them find their voice, as I was continuing to find mine.

In 2007, I accepted the position of executive vice president at DBSA. I moved from a state-level role in New York to Chicago, where my voice could be heard on a national level. Our mission at DBSA is to improve the lives of people living with mood disorders. Being one of those people myself, and having seen my own life improve, I feel like DBSA is the right place for me, both professionally and personally. Here, I've returned to my roots and come full circle to lead an organization that got its start the same way my recovery got its start—support groups. That's why DBSA's motto is "We've been there. We can help." And, in a way, that's my motto, too.

Clothes Make the Man

By Joshua Koerner, Executive Director
CHOICE of New Rochelle

Stigma means “a mark of infamy.” In ancient times they used to literally brand criminals and slaves. Now we talk about the stigma of mental illness. We know how we are marked by others; that’s obvious. We’re marked by the media, the medical establishment, the ignorant and the uninformed. But it’s worth asking: do we pick up the branding iron and mark ourselves as well?

I own one suit; I trot it out when I need to dress like a banker, or a psychiatrist; when I need to pass as a very responsible person. I am currently the Executive Director of CHOICE, a nonprofit, publicly funded agency with a budget approaching one million dollars. I was the co-chair of the board of directors of the New York Association of Psychiatric Rehabilitation Services, and recently I became the President of my condominium association, with over 180 members. By definition, I am a person in whom others have entrusted a significant amount of responsibility.

How I got here from the disheveled, manic, stoned individual who was dragged on more than one occasion into an ambulance or a police car is too long a story to recount here. But at least part of that transformation involved buying a suit.



Joshua Koerner

Buying clothes has never been an easy process for me. A fat kid, I had to buy my clothes at a Big & Tall Men’s store by the time I was 14. I despised having to stand in one of those three way mirrors, to behold my misshapen body from all directions. Being a fat kid was my first stigma, and there was no way to hide it.

Even though I was much thinner in high school and college there was still that fat boy waiting to re-emerge, and after a

six month stint on an inpatient unit, during which I kept boxes of Triscuits and squeeze-a-cheese under my bed and made forays to the hospital gift shop for half pound bags of peanut M&Ms as soon as I had a grounds pass, my weight ballooned. After my discharge I was a poor, depressed, fat alcoholic (couldn’t afford drugs anymore) and I dressed the part: in ill-fitting jeans and beat up sneakers.

Much, much later, I learned that I could buy a suit, at Sims, “where an educated consumer is our best customer,” (I thought they meant me!) for the approximate cost of the following: 12 cases of beer, nine cartons of cigarettes, six month’s worth of lottery tickets, and 4 bags of really fine weed.

All of which, at one point or another, I was using my precious disability checks to purchase.

Looking back on it now, I would consider all of those purchases self-inflicted wounds, ways in which I accepted and internalized the stigma of mental illness. As poor as I was, with my Medicaid and Medicare and Section 8, I was even more poverty-stricken in terms not financial but aspirational. I was the square peg that would never fit into the round hole (perhaps a round peg in a square hole was more like it, given my shape).

What I failed to realize was that life isn’t like that. There isn’t some great existence out there that, if you could only

change yourself to fit, you could then enter. You have to build yourself the life that you want and then start to live in it, and become the person that belongs in that life. On the day that I became Executive Director of this small mental health agency (and back then it was tiny - I was the only full time employee), my most extensive professional experience as anything was cab driver. I dressed, talked, and walked like a cab driver. I had no experience or education in administration, budgets, personnel management, fund raising, or anything else close to what I would end up doing. But once I got the job as an administrator, I looked at how the other administrators dressed. I wanted to look like them. As much as I needed to look like a road warrior before (and believe me, your literal survival as the operator of a rolling ATM machine depends on your street image), now I wanted to look like an executive. I was ready to run out and buy the appropriate clothes so I could at least look like I knew what I was doing. Having the suit felt better, not worse. And, little by little, day by day, I became the person I was pretending to be.

I make this point to people in IPRTs and CDTs and clubhouses who insist they’re not ready to work. They have to finish studying that manual they think is going to teach them how to swim before

see Clothes Make the Man on page 36

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Supporting Transformation Towards Recovery Based Services

By Edythe S. Schwartz, DSW
Executive Director, Putnam Family
and Community Services, Inc.

Since the late 1980's, I've had a strong belief in the principles and practices of Psychiatric Rehabilitation and their ability to assess an individual's readiness to change, intervene to increase readiness if needed, and increase the skills and supports each person needs to enjoy life to its fullest. I've always managed under the premise that an agency is a living organism and as such can be approached in the same manner as an individual when assessing readiness to change. In 1997, I was given the opportunity to apply Psychiatric Rehabilitation tools to assess an agency's readiness to engage in the transformation from a governmental organization to a private nonprofit, and to allow for the shift towards recovery-based services.

I was hired as the first Executive Director of Putnam Family and Community Services (PFCS), a voluntary not-for-profit agency created on July 1, 1997. Just a day before, PFCS had been a collection of mental health and substance abuse programs operated by Putnam County. In the space of 24 hours, Putnam, with its population of only 100,000, became the first county in New York State to privatize its mental health services, and PFCS became a nonprofit responsible for



Edythe S. Schwartz, DSW

its own services, its own finances and its own future. What makes our experience unique is that, while privatization historically has negative effects on service provision, in the last eleven years, PFCS has flourished, with increased productivity, cost-effectiveness, and most importantly, innovative new programming based on recovery concepts and outcomes. The profound organizational change created by privatization allowed for a shift from a

maintenance model of service delivery to a recovery model supporting consumers to become actively involved in leading their treatment and rehabilitation and achieving what they want from life.

When I came to PFCS, I knew that we had to move to recovery-based services and I used a Psychiatric Rehabilitation Readiness Determination (PRRD) tool to assess PFCS' readiness to change. Readiness Determination begins with assessment of the need to change and the level of dissatisfaction with the existing situation. For PFCS, dissatisfaction had been growing during the 1990's, as the government agency had been unable to access funding and training reserved for private nonprofits. In addition, behavioral healthcare was rapidly changing and Putnam County felt that a nonprofit service provider could be more responsive to changes in insurance laws, the growing role of managed care companies, state regulations and reduction in government funding.

The second dimension of readiness assessment is commitment and motivation to change, based on the belief that the change will be possible, positive and supported. Staff and consumers initially feared privatization, worrying that the agency would be forced to abandon the county run mental health service's mission of seeing all people regardless of their ability to pay. Although there was understandable fear about the impending changes at PFCS, stakeholders did come

to believe in and commit to the change. Government funders also committed to ongoing financial and professional support for the agency to assure that it would have what it needed to survive the turbulent road ahead.

On the third dimension of environmental awareness, or understanding of options that the change will afford the organization, PFCS rated fairly high. Stakeholders worked side by side to research all possibilities for change in the community and it was decided that creating an independent organization was the best way to privatize. Although small, Putnam County is fiercely independent and staff and consumers wanted to maintain their own sense of identity.

PFCS stakeholders also rated high on the dimension of self-awareness, or the amount of knowledge the organization has about why they like or dislike something they are experiencing. They developed a strong mission statement and a listing of goals and objectives for the new agency. Stakeholders were clear about the direction in which they wanted the agency to go. Staff, consumers and Board wanted their independence and they were insistent on following their own vision and mission.

Personal closeness, the last category, measures an agency's desire and ability to trust someone enough to lead them successfully through the change process.

see Transformation on page 20

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POINT OF VIEW

How About Recovery for People with Psychiatric Disabilities in Long-term Care?

By Michael B. Friedman, LMSW
and Kimberly A. Williams, LMSW

Happily, the concept of “recovery” has become a powerful force in the mental health system. We talk now about a “recovery-oriented system” and “recovery-oriented services.” In doing so we express our sense of hope—our conviction—that people with serious, long-term psychiatric disabilities can lead satisfying and meaningful lives despite mental illness.

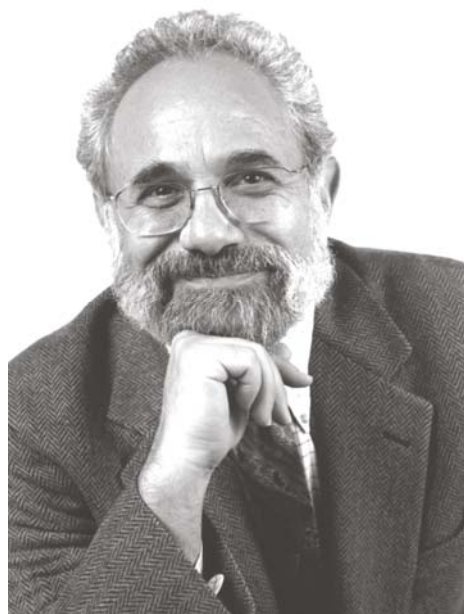
Unhappily, the concept of recovery is not a significant organizing principle in systems other than mental health where large numbers of people with serious, long-term mental illness are incarcerated or cared for—not, for example, in the penal system and not, for example, in the long-term care system.

By “long-term care system” we mean the spectrum of services that are the responsibility of the health and aging services systems and include: home-based health and personal care services, in-home case management, adult protective services, social and medical adult day care, assisted living, and nursing homes.

This system is conceptualized in terms of the needs of frail elderly people and of people with physical disabilities—including dementia, which from a policy point of view is regarded as a physical rather than a mental disorder just because it has a readily identifiable physical cause. (Strange, of course, to make such a hard and fast distinction in a period of psychiatric history dominated by organic theories of mental illness; while Cartesian mind-body dualism, which has been antiquated for at least a century, is still alive and kicking.)

It is unfortunate that the long-term care system is conceptualized solely in terms of physical disability because a majority of people getting, or in need of, long-term care have co-occurring mental disorders. Many, in fact, are in long-term care solely because of mental or behavioral disorders.

Shouldn't the concept of recovery apply to them as well as to people with serious, long-term mental illness served in the mental health system? We are—it seems to us—denying the advantages of recovery-oriented services to a very large number of people just because they are cared for outside the mental health system.



Michael B. Friedman, LMSW

Keep in mind that about half of people in long-term care have a mental disorder other than dementia, often co-occurring with dementia or with physical disabilities. And about 10-15% of people in nursing homes are there primarily because they have mental illnesses with behavioral symptoms that make it difficult for them to be served in community settings or cared for by their families. And let's not forget that one of the ways we reduced the census of state psychiatric hospitals was by discharging older adults with serious mental illness to nursing homes and adult homes—trans-institutionalization rather than deinstitutionalization.

Now they are out of the mental health system, but that does not mean they don't have the same needs and same potential as those who are in the mental health system. It does not mean that recovery is not a hope of them.

There is, of course, a widespread sense that needing long-term care is a terminal state—that hardly anyone who meets the criteria for long-term home health care, let alone for nursing home care, will be able to live independently ever again. Recovery is not possible, it is widely believed.

No doubt people in long-term care have profound problems, but some of them do return to independence. And, more importantly, the beauty of the concept of recovery in mental health is that

even people who continue to have serious mental illnesses can develop lives that are satisfactory and meaningful to them. Recovery, in this sense, does not mean that the illness and some of its disabling consequences are gone; it means that a decent life is possible nevertheless.

What specifically would the concept of recovery bring to people with serious mental and behavioral problems in the long-term care system?

Recovery-oriented systems and services would convey a strong sense of hope for a satisfying life. In addition, the concept of recovery rests on respect for the person with a psychiatric disability and on a sense of their right to dignity and self-determination. Choice, that is to say, is a key dimension of recovery. This means that individuals should have the opportunity to define their personal goals and that they should get the support that they need to achieve these goals. This is the essence of psychiatric rehabilitation, which includes help for people to develop the skills they need to achieve their own goals, the removal of environmental obstacles—such as discrimination or inflexible requirements for access to a life in the community, and ongoing support of the life they choose for themselves.

Some of these themes, it is important to acknowledge, are implicit in recent efforts at long-term care reform, which focus on opportunities for choice, culture change in institutions—un-institutionalizing them as it were, nursing home diversion and transition, and the use of resident and family councils to bring a consumer perspective to long-term care.

But, to support recovery, more is needed. This includes a recovery-oriented staff in long-term care—i.e. a staff that understands psychiatric disability and how to interact with people with respect and in a way that supports as much autonomy as an individual is capable of. Recovery also calls for the use of a psychiatric rehabilitation model that engages people to achieve their highest possible level of functioning. Long-term care, like the mental health system, would also benefit from peers in program planning and in service delivery. They are messengers of hope and models for alternatives that often seem impossible. Families play a critical role in caring for people with disabilities in the community. They need and

deserve far more support than they get as well as a much more meaningful voice in the service system.

In addition, there is a need for housing alternatives to institutional settings, especially for people who have co-occurring physical and mental disabilities. The mental health housing and community support systems are usually overwhelmed by people with complex physical disorders. It does not need to be that way. A recovery orientation calls for integration of health and mental health services in the “most integrated setting,” and models already exist for doing this.

At this moment in the history of mental health policy, recovery has become a central theme but, as we have said, only for people served by the mental health system. Sadly, the mental health system—to overstate just a bit—washes its hands of people with psychiatric disabilities when they develop serious, chronic physical disabilities. And just as sadly, the health care system that then takes responsibility for them has done little to prepare itself to serve these people well. Both systems need to step up and take responsibility together for people with psychiatric disabilities who are in, or need to be in, long-term care.

That is why we at the Geriatric Mental Health Alliance are pressing for passage of The Behavioral Health, Chemical Dependency, and Long-term Care Act, which would require New York State to face the fact that, without attention to behavioral health, long-term care reform is incomplete and, in fact, impossible. It is time, we believe, that people with behavioral health conditions have the same opportunity for recovery in the long-term care system that they are gradually getting in the mental health system.

Michael B. Friedman is the Director of the Center for Policy, Advocacy, and Education of The Mental Health Association of New York City. He is also Chair of the Geriatric Mental Health Alliance of New York. Kimberly A. Williams (formerly Steinhagen) is the Director of Advocacy for the Center and Director of the Geriatric Mental Health Alliance. The opinions in this article are their own and do not necessarily represent the opinions of The Mental Health Association. They can be reached at center@mhaofnyc.org.



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The NYSPA Report:

New Federal Parity Law May Expand Coverage for Mental Illness in New York

By Rachel A. Fernbach, Esq., Seth P. Stein, Esq., Barry B. Perlman, MD, and Richard Gallo

This edition of the NYSPA Report discusses the impact that new federal parity legislation may have on the coverage of mental health and substance abuse services in New York State. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, signed into law on October 3, 2008, requires employers and health plans to provide parity in mental health and substance use disorder benefits offered to workers. It represents the most comprehensive mental health and substance abuse treatment parity law ever enacted on the federal level. The Wellstone and Domenici Act was enacted into law as part of the Emergency Economic Stabilization Act of 2008, which provided \$700 billion in financial assistance for the faltering national economy.

It is important to remember that the new federal law is not a mental health mandate, but rather a requirement for parity in treatment coverage. It requires all health plans (or health coverage provided in connection with a plan) that cover mental health or substance use disorder benefits to provide full parity with other medical and surgical benefits. The federal law will apply to all group health plans for plan years starting after October 3, 2009.

Overview of the Federal Parity Law

If a plan offers any mental health or substance use disorder benefits:

- Financial requirements applied to mental health or substance use disorder benefits must be no more restrictive than the requirements applied to medical or surgical benefits, including deductibles, copayments, coinsurance and out-of-pocket expenses.
- Treatment limitations applied to mental health or substance use disorder benefits must be no more restrictive than the limitations applied to medical or surgical benefits, including limits on frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.
- The plan must cover mental health and substance use disorder benefits provided by an out-of-network provider, if the plan also covers medical and surgical benefits provided by an out-of-network provider.

The federal law applies only to large employers with more than 50 employees. Small employers with 50 employees or less are not covered by the federal parity law, but are covered by New York's Timothy's Law, discussed in greater detail below.

Overview of New York State Parity Law

Many readers may be familiar with Timothy's Law, the New York State law



Rachel A. Fernbach, Esq.

that mandates certain health insurance coverage for the treatment of mental illness. Timothy's Law went into effect on January 1, 2007, and applies in some respect to all employers in New York State, except employers that are ERISA-exempt (see below for further discussion of ERISA exemption).

Timothy's Law

- requires all group health plans to provide coverage for at least 30 inpatient days of treatment and 20 outpatient days of treatment for all mental illnesses. Such coverage must be "at least equal to coverage provided for other health conditions" and deductibles and co-payments must be "consistent with those imposed on other benefits" in the plan.
- applies the 30/20 basic benefit to all mental health diagnoses that are covered by the health plan provided to New York State employees and their families, which covers essentially all mental illnesses.
- applies to both large and small employers, but for employers with 50 or fewer employees, the statute requires the state to pay for the cost of the 30/20 basic benefit.
- requires large employers (with more than 50 employees) only to provide full coverage of the following biologically based mental illnesses: schizophrenia, psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, and bulimia and anorexia. Insurance carriers and HMOs are required to offer small employers the option of purchasing the additional coverage for biologically-based illnesses at their own expense.
- mandates coverage by large employers for treatment of children under age 18 who have one of the following diagnoses: attention deficit disorder, disruptive behavior disorder, or pervasive development

tal disorder and where other aggravating factors are present.

Timothy's Law sunsets on December 31, 2009, but we strongly anticipate that the New York State Legislature will move to extend the law in advance of the deadline, either permanently or for at least one or more additional years.

Impact on New York State Law

Although federal regulations implementing the new parity law have not yet been released, it appears that the new federal requirements may work to enhance and amplify the provisions of Timothy's Law by requiring employers with more than 50 employees and that are subject to Timothy's Law to provide full parity coverage for the treatment of a broader array of mental illnesses than those enumerated under current New York State law. For example, it is expected that PTSD will now be covered.

For example, if a health plan in New York offers unlimited visits per plan year to a participant's primary care physician, the federal requirement for parity in treatment limitations will require the plan to increase its coverage for mental health outpatient visits from 20 visits per plan year to an unlimited number of visits per plan year.

There is an exception under ERISA, the federal law regulating employee benefits, for health plans provided by employers who are self-insured, large plan multi-state employers and labor unions. ERISA-exempt health plans are not subject to state insurance mandates such as Timothy's Law and, therefore, are not required to cover any specific mental health diagnoses. ERISA-exempts, however, will be subject to the new federal parity law and will be required to provide parity in benefits only with respect to any mental health or substance use disorder benefits offered under their plan.

Although Timothy's Law excludes coverage for alcoholism and substance use disorder benefits, a separate New York State law requires health plans to provide at least 60 days of outpatient treatment for alcoholism and substance use disorders. We have learned that the NYS Insurance Department and the NYS Office of Alcoholism and Substance Abuse Services recently made a determination that (for employers with more than 50 employees that are not exempt from ERISA) New York's 60-day outpatient alcoholism treatment benefit will be expanded by the federal law into a parity benefit for inpatient and outpatient treatment of alcoholism and substance use disorders.

see Parity Law on page 36



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The Economics of Recovery: The Making of A Consumer Advocate

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

It was in the fall of 99', Ira and I were having our weekly meeting at Starbucks in Larchmont. We would linger for hours in those big, plush club chairs sipping Lattés and snacking on cookies – caffeine and sugar – just the fuel two bi-polars needed to figure out their next career move.

We were discouraged. In spite of our years of experience, education and charm, we weren't getting any job offers. "You're overqualified" we were told. "You're too old and too smart to manage" was probably what they were thinking.

My vocational counselor said with my background I should start my own business again. Ira said he always dreamed of running a newspaper, though he had no experience.

Although I was ten years older, we had a lot in common; we both grew up in Westchester, graduated from N.Y.U. had built successful, respected careers, became parents, divorced, suffered mental breakdowns, were hospitalized, received SSDI and supported housing. We cooperated with our treatment; we took our meds, kept our therapy appointments, and were stabilized in the community. Here we were hanging out at Starbucks at mid-life; reeling from the fall, struggling to regain control, self-respect and some of our former lives. The "hot-shots" were finally out of ideas and surviving on twenty dollars a day. Was this it?

We had no idea this was our milestone moment, the tipping point, the embarkation of not just another career, but a whole new life. We were only partially aware of the connection between our career choice, our lately acquired "street smarts" and our diagnosis.

According to Kay Jamison, Ph.D, there were quite a few characteristics common to both hypomania and creativity; lots of energy, fluid associational thought process, flights of ideas, rapid speech, grandi-



Donald M. Fitch, MS

osity, over confidence, stubborn independence, etc.

These qualities (symptoms) combined with a strong work ethic and self discipline propelled us down our new path.

Ira gave birth to *Mental Health News* alone, in his third floor walk-up apartment in New Rochelle. There were no employees, no investors, no mentors, just Ira, the PC and the cat.

I went back to Graduate School at LIU to finish up my MS in Counseling. I attended nights, going to CDT at White Plains Hospital some days and working other days as a Job Coach at MHA. My dream for a Center; a computer school with a mission of "rehabilitation and recovery leading to competitive employment" came from my own struggles. I believed I could make a real difference in our populations' lives by applying my business-consultant skills to the delivery of social services.

Funding my dream was realized when, on a whim, I added a budget page to a program design paper I wrote for a course in Psychometrics. I sent it to Steven Friedman, Commissioner of Westchester's Department of Community Mental Health.

The interview with DCMH's Program Director was not going well – I was coming across too corporate; they kept asking me if I had any personal experience working with this population and intimated perhaps I was more interested in the money than the mission. Out of exasperation I stammered "but I'm a consumer, this is personal, not business". They gave me a grant for 50k. (I often think back to that moment; what if I hadn't disclosed? Would they have given me the grant?)

Three DCMH Commissioners have supported the Center as a Drop-In (1770) these past ten years and we are very grateful for their continued support. The current contract expires in December 2010, I'll be seventy-one – seems like a good time to retire and go back to consulting.

Our NYS Department of Education Business School license was facilitated by the Pro Bono Partnership which supplies first class legal services to non-profits. I successfully completed our 501 (c) (3) non-profit application and secured certification from Microsoft as an Office User Training Center. My son Thomas, an IT exec with the College Board at the time got them to donate twenty computers and we were in business. With a great staff of six, we trained over two hundred fifty students the first year. We've served over fifteen hundred since.

What we were not prepared for was the scores of students asking for our help in securing government benefits; disability income, housing, food stamps, half-price bus fare, legal & debt assistance. We found ourselves scrambling to find the appropriate government agency, eligibility criteria, application forms, required documentation, earning penalties, etc. We had to learn the code, read the fine print and translate it all in layman's terms. To meet this need we developed a series of Case Manager's Toolkits (see www.economicsofrecovery.org).

We then added a fourth activity; we transformed our community meetings into focus groups, administered opinion surveys, conducted proto type testing, web content development and economics of

recovery research.

The more we listened, the more questions were raised and the more we searched the web and interviewed officials for answers. So many of the problems appeared to tie-back to monetary or typically bureaucratic issues.

As a business consultant, ("someone who is paid a lot of money to come in and tell the boss what everyone already knows but, does not have the courage to tell him"), I could hand the CEO unflattering charts and they would thank me and pay me because they knew there were always problems that needed to be identified and fixed. It was one of those painful facts of doing business. You can ignore them at your own peril.

However, in the world of Government, I found when I tried to show my unsolicited "truthful charts" to the Chief Execs – I think they thought I was trying to blackmail them! I was being disloyal, a troublemaker. Suddenly I had morphed from Messenger past Advocate to Whistleblower. Publishing studies about "The Homeless of Westchester County" or "How SSI Recipients are prevented from working their way off Government Benefits" or "How state-run facilities ignore the Olmstead decision and cost taxpayers two hundred thousand dollars a year", etc., didn't help us make any friends.

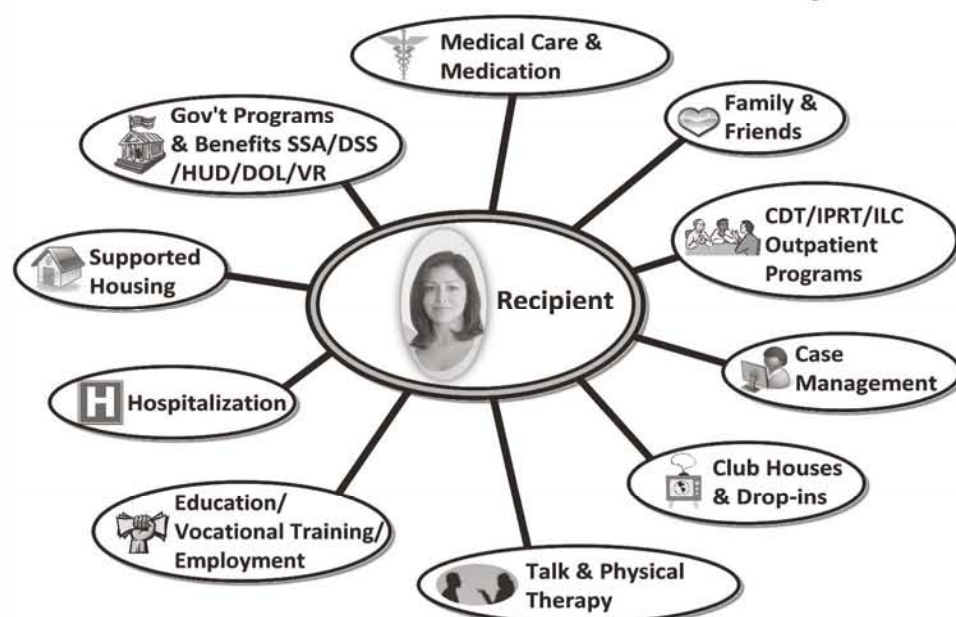
For seven years we submitted unsolicited proposals with cool research charts and street smart case manager tools to dozens of Government agencies and Foundations. Sometimes we'd get polite replies declining, but mostly, there was silence.

Being in the trenches of direct care among hundreds of recipients and fellow providers we are able to validate our tools every day. But the Grant Review Committees and decision makers in the corner offices were not impressed. There was a disconnect, a divide we weren't able to overcome.

Then along came the Internet. Our tools and charts could reach thousands of providers and recipients around the world

see *Consumer Advocate* on page 36

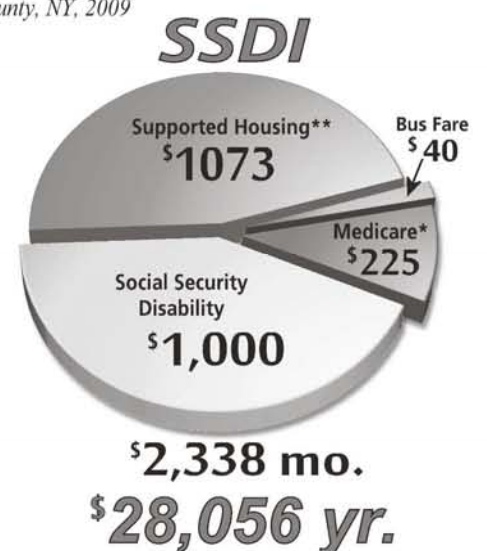
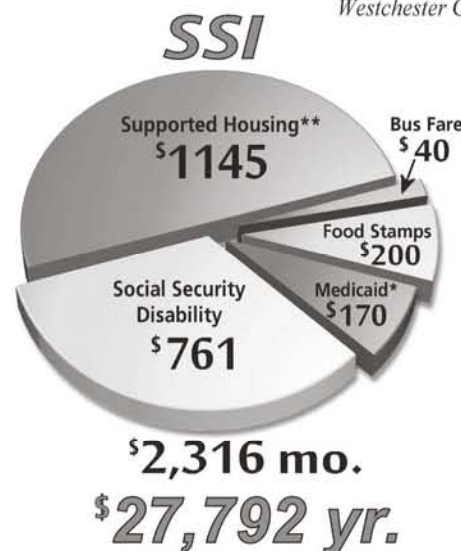
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THE MENTAL HEALTH LAWYER



An Overview of Timothy's Law: Its Past, Present, and Future

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

Like many structural shifts in public policy, it often takes a horrific tragedy to move us to do the right thing. Case in point—Timothy's Law. Named after Timothy O'Clair, a 12-year old boy who committed suicide shortly before his thirteenth birthday, the law demands that insurance companies provide equal coverage for mental health treatment and treatment for physical ailments. This article will discuss the struggles of Timothy and his family and the ultimate passage of the law. Timothy's story is important because it captures, in the most tragic and unfortunate manner, the difficulties families faced in attempting to obtain mental health treatment for those they love. The article will also discuss the state of the law prior to the passage of Timothy's Law and address the movement to broaden the coverage mandated in Timothy's Law. Lastly, the article will discuss the nuts and bolts of Timothy's law and what it requires in terms of insurance coverage.

Timothy O'Clair, born in Schenectady, New York on May 5, 1988, grew up as any normal little boy would, playing baseball, fishing, and bowling. As he continued to age, however, it became evident to his family that he was developing difficulties. It started with problems maintaining attention and grew into a quick and fervent frustration that eventually developed into serious issues with his temper. The O'Clairs knew that they needed help for their child.

Although the O'Clairs had health insurance they quickly learned that the coverage they were used to for the treatment of physical ailments was vastly different from the coverage provided for the treatment of mental health issues. Timothy was allowed only 20 visits a year for psychiatrists and psychologists combined. Moreover, after only a few visits the co-payment rose from \$10 per visit to \$35 per visit. As a result, the O'Clairs suffered significant financial difficulties, and worse, they were not able to obtain all of the treatment required for their young son because they used the allotted number of visits and further treatment simply cost too much.

Timothy's difficulties began to escalate. In the 4th grade he refused to attend school. He had his first psychiatric admission in 1998 to Four Winds Hospital because he started engaging in seriously dangerous behavior like throwing rags in the furnace at his house. Although his treatment had not yet been completed, Timothy returned home when his parents' insurance company would no longer pay for his stay.



Carolyn R. Wolf, Esq

Just a year later, with further behavioral disturbances and spotty treatment because of financial issues, Timothy was hospitalized yet again. Over the years, Timothy carried rather significant psychiatric diagnoses, such as Depression, Attention Deficit Disorder, and Oppositional Defiance Disorder.

Because the O'Clairs were rendered helpless in obtaining adequate treatment for Timothy they were forced to make one of the most difficult decisions faced by a parent, relinquishing custody of their child. Once Timothy was in foster care he would immediately become eligible for Medicaid, which would pay for the treatment he needed.

In foster care, Timothy bounced around the system. For the first few months he lived at a state-run residence in Albany, he then went to live with a foster family, whom the O'Clairs found completely unacceptable, and then to another state-run foster home. After a brief respite at home Timothy was finally sent to a residential placement center for about one year.

After what his treating clinicians thought was significant improvement, Timothy returned home. Unfortunately, within a short period of time, his condition deteriorated. On the day of his death, he started destroying his sports trophies, emptying the contents of his drawers, and threatening to take his own life, as he had many times before. That day when his parents returned home from work they found Timothy in his bedroom where he had hanged himself in the closet. This horrific event caused Timothy's family to become staunch advocates for a law that would guarantee parity for mental health insurance benefits within the State of New York.

Prior to the passage of Timothy's Law the only protection for mental health insurance benefits was the rather slim Fed-

eral Mental Health Parity Act passed in 1996. This law requires large employers, defined as having 50 employees or more, to provide coverage for mental health treatment although the treatment is capped at \$5,000 per year and a total of \$50,000 in one's lifetime. Simply put, this is a paltry amount in comparison to exorbitant costs of mental health care for an individual with a serious illness.

A few years prior to the passage of Timothy's Law, a mental health advocacy group in New York City sued the New York State Insurance Department, contending that existing non-discrimination insurance laws demanded that mental health coverage be on par with coverage for physical illnesses. The case went to the Court of Appeals, the highest court in New York. The Court concluded that there was no discrimination where an insurance company provided less coverage for mental health benefits as compared to benefits for physical illnesses so long as the rules were the same for everyone. In other words, because everyone had unacceptable coverage for mental health benefits, regardless of whether or not you suffered from a mental illness, there was no discrimination.

At last, in the final days of 2006, the New York State Legislature passed, and the Governor signed, Timothy's Law. Under Timothy's Law there is a require-

ment for a base benefit for all employer-based insurance plans, regardless of the size of the employer. This benefit requires that the insurance plan provide a minimum of 20 out-patient mental health visits per year and 30 inpatient mental health days per year. Often this is referred to as the 20/30 base benefit. Most importantly, the co-payments for this mental health coverage must be equal to the co-payment for any other medical visit.

For larger employers, those with 50 or more employees, employers are required to provide insurance with unlimited mental health coverage for biologically-based mental illnesses. These illnesses include major depression, schizophrenia/psychotic disorders, bipolar disorder, delusional disorders, anorexia, bulimia, panic disorder, and obsessive compulsive disorder. Additionally, small employers must provide their employees with the option to buy into this broader coverage.

Unquestionably, this change in the law is not only equitable, but cost effective as well. A 2002 study conducted by PricewaterhouseCoopers, based upon 34 states that already had mental health parity laws already in effect, concluded that the total cost of implementing Timothy's Law in New York would be \$1.26 per insured individual per month. At such a limited

see *Timothy's Law* on page 24

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

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How Our Programs Are Making a Difference

**By Donna Gillet, MA, CRC, LMHC
Manager, Psychosocial Rehabilitation
Department, Program Coordinator,
The Retreat, New York Presbyterian
Hospital-Payne Whitney Westchester**

Numerous consumer surveys, research projects, interviews and patient satisfaction studies confirm what most clinicians already know—behavioral health consumers want and need the same things the rest of us do; a balanced, rewarding and healthy life. The role of psychosocial rehabilitation therapists (PSRs) is critical to achieving these goals and aiding in the recovery process. In fact, OMH, OASAS, and NIDA report that consumers consistently rate living independently, being employed, having a social network and managing their symptoms with few side effects at the top of their purpose for seeking treatment.

At NewYork-Presbyterian Hospital-Payne Whitney Westchester, we provide comprehensive services that support and facilitate consumer goal attainment. The Psychosocial Rehabilitation Department has adapted the Center for Psychiatric Rehabilitation's and Dr. William Anthony's model of recovery, believing that healthy functioning is a recovery tool in and of itself, and that most consumers can assume multiple roles in their lives regardless of symptoms.

Consumers at Payne Whitney Westchester acquire necessary skills by participating in practical tasks, groups, assessments, classes, and other on-site programs. Services are provided by occupational, recreational, and creative arts



Donna Gillet, MA, CRC, LMHC

therapists as well as CASACs and experienced vocational and psychological counselors.

Vocational goals are addressed through a SWE (simulated work experience,) job hunting groups and volunteer work, among other activities. Educational goals are developed through testing and other forms of assessment while consumers are assisted with applications, and counseled as they adjust to new settings. An example of the work done in vocational and educational areas can be found in the story of a young law student who was diagnosed with bipolar disorder while in school. He continued to attend classes after beginning treatment, but

was frequently hospitalized and still symptomatic. He found the school work too taxing and a lack of sleep contributed to his being ill. At his request we explored alternative careers he was interested in exploring and administered vocational testing and counseling. He eventually made the decision to become a paralegal and was referred to VESID (Vocational educational services for individuals with disabilities) which sponsored the training for his new career.

Exposure to a variety of leisure activities, community resources, and volunteer opportunities are also provided. Occasionally, consumers request assistance with structuring their free time or expanding their social network, both essential tools for recovery.

Cooking groups are mandated by OASAS for consumers who attend the Addiction Recovery Service. Nutritional education, healthy diet selection and weight management are all components of the PSR approach. Consumers will select a recipe and determine the cost of the ingredients, which also helps with budgeting skills. Shopping for the products in the grocery store as a group is an enjoyable social event without the use of alcohol or substances. Preparing the ingredients and cooking the meal teaches math, measurement, portion control, collaboration, hygiene, sanitation and safe food handling. Serving the food, setting the table and enjoying a meal with peers is a normalizing activity which distracts from maladaptive cravings and symptoms.

Exposure to these tasks helps them to make career choices and in some cases, consumers have then transferred these

skills learned to new jobs in the Food Service industry.

Life skills such as stress and symptom management are learned through demonstration and practice utilizing many different mediums, techniques and therapies.

As we well know, improving family and significant other relationships directly benefits consumers struggling with psychiatric and substance abuse issues. When consumers identify deficits in parenting, managing households and social relationships, they are assessed and assisted in seeking helpful information.

Self-Help interventions such as those we offer for individuals struggling with substance abuse get high marks from consumers. The intergenerational intervention of "Straight up Wisdom," which joins adult recovering substance abusers who present the negative impact drugs and alcohol have had on their lives with adolescents, is a powerful approach. The adolescents, in turn, communicate their new insights to children currently in treatment.

Programs and Services in the PSR Department at Payne Whitney Westchester are continually evaluated and refined as suggested by consumer surveys and feedback.

For further information about Psychosocial Rehabilitation and the Recovery Model, contact: the Center for Psychiatric Rehabilitation at Boston University, 940 Commonwealth Avenue West, Boston, MA 02215, (617) 353-3549; the International Association of Psychosocial rehabilitation Services, www.iaprs.org; and the US Psychiatric rehabilitation Association, www.uspra.org.

Black Teens, Especially Girls, at High Risk for Suicide Attempts

**By The National Institute
of Mental Health (NIMH)**

Black American teens, especially females, may be at high risk for attempting suicide even if they have never been diagnosed with a mental disorder, according to researchers funded in part by NIMH. Their findings, based on responses from adolescent participants in the National Survey of American Life (NSAL), provide the first national estimates of suicidal thoughts and behaviors (ideation) and suicide attempts in 13-to 17-year-old black youth in the United States. The study was published in the March 2009 issue of the *Journal of the American Academy of Child and Adolescent Psychiatry*.

Background: Suicide is the third leading cause of death in all teens in the United States, according to the National Center for Health Statistics. Historically, black teens and young adults have lower suicide rates than white teens, but in recent decades, the suicide rate for black youth has increased dramatically.

The NSAL is a nationally representative household survey of African Americans and

blacks of Caribbean descent. From the NSAL households, 810 African American and 360 Caribbean black teens, ages 13-17, were randomly selected to complete the NSAL-Adolescent (NSAL-A) survey.

Findings from this Study: Sean Joe, PhD, LMSW, University of Michigan, and colleagues evaluated NSAL-A teens' responses to questions about suicidal ideation and nonfatal suicide attempts. According to the researchers, such attempts may occur up to 10-40 times more often than completed suicides and are important risk factors for future suicide.

According to the study, in a given year, African American teen girls are most likely to attempt suicide, followed by Caribbean teen girls, African American teen boys, and Caribbean teen boys.

However, Caribbean females in the study reported the highest rates for suicidal ideation, while Caribbean teen males reported the lowest rates for ideation and suicide attempts. This is in contrast to a previous NSAL report, which found that Caribbean adult males had the highest rates of suicide attempts among black Americans.

Also in contrast to previous studies, the researchers noted that youth from



lower income households (\$18,000-\$31,999 annually) were least likely to report attempting suicide, while youth living in homes of modest means (\$32,000-\$54,999) were most likely.

Having a mental disorder was closely linked to attempted suicide among study participants. Teens with anxiety disorders were a highest risk. Despite this relationship, roughly half of teens who attempted suicide did not have or were never diagnosed with a mental disorder.

As in previous studies, teens living in the U.S. South and West appeared to be less at risk for attempted suicide than those living in the Northeast.

Overall, the researchers estimated that at some point before they reach 17 years of age, 4 percent of black teens, and more than 7 percent of black teen females, will attempt suicide.

Significance: Suicide prevention efforts require a better understanding of population-specific risk factors. This study provides the first national estimates for rates of suicidal ideation and attempts among black youth in the United States, including important information on ethnic differences.

What's Next: According to the researchers, their findings show the need for further studies on risk factors for suicide in this population, especially on ethnicity-specific risks and non-psychiatric risks. Because only half of suicide attempters had ever been diagnosed with a psychiatric disorder, Joe and colleagues suggest that suicide prevention efforts should include screening for suicidal behaviors in clinical and non-clinical settings (schools, community centers, etc.) when working with black teens, especially females.

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VNSW Mental Health Home Care Program: *In Harmony With the Consumer Movement*

Staff Writer
Mental Health News

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

The transformation of mental health services as we know them today began in the 1970s with the development and influence of consumer organizations. Consumers are typically defined as individuals who are current or past clients of mental health services. The movement campaigns for increased choice, empowerment, improved services and user-defined alternatives. Individuals consider themselves consumers of mental health services rather than passive patients. They are seeking to reform the mental health system in order to have this greater choice and to gain access to the best services and treatments available. Individuals desire more control over their own treatment and a voice in the public mental health system. Some consider themselves survivors rather than consumers but, despite the name by which they choose to define themselves, the ultimate goal is the same: to recover and live a full life in the community.



Building a life in the community is part of the recovery process. A goal of all treatment is for individuals to be active members of the community. In order for this to be accomplished it is important to identify a person's strengths, capacities, preferences and needs, as well as, their knowledge of their local community, its opportunities, resources and potential barriers. This will enable the individual to find their niche in the community in which they reside. Two main components to building a life in the community are housing and employment.

Employment is an important component to assimilating into the community. For some, the individual needs assistance capitalizing on skills and education they already have. For others, it is necessary for them to receive job training so that they have the skills needed to obtain a job. There are many job-training programs in the community that assist individuals, including those with a disability, to learn a variety of job skills. The consumer movement has had a substantial influence

on increasing the utilization of consumers as employees in the traditional mental health agencies, as well as other human service agencies.

Patient independence and the ability for the patient to recover at home are among the primary objectives at Visiting Nurse Services in Westchester. VNSW's services allow individuals with all levels of mental illness the ability to remain in their homes and involved in the community mental health programs that are an integral part of their treatment. The agency's ability to monitor psychiatric symptoms and medication compliance – in addition to teaching the skills needed by each individual to help manage their specific psychiatric needs- empowers patients to obtain their optimal level of independent functioning/living. VNSW's nurses regularly observe individuals in their homes, enabling the agency to provide feedback to caseworkers on the appropriateness of the patients housing and often to assist in obtaining housing with increased or decreased supportive ser-

vices. VNSW nurses have the ability to help the patient advocate for their desired housing needs as they see the person in their environment and are well aware of their needs and ability to remain safely in their homes.

At Visiting Nurse Services in Westchester, patients are considered partners – the agency works together with patients toward recovery and reaching a maximum level of independent functioning. The staff supports and encourages patient independence and its services strengthen care coordination. VNSW's mental health program is an important adjunct service to community mental health services. The program provides daily visits 365 days per year, if needed. VNSW works collaboratively with the patient, supportive and intensive case managers, and the agency's flexible visitation schedule is designed to accommodate patients' day treatment attendance. Although VNSW is not itself a consumer affiliated agency, the organization works closely with its patients to empower them to receive the care and treatment they desire to meet their mental health needs. VNSW's nurses offer their patients support and monitoring to ensure success during times of stress and transition.

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

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

Helping Others from page 1

Joe: He gave me the option that I could go on medication that would bridge the gap to clarity quicker. I chose to go on medication, and I still take my medicine for my depression every day, just like I still take my cholesterol medication every day as well as a baby aspirin once a day.

The troubling thing is that I was never yelled at for taking my cholesterol medication and was never yelled at for being diagnosed with high cholesterol. It's OK with everyone that my body produces too much cholesterol, BUT IT'S NOT OK that my body doesn't produce enough dopamine to enable me to have a balanced emotional state? That makes no sense at all.

Ira: What was it that inspired you to start *No Kidding Me Too*?

Joe: It began with my own discovery that we were talking about. I realized that you need to thoroughly overcome the shame and

stigma that your illness presents you with before you can get the recovery and the treatment that you really need. You've got to believe that you can get better.

In my talks with people I discovered that there's an upwards of 80% recovery rate for all forms of brain dis-ease just by surrendering to the idea that your brain is designed differently. I didn't know that. I didn't know that one in four people have a mental illness, and that 25% of the people in the US will be personally affected by mental illness this year alone.

When I started *No Kidding Me Too* (www.nkm2.org), I wanted to use my celebrity to bring attention to the issues surrounding mental health and to speak out for eliminating the shame and stigma associated with it.

One of the things we are doing is reaching out to the schools to put our awareness project into the curriculum much like we teach sex education and hygiene, so the kids can feel that it's OK to talk about mental health and to be more

open if they themselves are overwhelmed by a particular emotional problem. Kids should not feel that it's a sin or a mark against them to be going through a bad time in their life.

In my movie that we are bringing to the schools we explain that some kids are being diagnosed as early as the fifth grade – cutting themselves as early as ten years old – being sexually promiscuous and using heroine as early as twelve years old because they thought by doing so it would make them feel better. The simplicity in a kid saying, "Mom, I don't know what's wrong with me but I'm awful tired all the time, and my teacher said that if I feel like that more than three days in a row I should talk about it in school or with you."

This is an especially important issue, especially here in the tri-state New York area. Kids here have been exposed to 9/11, horrific deaths and an attack on our country. They had psychologists that came to talk to the kids right after this happened and now they're not around, but

our kids are still being affected by it. Same thing with Katrina – these emotional scars in our kids are ongoing.

Here's another issue. The money the insurance companies would be saving if they covered preventive psychological care to a greater extent is tremendous. In our movie we tell the story of a child named Jordan who jumped out of his ninth floor bedroom window over 100 feet and didn't die. The hospital said that they never had anybody jump more than 50 feet and live. His insurance carrier would only cover twelve talk therapy sessions a year, but since his jump they've spent over two million dollars on his treatment for physical rehabilitation and operations. They would have been able to save that money if they had allowed this kid to come and talk to someone thirty or forty times a year.

The insurance companies are finally now coming to terms with the cost-benefit

see Helping Others on page 36



Mental Health Treatment in Westchester

The VNSW Mental Health Home Care Program provides:

- **Adjunct service to community mental health programs**
- Structure in the home environment.
- Assistance with home management focusing on inadequate levels of functioning, hygiene issues and compliance with medication regimen.
- Administration of I.M. long-acting psychotropics.
- Liaison with the community treatment team informing them of changes and important symptoms that may indicate decompensation or need for changes in the treatment plan.
- On-going assessment of all health needs relevant to the individual's diagnoses.
- Consultative services for the individual whose primary diagnosis is medical/surgical in nature, however, due to difficulty coping with illness, requires mental health intervention.
- Coordinated home care services for non-compliant individuals and those with complex combined mental health/physical needs that present ongoing problems.

Program Features

- Facilitate psychiatric care from in-patient to home & community
- Prevent in-patient psychiatric hospitalization
- Decrease symptoms & improving functional ability
- Improve knowledge base about medications, illness, coping & staying well
- Improve medication compliance
- Access community services

The Big Picture

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

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

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

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



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Stigma and Recovery: New Approaches to Old Challenges

By Larry Hochwald, Nat Etrog, LCSW and Elaine M. Edelman, LCSW

Thomas R. Insel, MD stated, "Psychiatry is the only part of medicine where there is actually greater stigma for receiving treatment for these illnesses than for having them." (Insel, NIMH Report 2006)

There are many aspects to the stigma surrounding mental illness. It manifests itself as a constellation of attitudes and actions that negatively affect individuals in recovery because of misunderstanding, ignorance and fear from an uninformed public. It creates shame and low self-esteem that can inhibit recovery.

The stigma of mental illness has been around as long as the illness itself. However, anti-stigma efforts have not kept pace with treatments and medication. Stigma presents a barrier to almost every area of recovery. As the United States Surgeon General reported in his landmark 1999 report on mental health, "...the stigma that envelops mental illness deters people from seeking treatment. Stigma assumes many forms, both subtle and overt. It appears as prejudice and discrimination, fear, distrust, and stereotyping. It prompts many people to avoid working, socializing, and living with people who have a mental disorder. Stigma impedes people from seeking help for fear that the confidentiality of their diagnosis or treatment will be breached."

Current advances in treatment, as well as the powerful message of those in recovery who are working and living in our communities, show us that now is the time to confront the issue of stigma. As the Surgeon General's report goes on to point out,

"For our Nation to reduce the burden of mental illness, to improve access to care, and to achieve urgently needed knowledge about the brain, mind, and behavior, stigma must no longer be tolerated." (Sacher, Surgeon General's Report, 1999)

Examples of the negative impact of stigma are everywhere, even in our own neighborhoods. This was illustrated by a service recipient who had been a successful businessman when he had his first psychiatric hospitalization over 20 years ago, as a young adult. After a three week absence



Larry Hochwald, Nat Etrog, LCSW, and Elaine M. Edelman, LCSW

from his job, he attempted to return to work. He was informed that his services were no longer needed. His absence was shorter than that of colleagues who left on maternity leave or for other illnesses, but due to the circumstances of his hospitalization (it was well known at work that he was now challenged by mental illness) that door closed to him. Today, he is successfully working in peer services. Because of limited opportunities, however, he is quick to point out that he is only earning the same hourly wage he made back in the 1980s. As he summed it up: "At less than \$8 an hour, where is the American dream for me?"

Another current situation that illustrates stigma is a neighborhood up in arms about a proposed mental health housing project. A popular local newspaper in that borough has published several articles opposing the housing proposal and its sponsor. At first glance, it might seem that many different points are being considered in the argument of those opposed. They cite safety, appropriateness, zoning and property values. As you might expect, most of these arguments are unfounded. The legal issues cited had been addressed. Steps had been taken to clarify the issues and set the community at ease but some local politicians aligned with the opposition. In an editorial of the local newspaper, the point was made that the project could make an excellent building for some health-oriented facility, but that a home for more than 50 mentally ill people was unacceptable.

Would the community or its newspaper feel comfortable printing such statements about any other group? Numerous studies, including two recent ones (NYU's Furman Center 2008 and Elbogen, PhD; Johnson, MD. 2009) show housing for those challenged by mental illness is safe and does not negatively impact property values.

It is not hard to see that news stories sensationalized by the press, involving crimes committed by the mentally ill, increase stigma. It is not hard to see that the overwhelming majority of those stories involve people who were not in treatment at the time of the negative occurrence. Unlike most other chronic illnesses, which garner sympathy and support, the fear of being labeled or misunderstood can be a major barrier to diagnosis, treatment adherence, and recovery. The burden placed on those challenged by mental illness by the ignorance and fear of an uninformed public can impact these areas as well as employment and housing. Fear of being labeled may explain why statistics show as much as 20% of the population will be touched by mental illness at some point, yet on average, those who need treatment wait 8 years to seek treatment, with some waiting up to 20 years, with 1 in 5 of those with serious illness never seeking treatment (Insel, 2006). That's the bad news. The good news is that there are effective steps to counter fear and stigma that are consistent with

the goals and process of recovery.

The government can fund and disseminate anti-stigma efforts, such as public service messages, educational materials and school-based programs. Service providers can employ more effective community relations programs. However, some of the most effective anti-stigma efforts come from recipients themselves. Among the ideas that can help combat stigma:

Public Openness: Recent research suggests the single most effective way to combat stigma is by direct contact. Seminars, art exhibits, and discussion forums where the public can meet with self-disclosing recipients goes a long way to dispelling unwarranted fear and stereotypes (SAMHSA, 2006).

Wellness: Public displays of active symptoms, poor hygiene and poorly maintained health can create misconceptions, fear for personal safety and negative impressions. Since these are the antithesis of recovery, maintaining wellness, even to address arbitrary public perceptions, is consistent with the personal goals of consumers.

Employment: When we work alongside people, we build relationships. Through public openness, the connection made can break stereotypes and serve to educate more effectively than any public service message or pamphlet.

Recovery: It's the challenge, the goal and the result of your efforts. Recovery erodes stigma. We think of this as POWER: The power for positive change, the power to achieve our goals, the power to end stigma.

Larry Hochwald, is co-chair of the Staten Island Mental Health Council, Coordinator of Rainbow Environmental Services Toner & Ink ; a division of Saint Vincent Catholic Medical Centers, Behavioral Health Services, Residential Services, and co-author of the Stigma Report to the NYC Federation to be included in the New York City Department of Health Mental Hygiene FY2010 Local Government Plan. Nat Etrog, LCSW, is co-chair of the Queens Mental Health Council, Director of St. John's Episcopal Outpatient Behavioral Health Services, and co-author of the Stigma Report to the NYC Federation. Elaine M. Edelman, LCSW, is the Program Supervisor of the Richmond University Medical Center Seaview Continuing Day Treatment Program.

Transformation from page 11

When I became Executive Director, I knew that PFCS needed a strong leader and I made it clear that although they had previously been a disparate group of services and programs, now we were one organization with one mission and a recovery vision, and if we were to survive, we all had to work together.

The next step was to implement the activities required to develop PFCS' readiness to change. If we view people and agencies both, from a strength-based perspective, we might see unwillingness to change, not as "non-compliance," but as lack of preparedness. Then, agency leaders can assist those who are not ready to explore the need for change and develop readiness so that systems change can be successful in the future.

To increase commitment at PFCS, I began to open lines of communication by setting up meetings and supervisions. We began to break down the barriers between the programs, encouraging staff from different programs to work together for the benefit of the consumer. I made it clear that all of us were in this transformation together and that we could be successful if we worked together. Soon, all began to understand that change was possible, very positive for them, and it was definitely going to be supported.

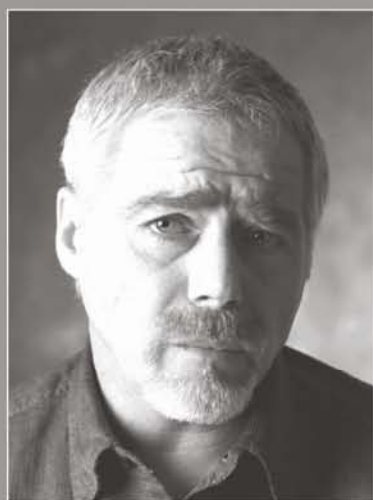
The areas of environmental awareness and self-awareness were also developed with a number of activities. We began training in person-centered, recovery-oriented techniques. We invited consumer leaders into the agency to talk with our staff and consumers about recovery and the possibilities that it offered. We purchased

computers and set up Internet access so that staff and clients could research job opportunities, medication education, clinical techniques and interventions and other agency websites to expand their knowledge past the boundaries of this small county.

To assure the continued success of personal closeness, I remained an extremely active and present leader, making sure that I was clear in my direction and also that I was visible. We created a shared vision and then I clearly stated the steps that we would need to take to accomplish that vision. Some staff, who did not agree or who could not change with us, left the agency. The majority of the staff, and the new staff we hired, shared our vision and began to work together to achieve it.

Managing is difficult in any environment but in our current environment of shrinking funds, increased risks of litigation

and excessive government oversight, leaders can easily lose their vision and also lose their way. Those of us who have chosen to be managers have a responsibility to assure that the agencies and programs that we oversee have the resources they need to provide services that support and promote recovery. Clinicians are taught to view each person as uniquely individual and managers should do the same for our agencies, promoting their uniqueness while concentrating on the specialized things they may need to be successful. Finding innovative ways to lead our agencies through the turbulence of change can help ensure the continuance of community nonprofit agencies and also assure that the vision of recovery for all people remains foremost on the agenda of mental health care agencies now and in the future.



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The Mental Health News

Nassau County Section

Mental Illness: Myths and Facts

By The Substance Abuse and Mental Health Services Administration (SAMHSA) Campaign for Mental Health Recovery

Mental illnesses are very common. They are also widely misunderstood. People with mental illnesses are frequently stigmatized by others who think it's an uncommon condition. The truth is, mental illness can happen to anybody.

Arm yourself with the facts, then use your knowledge to educate others and reach out to those around you with mental illness. Understanding and support are powerful, and they can make a real difference in the life of a person who needs them.

Myth: There's no hope for people with mental illnesses.

Fact: There are more treatments, services, and community support systems than ever before, and more are in the works. People with mental illnesses lead active, productive lives.

Myth: I can't do anything for a person with mental illness.

Fact: You can do a lot, starting with how you act and speak. You can create an environment that builds on people's strengths and promotes understanding.

For example: Don't label people with words like "crazy," "wacko," or "loony" or define them by their diagnosis. Instead of saying someone is "a schizophrenic," say he or she "has schizophrenia." Don't say "a schizophrenic person," say "a person with schizophrenia." This is called "people-first" language, and it's important to make a distinction between the person and the illness. Learn the facts about mental health and share them with others, especially if you hear something that isn't true. Treat people with mental illnesses with respect and dignity, just as you would anybody else. Respect the rights of people with mental illnesses and don't discriminate against them when it comes to housing, employment, or education. Like other people with disabilities, people with mental health problems are protected under federal and state laws.



Myth: People with mental illnesses are violent and unpredictable.

Fact: Actually, the vast majority of people with mental health conditions are no more violent than anyone else. People with mental illnesses are much more likely to be the victims of crime. You probably know someone with a mental illness and don't even realize it.

Myth: Mental illnesses don't affect me.

Fact: Mental illnesses are surprisingly common; they affect almost every family in America. Mental illnesses do not discriminate—they can affect anyone.

Myth: Mental illness is the same as mental retardation.

Fact: These are different conditions. Mental retardation is characterized by limitations in intellectual functioning and difficulties with certain daily living skills. In contrast, people with mental illnesses—health conditions that cause changes in a person's thinking, mood, and behavior—have varied intellectual functioning, just like the general population.

Myth: Mental illnesses are brought on by a weakness of character.

Fact: Mental illnesses are a product of the interaction of biological, psychological, and social factors. Social influences, like the loss of a loved one or a job, can also contribute to the development of various mental health problems.

Myth: People with mental illnesses cannot tolerate the stress of holding down a job.

Fact: All jobs are stressful to some extent. Anybody is more productive when there's a good match between the employee's needs and the working conditions, whether or not the worker has a mental health problem.

Myth: People with mental health needs, even those who have recovered, tend to be second-rate workers.

Fact: Employers who have hired people with mental illnesses report good attendance and punctuality as well as motivation, good work, and job tenure on par with or greater than other employees. Studies by the National Institute of Mental

Health (NIMH) and the National Alliance for the Mentally Ill (NAMI) show that there are no differences in productivity when people with mental illnesses are compared to other employees.

Myth: Once people develop mental illnesses, they will never recover.

Fact: Studies show that most people with mental illnesses get better, and many recover completely. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that hope plays an integral role in an individual's recovery.

Myth: Therapy and self-help are a waste of time. Why bother when you can just take a pill?

Fact: Treatment varies depending on the individual. A lot of people work with therapists, counselors, friends, psychologists, psychiatrists, nurses, and social workers during the recovery process. They also use self-help strategies and community supports. Often they combine these with some of the most advanced medications available.

Myth: Children don't experience mental illnesses. Their actions are just products of bad parenting.

Fact: A report from the President's New Freedom Commission on Mental Health showed that in any given year five to nine percent of children experience serious emotional disturbances. Just like adult mental illnesses, these are clinically diagnosable health conditions that are a product of the interaction of biological, psychological, and social factors.

Myth: Children misbehave or fail in school just to get attention.

Fact: Behavior problems can be symptoms of emotional, behavioral, or mental problems, rather than merely attention-seeking devices. These children can succeed in school with appropriate understanding, attention, and mental health services.

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Please Contact Us About Submitting an Article About Your Organization's Vital Programs and Services
That Serve the Communities of Nassau County, New York***

Eight Links to Recovery

By Phyllis Elliott, LCSW-R

As a Licensed Clinical Social Worker I was no stranger to the symptoms of bipolar disorder when I began having sleepless nights and racing thoughts at age 44. I worked as a counselor for adults with mental illness at a residential program and I was teaching daily living skills to clients, some who also experienced the mood swings that I was having. I lived in denial for a short time but then I sought help. I have worked very hard to manage my symptoms so that I can live the life I want. At this point, 14 years later, I desire to help other people reach their potential and see their worth by giving them the tools to succeed with their recovery goals. These 8 links have helped me attain success in many areas of my life and I want to pass them on to anyone who feels confused about how to enjoy life again despite their illness.

At this time I am a 58 year old woman who is a wife of forty years, a mother of

three, a grandmother of four, I have a full time job and I have my own private practice and by the way I still have Bipolar Disorder. My illness is never first on my list because I refuse to let it define me. I hope these 8 links will be helpful to you.

1. Write a positive self-assessment. Look at what you can do, not what you can't do. Appreciate your talents and strengths and use them to build a self image that allows you to have success. Success comes from using our strengths to solve our problems and overcome our challenges.

2. Recognize your symptoms. Being aware of how each episode starts, what your first symptoms are, will allow you to get help quickly. The longer you wait to get help, the harder it is to recover. Hoping that symptoms will go away without intervention just doesn't work. With help you can return to your life more quickly.

3. Get appropriate treatment. You have the right to work with providers that you

trust and who can listen to you with respect. We need to have faith in our ability to be at the center of our treatment plans. No matter how much a professional knows, they can't be inside us and they need our help to know how to treat us effectively.

4. Have a good support team. You want to surround yourself with people who believe in your ability to recover. You want them to be supportive yet always honest about what they see. If we don't recognize our symptoms it is good to have people we trust tell us how they see us. These people should be cheerleaders who encourage us, not caretakers who enable us.

5. Have a vision and be able to set goals to work towards it. Think about what you are passionate about, what your dreams were before this illness intruded on your life. Make small achievable short-term goals that can help you realize that overall vision you have for yourself. When I was in school, I had to break the workload into

manageable portions so that I wouldn't get overwhelmed. The only thing you have to do is the next thing.

6. Find meaningful work. It can be paid or unpaid and it should make you feel like you have a purpose. Your unique strengths and talents are needed somewhere and you will feel closer to recovery if you can find your niche.

7. Accept your illness. Fighting the illness is a battle you will lose. Working to manage it will work in your favor. When symptoms strike, my response is, "You're not the boss of me." With my coping skills I can rise above it and regain control of my life.

8. Remain hopeful. You can experience change, growth and success at any age. Think about what can happen if you use all of the above links to help you and know that you have the ability, despite this illness, to have a life you enjoy and are proud of.

Luncheon Honors Pantoliano



Philip Matcovsky, Doris Wagner, Barbara Roth, Joe Pantoliano, Ruth DelCol, Barbara Faron

Staff Writer
Mental Health News

Keynote speaker, Joe Pantoliano, who played Ralph on the Sopranos, gave a truly inspirational talk. He spoke of his personal experiences dealing with clinical depression. The message was clear: mental illness like any other medical issue affects people, their families and friends. People who struggle with mental illness need to be accepted and treated with dignity and respect. Mr. Pantoliano, inspired by his diagnosis of clinical depression and the response of fans who often disclosed that they or their family members were living with mental illness, created No Kidding, Me Too! (www.nkm2.org), a not-for-profit foundation dedicated to educating people about mental illness and removing the stigma associated with it. Mr. Pantoli-

ano, autographed copies of the movie *Canvas* he recently appeared in, in which he played John Marino, the husband of a woman (played by Marcia Gay Harden) who develops schizophrenia.

Federation of Organization's 28th Annual Community Mental Health Awards Luncheon was well attended with over 300 mental health advocates, professionals, government leaders and consumers. The event, sponsored by Pfizer, Inc., celebrated the many accomplishments made in the service of individuals recovering from mental illness.

Federation of Organizations is a not-for-profit human services agency serving Long Island and New York City. It has been recognized as a pioneer in developing consumer-driven, community based services for individuals recovering from mental illness. For Further information, call Federation of Organizations at 631-669-5355 or visit their website at www.fedoforg.org.

The Truth and Nothing But the Truth

By Kathy Dellis-Stover
Support and Wellness Specialist, Western
Suffolk Clinic at Pilgrim Psychiatric Center

Being true to you is the key to feeling good about yourself. Doing what others think you should do leads you away from who you really are. We talk a lot about self-esteem but it cannot be achieved unless you are living the life you were meant to live. Being true to yourself is a form of self-love – not an egotistical self-love – but a love that indicates you respect yourself and care about who you are and what you do.

Doing what is meaningful to you nourishes the soul. It brings you to a place

where you feel that anything is possible. When anything is possible, you feel a sense of freedom you can find in no other way. Being true to yourself sets you free. It helps to bring you to a place on your inner landscape where it becomes possible for you to make your dreams a reality.

Know that you always have the choice to be true to yourself or to give in to outside pressures. Choosing the former will make your life a much happier place to be. It is often difficult to resist the messages that negative people share with us because of our own self-doubts. But everyone has the strength to reach deep within themselves and find the motivation it takes to be the best person they can be. And the best person you can be is the real you, the uncompromised you, the true you.

Timothy's Law from page 15

cost it is difficult to understand why it took so many years for Timothy's Law to be passed. Moreover, when one considers that the American Medical Association estimates that more than \$44 billion is lost annually in worker productivity as a result of depression alone, Timothy's Law simply makes sense both morally and economically.

Presently, there is a push to extend Timothy's Law's coverage to those who suffer from Post Traumatic Stress Disorder (PTSD). The amendment to Timothy's Law would include PTSD in the 20/30 base benefits and during the acute phases of the illness, coverage for inpatient and out-patient treatment in order to bring the person to stability. In this writer's estimation it appears likely that it will and should pass. Again, looking to the minimal cost and likely potential savings, it makes financial sense. Moreover, there

is increased concern, and rightly so, for the mental health issues that many returning veterans must deal with after the impact of a war zone. Clearly, including PTSD within the ambit of coverage for Timothy's Law would be of great assistance to this population of individuals.

Conclusion: The enactment of Timothy's Law has proven to be of immeasurable benefit to those in need of mental health treatment. As the readers of this article are surely familiar with the ravages of a chronic mental illness we know that like any other illness, mental illness requires care and treatment from trained professionals on a regular and sustained basis. This care is costly and requires adequate coverage under existing health insurance benefits. Timothy's law provides that coverage. The only sad point is that it took the tragic death of a young boy to force policy makers to recognize the right thing to do.

Successful Consumers Make Successful Providers

**By Doris Wagner, LMSW, CPRP
Chief Administrative Officer
Federation of Organizations**

There is a Danish proverb that says, “He knows the water best who has waded through it.” For those who are traversing the waters of mental illness, this is particularly true, and it is with this knowledge that Federation of Organizations was among the first to begin employing individuals who had been recipients of mental health services to work in positions where they could assist and motivate others who were in earlier stages of the same journey.

In 1981, Federation first established our Senior Companion Program. Modeled after our existing Foster Grandparent Program (which paired healthy seniors with at-risk children in schools), this new program paired individuals who were recovering from mental illness with people in adult homes and psychiatric institutions with the goal of helping to improve their lives and guide them toward a healthier, more productive future.

At this time, people were being released into the community from psychiatric institutions, and although new psychotropic medications were becoming available, “recovery” from mental illness was a concept that was just beginning to be acknowledged as a possibility. Individuals who had been institutionalized were now living with family members or in adult homes or group homes, and there were limited community programs available for support. Pre-conceived limitations were accepted as the norm, and it was expected that there was nothing to expect other than the status quo. As an agency that is built on the principle of “helping people help



Doris Wagner, LMSW, CPRP

themselves,” Federation understood the capacity of those who had overcome these barriers to help guide those on the other side over them to see that a brighter future was possible.

What began as a pilot program in one town on Long Island grew to encompass an entire county within five years. With the success of the program, younger people were referred to Federation, and expressed a desire to expand their recovery by reaching out to others, but weren’t able to participate in the program because of age restrictions (senior companions must be aged 60 or older). Federation responded to this need by expanding the role of peers within the agency, and their occupations vary as much as the individuals themselves.

People in recovery work in our homeless outreach program and in our PROS

recovery centers. They are part of our assertive community treatment team and they staff The Advocacy Coalition, a Federation program that is comprised of experienced advocates who are concerned about improving the quality of services available to the mental health community. In Brooklyn, our peers work in adult homes and in Queens they are employed in adult homes and in our vocational program, Big Nosh, operating a snack bar on the grounds of Creedmoor Psychiatric Center. As Federation of Organizations grew, so did the opportunity to employ people who had traveled the rocky road of recovery, enabling us to provide the most comprehensive and compassionate – and therefore effective – treatment possible. Quite simply, because of the common bond of experience, peers are able to help people find the means to their own recovery. The success of these programs is significant, and because of our commitment to this treatment method, approximately 20% of the 340 people who work for Federation of Organizations are former consumers of mental health services.

Federation of Organizations now provides services in Nassau, Suffolk, Queens and Kings Counties in New York. It is safe to say that having people in recovery partake in the delivery of services has contributed directly to our monumental growth. Nearly three decades after the inception of our unique pilot program, recovery from mental illness is now regarded as a viable possibility rather than an anomaly, and employing people who are examples of that recovery has become more widespread throughout the mental health community. These strides in the movement to employ consumers have been noteworthy because of the over-

From Consumer to Provider: A Personal Journey

**By Kathryn Cascio, CPRP, Advocate
Federation Of Organizations**

I identify as a survivor because I survived childhood violence, PTSD, depression, poverty and the mental health system. I saw inadequacies in the mental health system and the treatment I received and wanted to make a difference.

After completing peer support training, I became a Certified Psychiatric Rehabilitation Practitioner. One of the early challenges I faced is that “traditional” staff do not always know what to make of me. Now people find that my unique experience can be very helpful. Being able to empathize with someone is to connect on a very personal level. As a person in recovery, I can share my story of hope and empowerment, and I am living proof that there is a life outside the walls of a hospital, day program or mental health housing.

I have been frustrated by the slow pace of change, but the fact that there is still work to be done to transform the attitudes of the public and within the mental health system keeps me pushing to work on a more “human” human service system.

whelming evidence that they are an effective component in the treatment milieu. To quote yet another adage, “Nothing succeeds like success.”

About Therapy

**By Herb Ruben, Executive Director
Peninsula Counseling Center**

In this day and age, many people turn to therapists for help in dealing with troublesome personal or family problems. This is rarely a simple, easy thing to do. Such a step carries with it a certain amount of fear, skepticism and feelings about not being in control over one’s own life. On the other hand, there is also the hope and expectation of experiencing some relief from burdensome anxiety, of finding more effective answers or being able to cope more adequately with the situation at hand.

There is much in the therapeutic process which unfortunately contributes to myth building. The person seeking help usually feels in a more vulnerable position. He feels less resourceful. He sees himself at the moment as more dependent and is likely to endow his therapist with larger-than-life qualities. He is more unsure of himself, more doubting about his own capacities and more questioning of his own judgments. If progress isn’t tak-

ing place in the way he envisioned it, he is apt to be more critical and condemning of himself, or to rationalize that the process takes more time. He’s just being too impatient, he tells himself.

While all of this may be so, my plea to those in therapy is not to suspend your capacity for judgment and not to distrust what your feelings tell you. Don’t be so intimidated either by yourself or the professional you’re consulting with to downplay and ignore the signals you hear within yourself.

It is not unreasonable on your part to want to know more and to be told more about the nature of your problem and what can be done to deal with it. Vague answers from a therapist on having your question answered with a question are likely to make you feel that you’re stupid, guilty and wrong for daring to ask in the first place. None of this can be helpful or constructive for you. When faced with such a situation, keep in mind the following: (1) Skilled as your therapist may be, he is not a mind reader. He may sense

see About Therapy on page 35

Peninsula Counseling’s New Home

**Staff Writer
Mental Health News**

Peninsula Counseling Center has moved into a new home – a 25,000 square foot building housing (1) its child/adolescent, adult and older adult outpatient mental health services, (2) its outpatient chemical dependency treatment services, and (3) its clubhouse program. More than 60 therapists are providing services in this consolidated operation.

On May 8, Peninsula Counseling Center dedicated the Adam Cohen and Jonah Richman Adolescent Center. This development is to honor the memory of two young men who gave their lives in an extraordinary effort to save a friend’s life.

Congresswoman Carolyn McCarthy has announced that Peninsula Counseling Center will be receiving a \$190,000 federal grant. This is earmarked to provide mental health services at home for elderly unable to travel but who are experiencing a broad range of mental health disabilities.



Peninsula Counseling Center is proud to be completing its first year of a five year OMH grant related to Child Clinic Plus. This is an exciting new venture with a primary emphasis upon early screening, identification and prevention of emotional difficulties of children in their natural settings, including: schools, day care centers, pediatrician offices.

Peninsula Counseling Center’s new facility is located at 50 West Hawthorne Avenue in Valley Stream, New York. You can reach them at (516) 569-6600 or by e-mail at penctr@aol.com.



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The Mental Health News New York City Section

Wellness Self Management

**By Anthony Salerno, PhD, Co-Director
Evidence Based Practices Initiative
NYS Office of Mental Health**

Wellness Self-Management (WSM) is a curriculum-based clinical practice designed to assist adults to effectively manage serious mental health problems. The WSM program was based on Illness Management and Recovery (IMR), one of the nationally recognized evidence-based practices for adults with serious mental health problems.

In 2003-2006, the New York State Office of Mental Health (OMH) participated in a Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored initiative to implement and evaluate IMR. As a result of the feedback and experience of participating consumers, practitioners and administrators, OMH, in partnership with the Urban Institute for Behavioral Health, developed and evaluated the WSM approach. WSM incorporated many of the recommendations of participants as well recommendations of the OMH Office of Recipient Affairs. The recommendations included: (1) Change the name to emphasize the positive goal (wellness) and the central role of self management; (2) Expand the curriculum to include physical health issues; (3) Organize the materials into a bound personal workbook that belongs to the learners; (4) Use language that reflects recovery principles of choice, hope and shared decision making; and (4) Design a group format that corresponds to the workbook and provides a useful and easy to follow framework for facilitating a curriculum based program.

The WSM workbook consists of 57 lessons and includes topics such as:

- What helps and what hinders recovery
- How having goals helps recovery
- Practical facts about mental health symptoms, treatment, and causes
- How social support and using community resources help recovery
- How family and friends can support your work in WSM
- Developing and using a relapse prevention plan
- Finding and using coping strategies that work
- Knowing and using your strengths to support recovery
- How your cultural and family background affects decisions about mental health services
- Understanding the connection between physical and mental health



In the fall of 2007, OMH conducted leadership forums to inform and engage mental health provider organizations to determine their interest in participating in a statewide initiative to implement Wellness Self Management. The response was very gratifying with over 100 agencies including ACT, residential, continuing day treatment, clinic, PROS, VA programs, forensic and inpatient treatment programs choosing to participate in the initiative.

To support the participants, OMH, in collaboration with the Evidence Based Practices-Technical Assistance Center (EBP-TAC) at Columbia University, organized agencies into regional learning collaborative that included quarterly face to face meetings with key individuals in the participating programs, supervisory and line staff training sessions; monthly phone calls and data collection and analysis of a number of performance indicators.

Over one year later, 95% of the agencies remain actively committed with many expanding WSM in their initial start up programs and actively spreading or planning to spread WSM to other programs in their respective agencies. Since initial implementation of WSM in the spring and summer of 2008, over 250 groups are up and running with over 2500 consumers participating. We anticipate that as many as 3000 consumers will have completed or be enrolled in a WSM program by the end of 2009.

In addition to the high percentage of agencies that have remained active participants in the learning collaborative, a high percentage of consumers continue with WSM after beginning the program. Of all consumers who have ever enrolled in a WSM group since the program began nine months ago, approximately 65-70% continue to be involved.

The WSM program provides benefits to participants, mental health staff and administrators. For program participants, WSM provides consumers with research informed information and tools to better manage mental and physical health problems. This enables individuals to spend less time managing illness and more time pursuing goals and enjoying life. WSM is also designed to reinforce principles of recovery including shared decision-making, informed choice, involvement, and hope.

WSM participants comments: "I was very angry, I wasn't dealing with it. I wasn't taking my illness seriously. Now I decided to start taking my meds on time and not skip it;" "I thought I could never handle a job but now I'm looking forward to getting a job;" "It helps pinpoint symptoms. I can feel the storm coming and prevent it from happening;" "I asked my mom to help me with the WSM book. I told her about the program ... it gives me a push to keep going;" "It's about you... nobody is pushing you or forcing you... it's about you doing what right for you;" "This group gives me tools I can use ... different from other groups;" "I like the cultural background part. It doesn't violate your cultural background."

WSM benefits for mental health staff: The WSM curriculum, materials, consumer workbook, and corresponding training integrate a number of core clinical skills. These include motivation enhancing strategies, basic cognitive-behavioral approaches, teaching techniques, and practical group leadership skills. WSM is designed to support clinical staff in providing WSM services in group and individual modalities.

What staff facilitators say: "At first I was skeptical about this group because we start lots of groups. ... I noticed that the

consumers were really listening to this and using the stuff they say in the group. ... More and more clients are telling their friends about it, and they want to join. Even the psychiatrists want to see the workbooks;" "Running the group has affected me. I have been able to step out of my position for a moment and understand what they have been going through. ... I am learning from them and they are learning from me, we are both growing;" "Clients actually have something to look forward to. People are alive and alert ... up and active;" "It's really helpful because until now, they didn't have anything they could take home. People have the book now. Consumers talk about how they were able to sit down with the psychiatrist and therapist and ask questions."

Benefit for mental health agencies: WSM provides a comprehensive, structured, systematic, and cost effective individual and group curriculum that can be implemented, sustained, and spread in a practical and efficient manner.

What administrators say: "The WSM initiative is a terrific, engaging, and empowering intervention for mental health consumers. Giving staff a set of clear guidelines on how to involve consumers in the management of their own illnesses, this intervention helps our consumers take more responsibility for their recovery. Staff and clients love it!!" Amy Dorin, Senior Vice President, F.E.G.S., NYC.

"The timing of the wellness self management program perfectly married with SUS's organizational transformation efforts. For staff and consumers, it is the bridge between our values and ethics work and practical strategies to support individuals toward their recovery. The program's success demonstrates the power of collaboration." Donna Colonna, Executive Director, Services for the Under-served, NYC.

Frequently Asked Questions

Who provides WSM services? WSM can be provided by mental health staff and peer specialists who have received WSM training.

How long will WSM last? The length of time varies based on a number of factors including the treatment setting, the length of stay of people in the treatment program, individual or group modality, use of the entire or selected parts of the curriculum, and frequency and pace of meetings. In general, it takes about a year to complete the entire curriculum in groups that meet weekly for about an hour. Some programs may offer WSM more than once a week. It is important to remember that there is not a correct length for the program.

see Wellness on page 38

A Journey to Employment

By John Allen
Special Assistant to the Commissioner
New York State Office of Mental Health

As a person with a disability, it is understandable why I might be considered an advocate for people's rights. Although I am currently the Special Assistant to the Commissioner at the New York State Office of Mental Health responsible for consumer and family affairs, I regularly experience issues that would be related to the psychiatric labels which I have had since age six. After a lifetime of dealing with my own issues as well as listening to those of other peers, I have come to appreciate a quote from Thomas Eddy written in 1815, "Of all the modes maniacs use to maintain themselves, regular employment seems to be the most effective."

In the 1800's, at a time when Psychiatric Hospitals were working farms, every patient was engaged in gainful activities making hospitals profitable enough to contribute funding to state budgets. Full employment at a time before psychotropic medications were even invented seems almost implausible, yet it is our history. Employment provides an identity that for many creates a reason to manage symptoms.

In 1988, I was leading a group of people with psychiatric labels in Maryland and was involved with creating one of the first



John Allen

publicly funded job skills training centers run by peers (On Our Own Computer Center). Early advocates, including Jackie Parrish who was then at NIMH in the Community Support Branch, helped support the program design and encouraged the documentation of outcomes. Dr. Lauren Mosher was our first contract manager from government, and helped provide a linkage to sound clinical approaches that resulted in homeless individuals with psy-

chiatric labels successfully sustaining employment. This program became a model employment center recognized by the National Institute on Disability and Rehabilitation Research (NIDRR).

By 1994, I was working with Matrix Research in Philadelphia under a NIDRR contract, and providing national training on the development of agency-run businesses. This afforded me the opportunity to assist hundreds of others with disabilities to achieve employment goals with their own businesses. Individuals with psychiatric labels, who would be considered unemployable by many, achieved competitive employment or owned their own businesses, and set a standard that every provider should achieve. This experience has become a hallmark of my personal advocacy efforts.

Despite the fact that many work incentives have been available under Social Security rules since 1987, few of these options are actually used in New York. One of the goals of the OMH Office of Consumer Affairs, which I direct, is to insure that recipients, families and providers are aware of these incentives and begin to take advantage of them. The Medicaid Buy-in Program for Working People with Disabilities (MBI-WPD) is one of these programs. Available since 2003, barely 6,000 New Yorkers currently use this program. The MBI-WPD provides New Yorkers with disabilities who work (full or part-time), to obtain Medicaid health insurance benefits

while earning up to \$55,188 per year and / or having assets as much as \$13,800. Presently there isn't even a premium cost for individuals and yet few are taking advantage of this opportunity. Individuals on "spend-down" who are employed will find an advantage to signing up for the "Buy-in," saving the cost of "spend down" each month and eliminating monthly paperwork requirements.

New York State now has an exciting set of opportunities, as the result of receiving a federal Medicaid Infrastructure Grant (MIG). This grant has provided \$5.9 million dollars this year to advance the employment of individuals with a disability, including expanding the use of the Medicaid Buy-in. The major goals to this grant for New Yorkers with disabilities are to: (1) Develop a statewide strategic plan on employment and economic development; (2) Align disability services, workforce and economic development efforts; (3) Improve employment outcomes using evidenced-based and promising employment practices; (4) Identify and address policy, practice and economic barriers to work and self-sufficiency; (5) Increase work incentives utilization; (6) Research and evaluation support related to disability policy and practice; (7) Link employment at livable wages with asset accumulation tools and strategies;

see Employment on page 37

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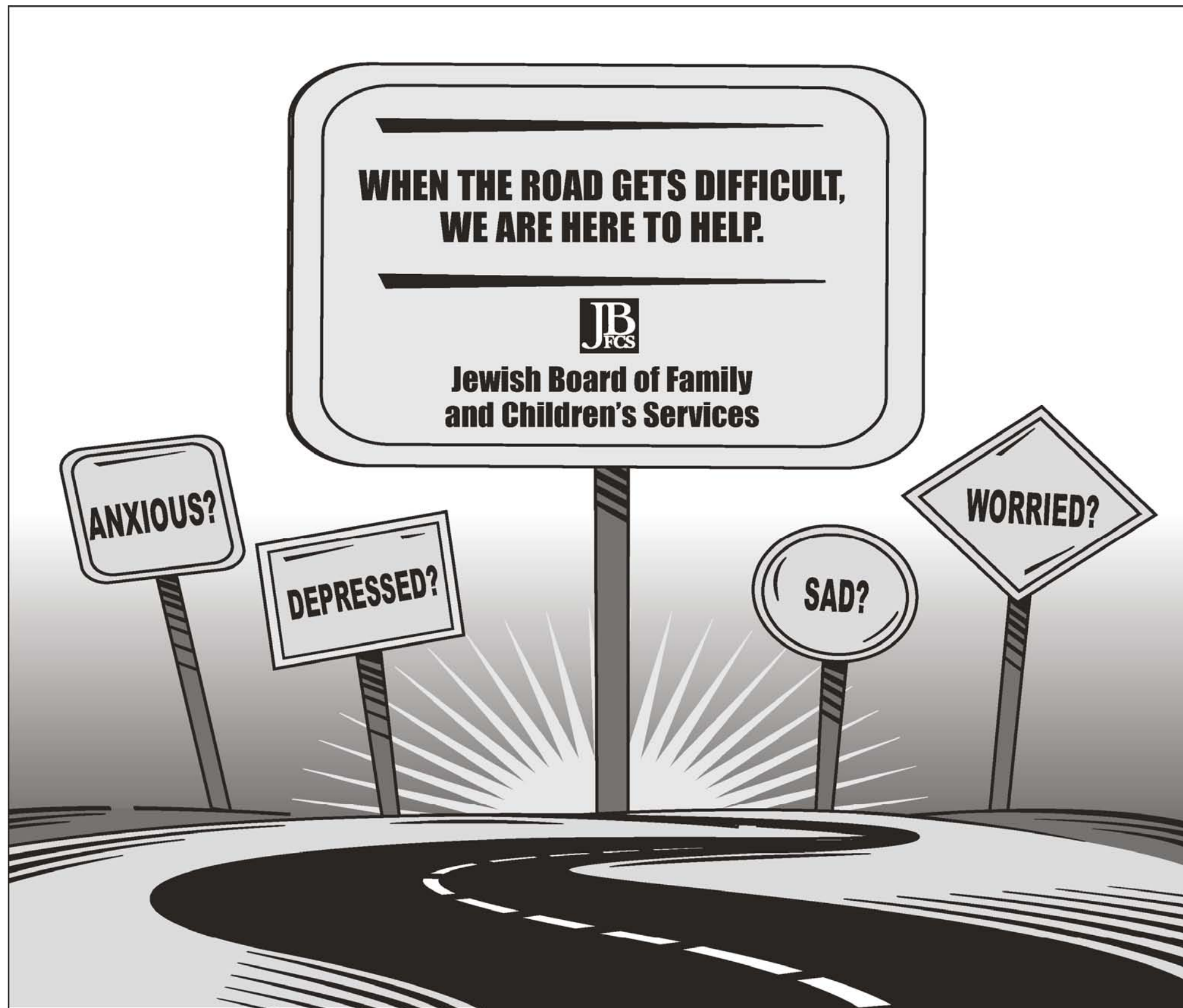
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Recovery and the Consumer Movement: One Provider's Perspective on Change

By Ellen Stoller, Assistant Vice President
for Professional Development and Consumer
Affairs, Behavioral Health and Behavioral
Health Residential Services, F.E.G.S. Health
and Human Services System

Since sometime in the early 1990's I have had the privileged experience to learn about recovery, the power of self-help and "natural supports in the community" directly from the NYC Consumer movement itself. I gained access to this community by virtue of the fact that I had some skills that they needed. Sort of like barter, the NYC consumer community needed my help in putting on conferences and I needed their help to do my job better.

I learned about recovery from the best, Dick Gelman, Howie the Harp, Mimi Kravitz, Dave Schneider all of whom died before their time. It was never a secret that people with mental illness die 25 years before their non-diagnosed peers... we only had to look around to know that.

I was not trying to pass as a consumer, no one ever asked, I never said. What's more I never cared whether people thought I was or I wasn't.

Any one who knows me knows that I talk a lot. I am often "in charge" of meetings, trainings, workshops. Although I didn't hold back, I learned to listen more at these conference planning meetings. When we find ourselves in a culture different than our own it is best to listen and learn.

Working on those conferences, I learned more about the mental health system, person-centered work and being a guide in someone else's recovery than I ever learned in school or on the job. Dick Gelman's business card read "Advocate/Shepherd." To me that said a lot.

I got to put what I learned to work in helping to shape our conferences.

In 1993, '94 and '95 the conferences were for consumers, people using the NYC mental health system. Now in 2007, '08, '09 the conferences I am working on with people from the NYS Bureau of Recipient Affairs, NYC Department of Consumer Affairs, Health and Hospitals Corp., Howie the Harp, MHEP, The Empowerment Center, the Coalition for Behavioral Health Agencies and NYAPRS are for Peers who are working in the

Mental Health system. In the 1990s there was a smattering of peers working in the mental health system. Last year at our conference we topped 200. What once was a dream is now a reality.

Mental Health professionals think a lot about boundaries but whether peer provider or professional provider, people working together to put on a conference is just that, people working together. It's a status free zone where the goal is to create the best product you can. There is no US and there is no THEM. We are people on a mission. We share, we create, we meet, we argue, we agree, we disagree, we problem solve, we decide.

From my insider/outsider view I have seen a real evolution in the NYC Consumer Movement. I wrote the following statement for our third conference, June 22, 2009, at the NYU Kimmel Center:

"In our third annual conference, *Peer Specialists in New York City: A Change We Can Believe In*, we are highlighting the accomplishments and sharing the combined experience, knowledge and expertise of people working as Peer Specialists throughout New York City. The conference workshops all come from you, working peers, who have let us know what is important in your work and your lives. Learning from each other we will continue to change and transform the mental health delivery system in New York City.

As Peer Specialists we embody the potential for recovery. Because we have been there and done that we really understand the barriers to success many of our peers face. We understand recovery because we are recovering people. We understand where there are barriers because we have faced them and overcome them. We are systems transformers, we are motivational enhancers, and *we are a change you can believe in.*"

Sometimes it takes an "outsider" to point out strengths and progress. I am glad I have occasionally played that role for the NYC Consumer Community, shaping their evolution and work into words and workshops and "marketing" their success so all can see it.

Mental Health News Fall 2009 Issue

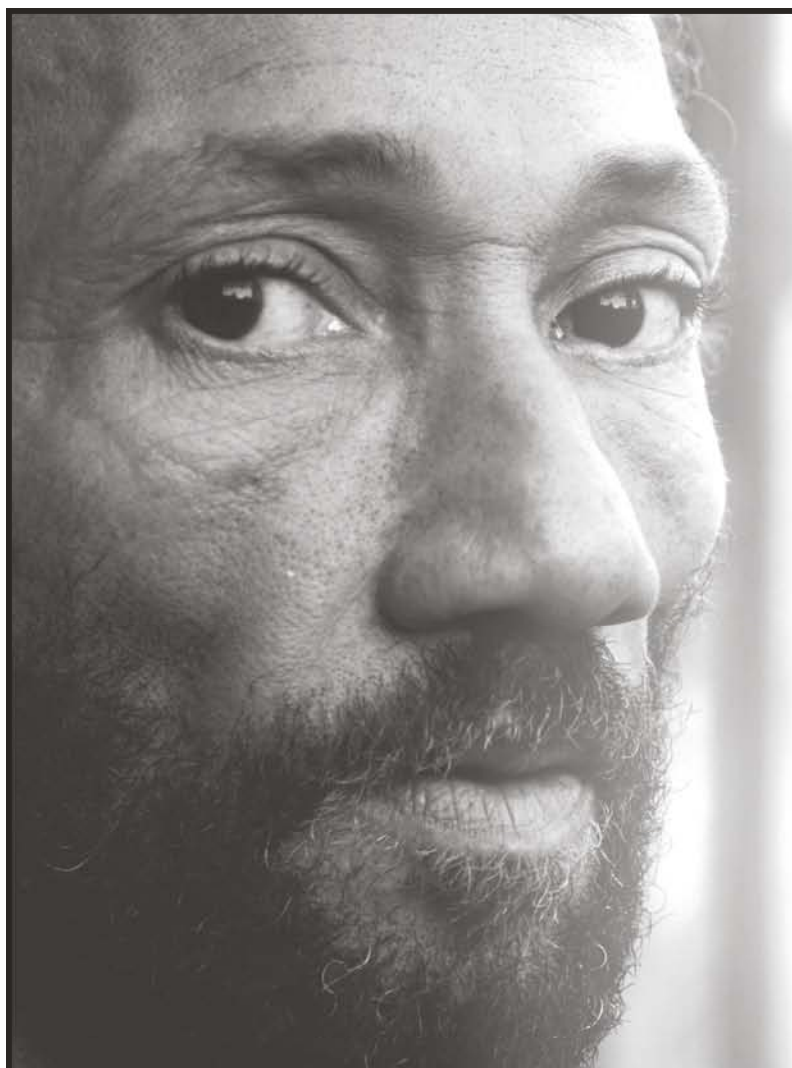
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Self-Empowerment In An Adult Home

**By Norman Bloomfield, President
Surf Manor Resident Council
Brooklyn, New York**

The so-called adult homes in New York State became a repository for those with mental illness in the wake of the deinstitutionalization movement in the 60's and 70's and no community-based housing available. These privately owned facilities for the frail and poor were not designed for this population and became de facto institutions themselves.

Whatever your history before you came to an adult home, once you are in this new living situation you have a new host of problems in the shared identity of an adult home resident. These problems now tend to dominate your life in a system which encourages passivity and dependence.

Pressure by staff, impositions on privacy, and lack of choices and activities in the home create a sense of demoralization and intimidation. Poor or mediocre food in many homes and lack of free air-conditioning in some homes undermine residents' physical and mental health.

The home sponsors a patchwork of uncoordinated mental and physical services which may not put the resident first. Residents who are trying somehow to overcome things may find that the people who are supposed to be helping them have their own agendas and are creating new problems for them while presuming to know what's best for them.



Norman Bloomfield

This may include the home-arranged day treatment program which they may get little out of. Residents' responsibilities are decided for them like children while the responsibilities they want for themselves may be denied by the home if they get too independent.

Those residents who want and need to move on to more independent housing may be met with active discouragement and little information. Adult homes are legally required to help people who want to move out, but there are many homes that don't help many people.

Teaching residents about their rights, what they can do to advocate for themselves and others, and how to organize in an effective way, like resident councils, can help liberate residents from their environment. They can also pursue more independent housing options with knowledge and support. This increased independence and responsibility would support growth and give fulfillment.

Our lay advocacy organization is the Coalition of Institutionalized Aged and Disabled (CIAD). CIAD is a consumer-led organization that helps residents advocate for themselves through education and organizing. It helps residents build effective resident councils. It helps organize food committees, has a Speaker's Bureau, an award-winning Resident Media Team, and an annual Speak-Out in Albany. CIAD's People's Waiting List Campaign documents the need of residents for more independent housing.

I have witnessed CIAD staff helping so many residents in so many ways: the resident who can't get her allowance, the resident who is humiliated by a staff member, the resident who can't choose his own doctor. But if management knows that CIAD is backing you up, they may think twice about any retaliation.

As President of the Surf Manor Resident Council for the past three years we have had many accomplishments. We have taken our own initiatives independent of management and sometimes at odds with management.

When a medical group established a presence at Surf, there was indiscriminate

scheduling of appointments, pressure to go to these appointments, and no coordination of care. These profit-driven services reimbursed by Medicaid depend on mass appointments for their success. We collected complaints, wrote letters, an investigation was started, and after two years they vacated the premises.

When residents were not being provided with flu shots at Surf and some other adult homes for the first time, we initiated with our local hospital an insurance-free flu shot program at Surf. In one day 81 residents and 6 staff members got flu shots in a model of preventive care.

We can advocate for our own health and wellness because we as the consumers have no other interest and our voice should be taken most seriously.

Air-conditioning is also a health issue with an especially vulnerable population. When there was a heat wave last summer and the air-conditioning in the lobby was broken down and the water fountain didn't work, we worked with CIAD in our complaints to the New York State Department of Health. A new administrator was brought in and a commitment was made for full air-conditioning in all resident rooms with no pass-on charge to residents. A large majority of units have already been installed and we expect full free air-conditioning for all resident rooms this summer.

Our food committee was also successful with the new administrator in getting a

see Adult Home on page 37

Helping My Fellow Consumers In Their Recovery

**By Sandra Mitchell
Peer Specialist and Advocate
Kingsboro Psychiatric Center**

When I was diagnosed with depression, I was devastated. I thought that this could not be happening. However, I accepted it. I knew that if I could just keep holding on, this too would pass. Somehow I knew that I would get better. I enlisted into a partnership with a great psychiatrist, took medication, and began the journey of recovery.

After approximately 7 years in recovery I lost my company apartment, gained another, lost that one, lived with family and friends. After depleting my savings, I went into the shelter. It was horrific. No food, dirty, depressing, dangerous (fights, guns, knives, sexual predators, thieves, degradation), you name the horror – it was there. I kept myself motivated by helping to form a Client Advisory Board with the NYC Department of Homeless Services. I also obtained certificates from Workforce 1 and sharpened my skills by attending Arbor WeCare – Work Employment Program, Bottomless Closet Connecting Women and Work and church services. I moved to a studio shelter and now I am in a one bedroom apartment.

How I became a Peer Specialist was

purely magical. My clinic director asked me what I planned to do with my life. I told her that I wanted to help people like I was helped. She gave me the brochure of Howie the Harp Peer Advocacy Center, located in the old Theresa Hotel in the Harlem section of Manhattan. I attended Howie the Harp Peer Advocacy Center and obtained my Certification as a Peer Specialist. I moved on to complete an internship at F.E.G.S., Intensive Psychiatric Rehabilitation Treatment Dept. Simultaneously I did an executive internship at HAI (Hospital Audiences, Inc.) where I helped to reorganize their filing system, general office work – and played ball with the founder's two Hungarian sheep dogs.

It is now 12 years in recovery and I feel fantastic! I have left the corporate field for good and have decided to help my fellow consumers who feel devastated when they are diagnosed with any debilitating illness. I do not consider matters of the mind or body illnesses that should be hushed away like a terrible secret. I help my fellow consumers on their own individual road to recovery by first letting them know that I too have a road of mental and physical wellness to travel – just like them. I share with them that I chose this line of profession and am employed to help them to find their dignity. Each road is unique, but they all lead to mental wellness, hope, happiness, new life.

I facilitate groups such as: Expanding Your Recovery Network, Effective Communication Skills, Smoking Cessation, Stress Reduction, Money Management/Budgeting, Consumer Advocacy, Wellness and Self Management, and Community Orientation/Resource Development. These groups are real and provide the necessary tools to live comfortably in main stream society. I encourage them to set realistic goals. I am also the HAI liaison and escort them to wonderful, interesting and exciting events at the theater, Madison Square Garden, movie theaters, concerts and dances. I have fun with my fellow consumers and let them know that their very possible and that I care. I research anything that my peers may need to obtain the services that they may need. Some may need ambulatory care, home attendants, information on nutrition centers, schools, seminars on finance, self-esteem, job-fairs for the disabled, sports clubs, drop in centers, etc. I let them know that I love to see people succeed. My fellow consumers inspire me when I feel down. That let's them know that I truly believe they are important.

I also help the social workers to brainstorm about ways to find housing, day treatment programs, and mainstream agencies who want to get involved in helping someone back to mental wellness. I communicate with the Social Security

Administration, VESID, and outpatient clinics to find what benefits and resources my peers are available and are eligible for. I find out what hobbies that they may be interested in and find venues for them to explore and develop these hobbies. Some of my fellow consumers love to write poetry, dance, sing, do stand up comedy. Sometime we have impromptu and informal sing-a-longs. I interact with the families and friends and give them insight as to how they can help. I educate myself and others about mental illness – all types. The more you know the less scary it is and the better you are able to handle those bumps along the way. I help my fellow consumers to develop coping mechanisms for when they are not feeling 100%. We do simple things like listening to upbeat music (instrumental and with lyrics), we eat healthy foods like grilled chicken salad, fruits, we go for walks and look at the changing of the foliage and enjoy the cool breeze and sun on our faces, we tell jokes and enjoy each others laughter, we share our frustrations and brainstorm on how to make different choices for a better result. I help them to identify what they can control and what they can learn to accept and have the right perspective. My interaction is all on an individual basis and is person-centered. I

see Peer Specialist on page 33

Baltic Street in NYC Shows the Power of Peer Support

By Sam Tsemberis, PhD
Executive Director and Founder
Pathways to Housing

The power of peer-led mental health services is at work at Baltic Street AEH in New York City, and is making a real difference. Baltic's mission is to achieve full social inclusion for all persons living with mental illness. Its integrated network encompasses vocational, educational, social and housing services and reaches thousands of consumers each year—an estimated 12,000 individuals since the program began. Baltic Street, which is affiliated with Pathways to Housing, has exponentially expanded the reach of the most effective tools of well-being and recovery: respect, dignity, and peer-supported choice.

The five Baltic Street Peer Advocacy Centers located in Brooklyn, Staten Island and the Bronx are the first borough-wide, self-help and empowerment programs run by, and for, mental health service recipients. Baltic Street's net-**WORK**plus employment programs assist individuals to choose, obtain and keep employment that is consistent with each person's goals and abilities. In the past year, of the 164 consumers who sought employment services, 90% attained productive employment activities and increased their income levels. Eighty-one people (48%) obtained competitive employment; and 74 people (45%) obtained transitional employment. Baltic's housing program currently houses 86 people in independent scattered site apartments in the Bronx and Brooklyn. The program offers access to housing in neighborhood apartments, allowing individuals to move back into the community without the many difficulties and stigma that often follows such reintegration efforts.

In 2008, Baltic Street was honored with the National Council Award for Excellence in Consumer and Family Advocacy. The National Council Awards of

Excellence recognize mental health and addictions treatment providers, like Baltic Street AEH who are implementing innovative and effective programs to serve their communities. Award winners have demonstrated an ability to measure outcomes, translate research into practice, and service to the most vulnerable populations.

"Baltic Street is defining success one person at a time," said Linda Rosenberg, MSW, president and CEO of the National Council for Community Behavioral Healthcare. "Founded upon the heartfelt commitment and skills of their staff, they are transforming individual lives and whole communities with their far-reaching, peer-led service network. We are inspired by their dedication and commitment to recovery."

In His Own Words

Staff member Stephen Simpson's own story reflects Baltic Street's success in supporting the power of every consumer:

"I went through a system that focused on my weaknesses and illness rather than my strengths and health. I went from ward to ward in a state psychiatric facility and thereafter from community residence to community residence. I had a shared apartment that led to independent living in a scatter site supported housing program, finding employment as a peer advocate. I now use my work at Baltic Street to counteract the philosophy that defines people by their weaknesses rather than strengths. Joining other peers who faced the 'risk of living' and won, I am a powerful force in giving consumers a vision of themselves. I am committed to Baltic Street's mission and believe the mental health movement is the most important social movement of our time."

This article is submitted in honor of the life and work of Rick Sostchen. Baltic Street AEH, Inc. is headquartered in Brooklyn, New York and is actively seeking an Executive Director. Interested applicants please inquire by calling 718-855-5929 or e-mailing info@balticstreet.org.

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Peer Specialist from page 32

let my peers know that they are all special individuals and that they do not have to follow the crowd. I help them to stand strong and regain their determination to be healthy, happy and positively productive. Some do not or cannot work – it doesn't matter. What matters is that they are alive and have a chance to choose to live a new and good life today and this time forward.

I help my place of employment to find training programs and Webinar seminars for all levels of the treatment team. I attend trainings given by OMH in Albany and at the Coalition for Behavioral Health and the Recipient Affairs Regional Headquarters in New York so that I can have

my pulse on what is changing in mental wellness. I also share that new information with all staff. I communicate with administration on a quarterly basis and as necessary on policies/procedures and offer concrete suggestions on how we can be a stronger, more efficient hospital and MICA residence.

By just being humble, honest and putting my best foot forward I empower my peers to tap in to their own source that is lying dormant inside of them. And when they find that source – whooooo they just soar!!!

I'm standing here, still feeling the glow of several of my fellow consumers that found the right path of recovery. I'm waiting for the next opportunity to show someone that they can soar as well!



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- **The Housing Services Program**, available to low and moderate income individuals and families in Port Chester through the Neighborhood Preservation Company, includes tenant assistance, eviction prevention, home ownership counseling, landlord-tenant mediation and housing court assistance.
- **Hope House** is a place where persons recovering from mental illness can find the support and resources they need to pursue their vocational and educational goals. Located in Port Chester, the Clubhouse is open 365 days a year and draws members from throughout the region.
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Cultural Competence and Recovery

By Efrain Diaz, PhD, LCSW
Connecticut DMHAS
Office of Multi-Cultural Affairs

It seems to me that within the behavioral health service field, cultural competence is an approach designed to improve access, engagement, retention, and to contextually improve the quality of life of individuals and families. Within a cultural competence framework, services facilitate collaboration with culturally diverse communities. Cultural competence counseling is based on an inclusive theoretical orientation, which creates an understanding of the person's culture and worldview. Central to cultural competence is the socio-cultural context and its relationship shaping problem definitions and the consideration of social and intra-psych variables. The collaboration of cultural competence and recovery principles is a natural union in the improvement and compliance with mental health and addiction services. Working in partnership, both interventions can support and learn from each another. For example let's consider characteristics of both concepts.

Both interventions give legitimacy to the client's participation in her/his treatment and the socio-political process while at the same time challenging those social forces that affect a client's life while receiving treatment. Harmonious with cultural competence, recovery is a continuum process for improvement and self-efficacy. Recovery is about healing the effects of an illness and its consequences (Spaniol, Gagne&Koehler, 2002). It is related to reclaiming and affirming the self. Recovery from mental illness and addiction includes both the skills to manage a health condition and to facilitate life in the community (Tondora & Davison, 2006). It is about restoring self-esteem while endorsing self-identity (Deegan, 1997).

Cultural competence and recovery approaches must be tailored to increase



Efrain Diaz, PhD, LCSW

the quality and appropriateness of care. The person-environment interaction and a collaborative therapeutic relationship are significant to the integration of both culture and recovery. The person-environment construct reminds us that services need to be specific while validating different worldviews and reinforcing cultural identity (D.W. Sue, 1996).

Designing services that are in accordance to the client's culture equates to sustainability of recovery. Recovery principles and cultural competence inclusion can be defined as a service philosophy and a set of congruent practices, guidelines, skills, quality of life improvement, and symptom management. Also, recovery principles and cultural competence inclusion is about supportive behaviors and attitudes that enable a system of care and individuals to work effectively for the benefit of its clients. Integration of both principles makes recovery meaningful and relevant while giving

clients validity for knowing what they need. Therefore, cultural competence principles and recovery practice methods are inclusive and participatory.

Cultural competence informs recovery by its practical applications. For example, by understanding the cultural context in which behaviors are manifested and by knowing the cultural forces that influences people to seek help; organizations can develop recovery-oriented initiatives that enhance the treatment experience. In this way, recovery and culture are embedded in the development and implementation of congruent treatment practice.

Cultural competence and recovery treatment approaches must include interventions that respond to a client's often culturally pre-determined needs. And the organization providing services must incorporate a genuine commitment in words as well as in actions by developing policies and practices consistent with the goals of recovery and cultural competence. These commitments must come from the top administration and from a clear mission statement and strong leadership initiatives. The development of policies needs to be translated into a recovery and culturally competent operational definition. The organization must allow for cultural competence and recovery progress monitoring. In addition, a recovery and cultural competence committee must be formed and charged with the capacity to influence and make decisions inclusive of both initiatives. These services and interventions will serve as a strong message to their staff and clients about the seriousness and importance of good and quality care. Furthermore by incorporating cultural competence and recovery principles into performance appraisals the organization solidifies its mission and treatment philosophy.

The achievements of individual and organizational recovery and cultural competence goals are not accomplished by words alone. Careful planning is necessary.

Organizations must perform a cultural competence and recovery service assessment, addressing their strengths and areas needing improvement, barriers and available resources for instituting changes. Planning for both initiatives must include development of cultural competence and recovery policies. Staff from all levels of the organization and consumers must be involved in designing policies that reflect the community and all those individuals that could be affected by changes. The organization's administrative staff becomes responsible for policy implementation, while monitoring its daily effectiveness.

Cultural competence and recovery-oriented organizations will begin by developing training and supervision programs that focus not only on general multicultural knowledge, but also on the dynamics of difference within a socio-political system. Mental health and addiction professionals must be receptive to explore their belief system and potential stigma when working with individuals affected by behavioral disorders and the culturally different client. Clinicians must develop awareness, knowledge and the necessary skills to work effectively with multicultural populations.

Organizations need to develop policies and practices, as well as the structures that support and enhance cultural competence while including recovery principles in the provision of all its services. It's acknowledged that both principles require considerable commitment and time devotion.

Cultural competence services must be understood and recognized contextually, and recovery must be integrated as a significant and valued component of the organizational structure of behavioral health care. Mental health and addiction professionals will benefit by embracing both concepts and by becoming familiar with the President's New Freedom Report on Mental Health, the U.S. Department and Human Services report on Mental Health Culture, Race and Ethnicity, and the Institute of Medicine's report on Health Disparities.

Getting Honest from page 7

my lies. I never intended to listen to what they told me or to change my life in any significant way, and so I did not. I did not realize at the time that I could not go back to the life I had before – that was no longer an option.

I completed thirty days of treatment in Pennsylvania and came home to New York City to live with my parents and commute to Philadelphia for the remainder of my freshman year. I stayed sober until May, drank again, and went to a wilderness treatment center in Utah in July. After completing that program in September I moved into an aftercare program in Orange County California. I stayed sober there for one month, and spent the next four months drinking in secret, eventually getting caught, and being thrown out of various treatment center houses.

In late January I called my parents and told them I had to leave. My life had gotten so utterly out of hand that I

could no longer even pretend to be enjoying it. Since having fun was the most important thing in my life at the time, if I was no longer having any I needed to leave. I cried the entire six-hour flight back to New York. I did not know what had become of my life or how to fix it. I did not even know what I was going back to in New York. My parents presented me with some options of treatment centers, most of which resembled the ones I had already attended. They were the best of drug and alcohol treatment centers and have surely helped countless people, but they had not worked for me in the past and I had a feeling they would not in the future. And so I chose Wellspring, in large part due to the fact that it was in an old house in Connecticut with farm animals. It seemed like it could be something cool and different – I might even get some good stories out of it.

By the end of my first week at Wellspring I knew I had become a part of something very special. The opportunity

presented itself in Expressive Group one day for me to come clean about all the lies I had held onto. I felt safe enough in Angelus house, especially in the expressive room, to do so. Honesty came pouring out of me. From that moment on, I felt like I at least had a chance. Somewhere in between Kitchen program and chores and expressive group and yoga, Wellspring instilled in me a sense of moral values and integrity. The staff and therapists were able to help me work through things I had been holding onto for a long time. I had built up a very deep and intense anger towards my parents over the last year and a half while they tried to get me better and I tried everything in my power to prevent them from doing so. I had the opportunity at Wellspring to get this anger out hitting a cube with a bat – an activity you don't see in most treatment centers.

I cried so hard in expressive group that I almost had an asthma attack. I had countless fun times with the other residents and staff members. I got angry

about the rules and once tried to run away through a patch of thorny bushes (I turned around and came back before I even hit paved road). I learned how to cook and pulled our goat's head out of its feeding trough when it got stuck. The Wellspring atmosphere allowed me to experience my emotions at their fullest, and in doing so, helped me find myself.

When I left Wellspring, I became active in a 12-step program and transferred to Columbia University. I am now a full time student at Columbia and live in an apartment on the Upper West side of Manhattan. I have a very full and busy life, one that I never take for granted. I recognize that everything in my life, both the good and the bad, has led me here. Without a single part of it I might not have the life I do now. But I have to credit Wellspring with providing the treatment and atmosphere that allowed me to turn my life around. I came into Wellspring a broken girl, and left a woman of integrity, fully ready to reintegrate myself into the world.

Recovery: A Participant in Life

**By Patricia Feinberg, MS, Peer Educator
The Coalition of Behavioral Health
Agencies, Center for Rehabilitation
and Recovery**

Living one's own life: a rather simple concept but somehow thrown on the back burner. Somewhere along the path in this journey of mental illness, we lose ourselves. Prior to the onset of my mental illness—well into adulthood—I was someone: a daughter, an educated woman, a teacher, a wife, a mother of two children, a good friend, and the list goes on.

But mental illness is a disease of isolation. It's like the parting of the Red Sea. At least in my case, all those significant roles and relationships disappeared with the tides. Friends suddenly took sides, there were boundaries drawn and alienations ensued.

And then, my life was no longer my own. I entered a whole new world of caretakers, doctors, social workers, programs and medications. Welcome to your new family: Monday – Friday, business hours only.

My life became all about work. When that inevitable question came at the party, "What do you do?" I had an answer; I did volunteer work. Then I had a Transitional Employment placement at Venture House. Next I had a Supported Employment position at the Coalition of Behavioral Health Agencies, a real job for real pay! Work



Patricia Feinberg, MS

was all-consuming with expectations, and demands, Monday through Friday.

Then came the weekend, and I dropped out of sight. With no work, there was no meaning. I asked myself if that was all that there is.

Something shifted. I began searching for something else, for the real meaning of wellness. Happiness was finding the balance and harmony between work, play, and personal relationships, as a mother, wife, partner, and dog lover (how could I forget Dylan, my twelve-year-old pedigree Pug?!).

Wellness means rediscovering your passions, hobbies, interests. I became a participant in the world.

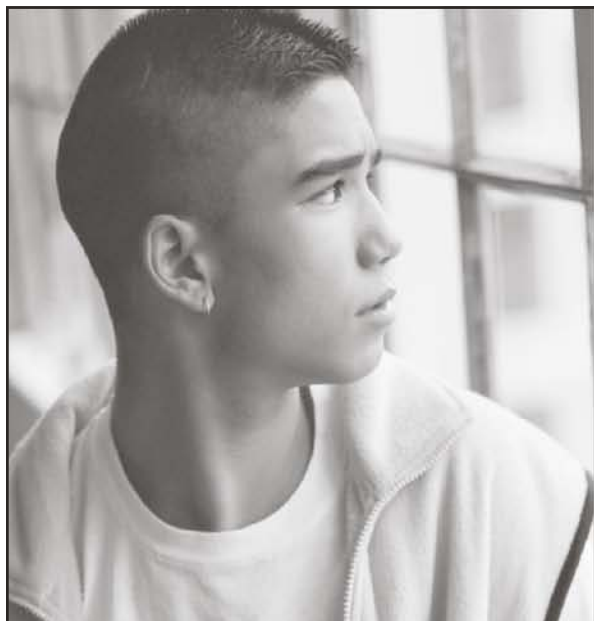
I decided to try to commit to just this one Saturday devoted to an afternoon of Wellness & Yoga. After a session of Yoga for beginners, as well as a long walk around the park, I could barely manage to sit down at a table. The next day was even worse as far as the aches and pains were concerned. The true test was whether I could commit to another Saturday. This was not an overnight transformation. Slowly I began to re-discover my passion for yoga. After about seven weeks of this regime, I noticed that I felt more energized and my posture had improved. A sense of well being was coming over me. Remnants of the old Pat began to emerge! My ability to multi-task returned and my ability to tackle everyday problems improved.

I rediscovered yet another passion: listening and dancing to 1970s-80s and Rhythm and Blues music. For several years I have assisted my boyfriend, currently a DJ, with the selection of vinyls for his set at fundraisers for a nonprofit organization. When New Challenges Clubhouse created opportunities to learn how to become a DJ, I signed up immediately for Session 1. I am now enrolled in Session 2 and am certified in basic wiring and set up on the CD mixer. As the course progresses, our instructor will help to refine and modify our techniques, so that

we can acquire a marketable skill. My grown children cannot believe that their "old" mother is becoming a DJ. As a DJ during a social event, I feel so empowered. I am no longer on the sidelines. I went from being a passive assistant to being in control of the music itself. I get a rush when I see the crowd's excited response to the flow of the play list.

With each new step I am taking I feel more mastery over my environment. It has a kind of domino effect, and I find myself taking risks. I'm entering a new and exciting territory and the possibilities are endless. "I feel my time to get a life is now," to quote John Allen, Special Assistant to the Commissioner, New York State Office of Mental Health, author of *Envisioning a Life Beyond Services*.

I aspire to live that American Dream and have a piece of that pie. To get a taste of life again, we need to recover our passions in our own natural environments, in addition to treatment. The new paradigm of intervention, at its core, should be based on a person's desires, wants, and needs. Staff and supports can be used to help people take advantage of naturally occurring organizations such as volunteer organizations, schools, parks, libraries. Being a native New Yorker and current city resident, there are vast arrays of free events touching on culture, art, music, sports, and nature that are listed in local newspapers. The possibilities are endless to exist in the world and live your life on your own terms.



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About Therapy from page 25

your discomfort but not have the faintest idea how strong your feelings are or what they may be related to unless you convey this to him; (2) Don't be concerned about offending or displeasing your therapist. Your task is to learn to be honest with yourself. The responsibility of your therapist is to listen to what you have to say in a non-judgmental, non-critical way; (3) Give the relationship a reasonable (but not unlimited) amount of time to see if the issues and roadblocks can be resolved in a way satisfactory to you. If within this time-frame you still feel the same way, recognize that it may be in your interest to consider a change. This is neither a reflection nor failure on your

part nor a statement of incompetence on the part of your therapist. Rather, in a field where feelings and communication are so crucial, it is an acknowledgement that you may need someone who enables you to reach yourself in a different way.

Being in therapy should enlarge your freedom, not diminish it; should increase your courage, not reduce it; should promote your responsibility, not dampen it. Translated into actual practice, you simply should not endure or tolerate what feels like an unproductive situation for you. You need to be able to speak up and speak out rather than wait-out or drop-out as a way of dealing with something not working well for you. Your therapy, after all, is supposed to belong to you and is for you.

Quality Life from page 6

it or worse, you may know it. Do I have to lose my mind and my life at the same time? It is backward thinking that the two go hand in hand, and hand in glove.

What is quality of life? In the simplest form, it is what you and I both want and need. What do consumers want? What everybody wants. If you are a human being you know what quality of life is. Does it mean eating McDonald's food everyday? I hope not, but you may want that. You could learn why that is not a good diet for an average person on a daily basis or what is a good diet or what would be a reasonable alternative to that. Quality means good! If you are going to force treatments on someone at least give them

good alternatives! Quality is about respect and considerations. I could go on forever like this, but I do not want to burden those who immediately think that the quality of life for consumers means more work for them. Quality means empowerment and participation in the process. Lastly, quality of life gives us back our own responsibilities and dignity before it is taken away by an intolerant society that can give value to the oppression of people in need. Our real quality in life must begin with when we maintain value for any human condition.

Dedicated to the memory of Rick Sostchen, Executive Director of Baltic Street, Advocacy, Employment, and Housing in Brooklyn, New York. In all his goodness, HE WILL BE MISSED!

Helping Others from page 18

ratio and the fiscal responsibility of bringing mental health care in par with other illness treatments. Nationally, we have lost billion's in productivity in the workplace because of company employees up to CEO's or VP's that are afraid to go to their human resources departments to talk about their depression. What happens? They wind up drinking or drugging their problems away and because they are such vital members of their team the company places them in rehab for thirty days hoping they can return to their jobs.

Ira: You certainly have hit upon many of the key issues that the mental health community has grappled with for many years. How can we learn more about *No Kidding Me Too*?

Joe: I would just invite everyone to visit our website at www.nkm2.org to learn more about our mission, to get involved by helping us in our mission so we can continue with the work we are doing. We hope to be the "go to" organization for college kids and the business community.

Ira: In addition to your outreach through your website and your many public speaking engagements, what other vehicles are you using with the organization to get the word out?

Joe: We have put together a documentary called *No Kidding Me Too – The Movie*. I will be doing a series of tours – including our upcoming stop at Westport High School in Connecticut where we will be showing the movie to over nine hundred families and teenagers. We also want to take it to colleges.

Ira: If there was one thing you'd like to leave our readers with about your experience and the good work that you are doing what would you say?

Peer Run Services from page 8

In response, in coordination with OptumHealth, NYAPRS is developing a NYAPRS Peer Health Care Coaching initiative that builds on our successful peer bridger model and incorporates innovations from several nationally recognized approaches. Our coaches are about to undergo a 6 week 6 college-credit approved Peer Wellness Coaching certificate program associated with the University of Medicine and Dentistry of New Jersey and the Institute for Wellness and Recovery Initiatives (CSP-NJ).

Our coaches will offer their unique ability to form unique trusted relationships, promote hope in ways that foster motivation and follow through and support enrollees on a broad range of topics including lifestyle factors for health & wellness, metabolic syndrome, smoking cessation, nutrition, exercise, oral health and medication side effects.

Joe: I would say, "You're Not Alone" and "You Can Get Better." I would also say "Surrender and Get Better," but I am not sure everyone would understand that.

Ira: I do know what you're talking about when you say that. For years during my own illness, I felt as though I was at a doorway with me on one side of the door and my depression on the other. We were both pushing hard against that same door and no progress was being made. It wasn't until someone told me to "Let go and accept your illness so you can begin to heal," that I finally stopped fighting my depression and blaming myself and I began my journey on the road to recovery. It's a message that our entire readership should understand and I am glad you said it.

Joe: People tell me that I am brave or that I am doing a great service in coming out about my illness and talking about it openly. In reality, talking about it and knowing that I am helping others by doing so helps to keep me well – it's the best therapy I have found.

David Minot: I want you to know that I watched *Canvas* and it brought tears to my eyes seeing the movie. I was a young boy when my father went through his long illness with depression, and seeing the child and the mother in *Canvas* really brought back a lot of feelings for me. I really think what you are doing for people in the community about mental illness is a truly wonderful mission.

Joe: *Canvas* is a wonderful movie that more people would benefit by seeing. Tell your readers that they can access ways to see it through our website, www.nkm2.org.

Ira: Joey, you're the greatest, and we thank you for taking the time to speak with us. I know our readers will really appreciate it.

They will also help to encourage and reinforce improved self health management, encourage each enrollee to complete a Wellness Recovery Action Plan that will help them anticipate difficult times, help enrollees self identify and engage with a broad range of valuable supports, including family and friends, religious institutions, support and 12 step groups and social, health or mental health service organizations.

Finally, they will also play a uniquely valuable role in providing input to the treatment team that reflects an up-to-date and personal knowledge of enrollees' current status and motivations and will support enrollees to advocate for themselves with various systems of care, support or entitlements.

Peer services are an approach whose time has surely come, whether it be to promote recovery, empowerment and employment or to provide timely interventions to help people avoid crisis and improve their health and wellness!

Parity Law from page 13**Impact on Employees**

Individuals who work for employers with more than 50 employees that are not ERISA-exempt can expect changes in their current health plans for new plan years commencing after October 3rd of this year. Limits on outpatient mental health visits will likely disappear and disparate co-payments for out-of-network mental health benefits are likely to be eliminated. Also, because Timothy's Law mandates the 30/20 benefit for all mental health diagnoses covered by the State employee's health plan, the federal law will now require large employers to provide full parity for essentially all mental illnesses. In general, we expect that bene-

fits, coverage limitations, deductibles and co-payments (for both in-network and out-of-network services) for mental health will become the same as for all other medical conditions.

Rachel A. Fernbach, Esq., is Staff Attorney of the New York State Psychiatric Association and Assistant Editor of the NYSPA Bulletin. Seth P. Stein, Esq. is Executive Director and General Counsel of the New York State Psychiatric Association. Barry B. Perlman, M.D., is Chair of the Committee on Legislation of the American Psychiatric Association and Immediate Past President of the New York State Psychiatric Association. Richard Gallo is Government Relations Advocate of the New York State Psychiatric Association.

Consumer Advocate from page 14

at a stroke for pennies. Suddenly, funding wasn't critical and we could avoid the paperwork and the committees. In the five hours it took for us to get to Albany and back, we could develop half-a-dozen e mailings. We are now able to reach over four-thousand professionals per mailing and our charts are being downloaded at the astounding rate of twenty-five percent!

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into the Democratic Club House in Chicago just a few short years ago – "I'm running for the Office of the President of the United States and I need your support". "And, I'll need about five-hundred million for the campaign". Could President Obama have been elected without the internet's power to connect him directly to the voters?

Whether you are running for office or tired of turning away from the financial waste and patient abuse, you can make a difference. It's never been easier to do the right thing.

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

Clothes Make the Man from page 9

they'll get wet. It doesn't work. Recently, however, one brainy clubhouse member said that it would, as long as you threw it out in the pool and made someone go in after it. He had a point.

Ever see *The Matrix*? The first one, not the crummy sequels. What is the Matrix? It's the perceived reality that swallows us all, our accepted reality. It's not created by a race of sentient machines (to the best of my knowledge); it's created by our culture, our political system, our economic system. It's a mile wide, but an inch deep. You want to belong? Act like you belong. Sound like you belong. Look like you belong. Dress like you belong.

Pick any one of a number of lives. Some of us have gotten doctorates: that PhD after your name really helps erase the stigma of mental illness. Some of us wear old clothes spattered with paint, exhibit in galleries, and paint right over the stigma. Artists are always a little eccentric. I'm too lazy to go back to school, not talented enough to be an artist. But I did get myself an American Express Card, gold thank you very much, and combined with the suit, I am Mr. Legit.

And what do you know, some bank loaned me enough money to buy a condo. I bought one and I moved in - I moved into my own new life. The stigma I left on the old one.

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Adult Home from page 32

larger food budget, a new cook, and a new nutritional service with new menus.

When the home was not helping eligible residents apply for their stimulus payment rebate checks in 2008, we arranged for Baruch College accounting students working for Volunteers Income Tax Assistance (VITA) to come to the home to help residents. In the process we found out about another tax credit New York City residents were eligible for. We tried to make sure residents had photo ID's to cash their checks by helping them get half-fare Metro cards with the help of CIAD.

When the home's nominee to be case manager was someone many residents objected to, we started a petition and the nominee was denied by the New York State Department of Health. When the independence of our resident council was under attack we complained to state agencies with CIAD's backing and there was corrective action.

We also started a People's Waiting List at Surf for residents interested in more independent housing. Over 40 residents signed out of about 190, and we documented barriers some faced. Several residents are now applying for supportive housing, with one having recently moved.

These accomplishments were accompanied by setbacks and frustrations. I've learned from mistakes, sometimes the hard way. Here are some lessons I've learned for effective advocacy:

- Keep your finger on the pulse. Mingle with residents and get all different points of view.
- Build open lines of communication with all sides: management, staff, Albany, advocacy groups.

- Cultivate good sources of information.
- Create a sense of community at resident council meetings. We're a community of shared interests and we can build power in a collective way.
- Take things step-by-step. Keep things cooking, but on a low flame.
- Reach out to management in a spirit of cooperation, but stick to your interests. Don't get co-opted.
- Documentation is important. Anything in writing with names and dates, and meeting minutes, requires a response and is read by inspectors.
- Share the credit. It's disarming and helps people work with you. What's important is the result.
- Build trust by knowing how to keep confidences and when you do say something, be able to corroborate it.
- Time is impersonal and people are personal. Figure out how to allocate your time effectively.
- When you are living with such a high concentration of people with urgent problems and needs, helping just a few people can become a full-time job. You have to decide what your full-time job is.

It is not now a story of smooth progress at Surf. With the resignations of key independent people in the past few months there is a fluid situation. But with the sense of shared interests we have built, and with allies who know our history being kept informed, we can work to protect and continue our gains. Because we are the ones who live here and our voice can influence how we live.

Norman Bloomfield is a member of the Coalition of Institutionalized Aged and Disabled (CIAD) Policy Committee.



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Employment from page 28

(8) Increase healthcare access through the Medicaid Buy-in; (9) Expanded opportunities for education, skills development and empowerment; and (10) Develop and expand customized and entrepreneurial approaches to employment.

The MIG grant will help to educate individuals and providers about some employment supports that are currently under-utilized. Social Security has had three options about which every provider should become aware: 1619(b); PASS Plans; and Employment Networks. The 1619(b) provision makes it possible for individuals on

SSI who begin earning too much to be eligible for cash benefits, to maintain Medicaid eligibility up to the state earnings threshold of \$43,421. PASS Plans enable individuals applying for or receiving SSI to save money to spend towards an employment goal, enabling them to receive training or even start their own businesses. Employment Networks make it possible for providers to be paid for assisting individuals with a Ticket to Work to acquire and maintain employment.

It is my fervent hope that with these initiatives, we will dramatically enhance the employment opportunities for all New Yorkers with disabilities.



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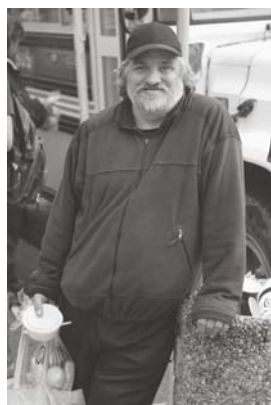
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Wellness from page 27

Can family members or friends play a role in supporting a person involved in WSM? Yes. The person involved in the WSM program is offered an opportunity to identify friends or family members he/she might want involved. Family or friends may help by providing encouragement, discussing topics of interest with the consumer, providing assistance with reading the material, and completing action steps.

What principles guide WSM? Belief that recovery is possible; Emphasis on personal strengths and health; Emphasis on informed decision-making, self determination, choice, and growth; Cultural respect; and Consistency with research-informed approaches

Are WSM Services Mandatory? No! Participation in WSM is voluntary.

Can a person end his or her involvement at anytime? Yes! The decision to continue to participate in WSM is left up to the individual.

Has the WSM workbook been translated into other languages? The workbooks are currently available in English, Spanish, and Chinese. The Korean translation is currently in process and will be available by the end of 2008.

Can the WSM program be helpful to people from various cultures and religions? Yes. The WSM program respects each participant's values and beliefs. It does not criticize or judge a person's cultural or religious points of view. Rather, the WSM workbook provides participants

with opportunities to better understand how their religious or cultural background affects their decisions about mental and physical health services. In this way, a person is in a better position to make informed health care decisions that work.

Does a participant need to read well to participate? No. If someone finds it difficult to read, he or she can attend, listen, and share ideas in the WSM group. People who have difficulty reading have successfully participated in WSM groups. This has been accomplished by the person: (1) Meeting with their group leader before the group to review the lesson; (2) Meeting with a family member or friend before or after the group to read or reread the lesson; and (3) Working with another member of the group who can help with the material. If working in a group program is not preferred, WSM can be provided in individual meetings.

Is the WSM program right for someone who didn't like school or doing homework? Yes. Getting involved in the WSM program is a person's choice. It's not the same as school that insists on homework or gives a grade. Participants are given opportunities to continue their learning outside the group, but that decision is left to the individual.

Participants are not given a grade but, rather, invited to set some goals on aspects of their lives they would like to improve as they participate in the WSM program. WSM is something people freely choose because they have decided to explore opportunities to support their mental and physical health.

How does a person get a copy of the WSM workbook? Adults who have mental health concerns, family members, students involved in human service and mental health education, mental health professionals, administrators, and interested stakeholders in the mental health system in NYS may request a copy of the workbook through the Evidence Based Practices - Technical Assistance Center (EBP-TAC) at Columbia University. Electronic copies of the workbook are available at no cost. Depending on the number of requests, the Center may need to require a fee to cover basic copying and mail costs for bound hard copies of the workbook. Please contact Melissa Hinds-Martinez at hindsma@pi.cpmc.columbia.edu or call 212.543.5941 to request a copy.

How does a mental health agency or program interested in providing WSM programs get involved? As word had spread about the value of the WSM approach, additional agencies have expressed interest in the WSM program. In order to promote widespread implementation of WSM, OMH and the EBP-TAC at Columbia is developing a highly efficient and less intensive method to support agencies. This approach is referred to as a Performance Improvement Network (PIN).

Mental health programs in NYS have the opportunity to join a Practice Improvement Network (PIN). This network of providers is offered educational and training resources to support agencies in providing high quality WSM programs. We request that agencies that are considering providing WSM programs do so as

part of a PIN. We also request that agencies NOT make copies of the workbook and implement the program without collaborating with the Center. Please use this link to learn more about how to join a Practice Improvement Network: www.nyebpcenter.org

In a PIN, resources are designed to enable agencies to successfully implement WSM programs without the expense and effort associated with numerous face to face strategy meetings and training sessions with supervisors and staff.

Agencies interested in joining a PIN are provided the following resources and tools: (1) Written materials including the WSM workbooks in both hard copy and electronic versions, group leaders quick guide, performance indicators guidebook and informational brochures; (2) Informational web site for WSM group members, group facilitators and other mental health providers; (3) Monthly phone consultations; (4) Training and promotional materials in DVD and VHS formats; (5) Web based data entry and analysis; (6) Web based 3 hour course for staff and supervisors on how to conduct a WSM group program.

The EBP-TAC at Columbia is currently accepting applications from agencies interested in joining a PIN. To find out more information about the PIN, please visit the following website: www.nyebpcenter.org. You may also contact Melissa Hinds-Martinez at hindsma@pi.cpmc.columbia.edu or call (212) 543-5941 for additional information.

The NYSOMH and the EBP-TAC at Columbia look forward to partnering with interested agencies to implement WSM programs.

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