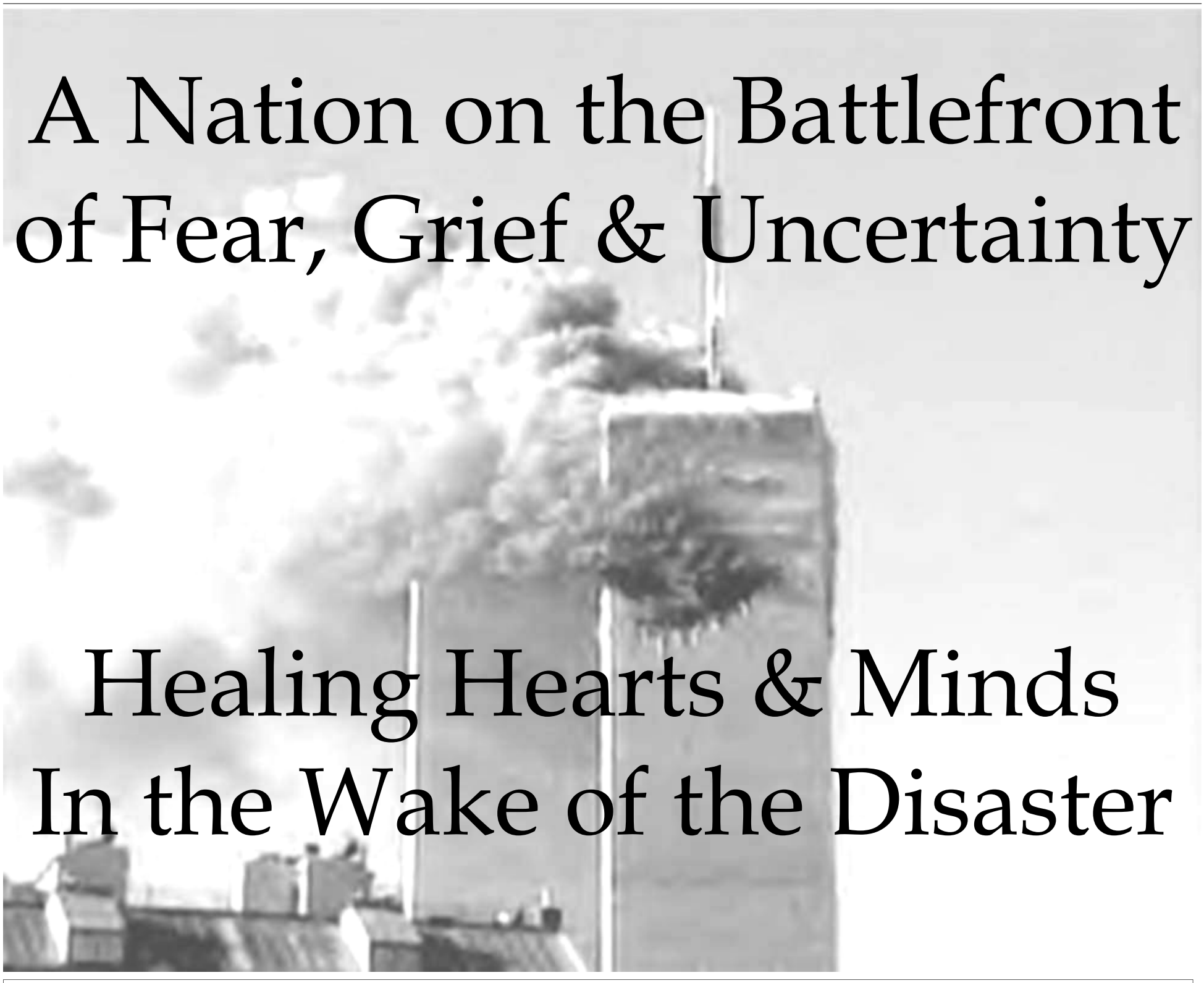
MENTAL HEALTH NEWS™

YOUR SOURCE OF INFORMATION, EDUCATION, AND ADVOCACY
FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE

WINTER 2002 VOL. 4 NO. 1

A Nation on the Battlefront of Fear, Grief & Uncertainty



Healing Hearts & Minds In the Wake of the Disaster

Inside This Issue Of
MENTAL HEALTH NEWS
Your *MUST READ* Newspaper

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MENTAL HEALTH NEWS™

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The Editor's Desk

"Now is not the time... to put Mental Health on the Back Burner!"

By Ira Minot, Publisher
Mental Health News

The attacks on America on September 11th have had a devastating effect on the hearts and minds of our entire nation. It has plunged the civilized world into a war unlike any it has ever undertaken—against an enemy whose main weapon is terror.

We know from past experience that cataclysmic events like September 11th are likely to have long-term effects on the mental health of the people who were directly and indirectly affected. Further, mental health treatment services and related community resources will be needed to address mental health needs during these times *more* than under normal conditions.

President Bush reported at a recent news conference that we are involved in a war that has two fronts—the front in Afganistan and the front here in America.

Perhaps we should expand on the President's remarks to invoke a mandate that *we are a nation at war on three fronts*; Afganistan, America and the unfolding and underestimated *mental health front* throughout the nation.

Immediately after September 11th, mental health organizations mobilized resources to handle the crisis and initiated contingency plans to prepare for what might arise in addition to their normal course of operations—which in most cases exist on tight budgets that require funding year in and year out.

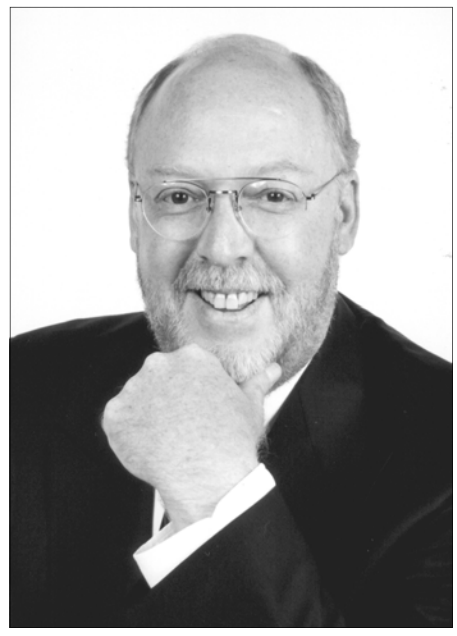
Soon after the scope of the tragedy's toll on New York City began to unfold, funds began to pour into the city to meet the enormous demand. Shortly thereafter, news bulletins warned that mental health funds were in jeopardy of being frozen at previous levels or might likely face cutbacks—directly contrary to *our* state of reality.

In one of this issue's feature stories, *Setting Priorities in the Wake of The Disaster* (pgs. 11-13), many of our community leaders have commented on the crisis.

One statement by Phillip A. Saperia, Executive Director of The Coalition of Voluntary Mental Health Agencies in New York City warns that "no plans exist to shore up a system that before the disaster was facing staff turnover rates of 36-54%. Can we find the resources and the will to fund the system of essential community-based care when energies and resources are focused on war and homeland defense? The fraying infrastructure of the community mental health system must be repaired and considered in planning for future disasters and to ensure a continuing mental health safety net for New Yorkers."

In our "SAMSHA's *Mental Health US 2000"* story (pg. 5), worrisome trends in mental health care have emerged. States expenditures for mental health care have decreased 7 percent between 1990 and 1997. One in 5 Americans suffer from a diagnosable mental disorder—illnesses as disabling as cancer and heart disease, and too few seek and receive care for these illnesses. The report concludes that since mental illnesses can affect anyone, the nation's health care providers and citizens must gain increased awareness of these problems and the availability of effective treatments. This requires broader ongoing mental health education.

The bottom line is that more people will suffer with mental health disorders and more people will seek care and services—yet less money will be available to



Ira Minot

fund these services. I believe we must continue to pull together as a community and meet the challenge to fight for the best mental health care system we can provide throughout the nation.

The writing on the wall points to a continuing need to advocate for more resources in a dwindling environment that should be more committed to mental health. We must shore up the existing system and have the resources already set aside so that we are not constantly playing a dangerous game of catch-up just to keep programs functioning at last year's level.

In addition, we must be aware of the need and continue to support ongoing, up-to-date and readily available community mental health education—*the cornerstone* of an effective and comprehensive mental health care delivery system.

That's where *Mental Health News* can help. This idea is clearly represented by this issue's very special *Project Liberty* supplement (pgs. 39-41), which we are proud to bring to our readers.

Thanks to the efforts of the Westchester Department of Community Mental Health, vital information and services, which Project Liberty has been funded to implement, will be brought to 60,000 *Mental Health News* readers. The Project Liberty supplement represents a new beginning, and is a meaningful and significant step in the right direction.

Mental Health News' mission is to provide news, information, education and advocacy to the community. Our goal is to be a vital component and ally to the existing mental health care delivery system.

I am pleased to report to you that *Mental Health News* is at an exciting new crossroads in its growth and development. A new effort is underway to help Mental Health News continue to publish and help it grow and prosper. Mental Health News is becoming a not-for-profit 501(c)3 organization and thanks to a grant by the United Way of New York City, a strategic study on how to accomplish our vision for the future has been launched.

I want to thank each and every one of our readers and organizations for their support and participation, which has helped me bring Mental Health News to this crucial point in its development. We are going to need the right funding to continue to grow.

During this holiday season, I want to wish you all health and happiness and urge everyone to reach out to someone who may be going through difficult times. People with mental illness who live in every community can benefit enormously by a simple smile, a hand shake, or a pat on the back. Become a volunteer or visit a drop-in center. You will be amazed at some of the things that are quietly going on and how much we can do if you believe in us. We have a wonderful mental health community, which we all need to support.

Best Wishes
Ira Minot, Publisher

NEWSDESK: TOP STORIES

Vital Mental Health Policy Issues Revealed SAMSHA's *Mental Health - United States 2000*

The Substance Abuse & Mental Health Services Administration Rockville, Maryland

A look toward the future, a review of past developments and a discussion of the current status of mental health services and statistics are contained in *Mental Health, United States 2000*. The compendium of the latest information available on mental health services, published every two years since 1983, was just released by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS).

Four major predictions for the future of mental health services are made in the report. Human rights will be established as fundamental in our health care system. Consumers and family members will seek and be given more responsibility for health and health care. Technology will become a primary vehicle for delivering health care. And, genetic treatments for mental health disorders will become routine.

"We look forward to the biennial publication of *Mental Health, United States 2000*. It serves as a reminder that one in 5 Americans suffers from a diagnosable mental disorder, real illnesses as disabling and serious as cancer and heart disease. Too few seek and receive care for these illnesses," said Acting SAMHSA Administrator Joseph H. Autry III M.D. "Since mental illnesses and, to a greater extent, mental health problems can affect anyone, the Nation's health care providers and citizens must gain increased awareness of these problems and the availability of effective treatments."

"This publication continues an excellent tradition of providing mental health professionals and policy makers a reference point and a compass for future direc-

Bernard S. Arons, M.D.

tions in an increasingly complex managed behavioral health care environment," said CMHS Director Bernard S. Arons, M.D. "Our coordination and compilation of Mental Health US 2000 is the cornerstone of our ongoing efforts to provide vital policy information that will impact mental health."

For the first time, this edition includes chapters on refugee mental health services, co-occurring addictive and mental disorders, mental health services in juvenile justice facilities, performance indicators for state mental health agencies, rates of psychiatric problems and related disability in the child and adolescent population, and new data standards for mental health services developed through Decision Support 2000+.

Availability - According to the report, 5,722 mental health organizations were operating in 1998. These organizations maintained 261,903 inpatient and residential treatment beds. Inpatient residential treatment admissions numbered 2,313,594, and admissions to less than 24-hour services numbered 3,967,019. Total episodes of care in mental health organizations reached 10,714,398.

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NIMH's Hyman To Be Provost at Harvard University

National Alliance for the Mentally Ill E-News Report

Dr. Steven Hyman

It was announced today that Dr. Steven Hyman intends to resign as Director of the National Institute of Mental Health (NIMH) after nearly six years in the job. In mid-December, Dr. Hyman will assume the position of provost at Harvard University - the second highest academic position at the university.

Under Dr. Hyman's tenure as head of NIMH, the agency's budget has nearly doubled, from $661 million in FY 1996, to just over $1.2 billion (the final funding level for FY 2002 has still not been resolved). These record increases in the NIMH budget have been the result of strong bipartisan support in Congress for doubling the federal investment in biomedical research. Dr. Hyman has been a key player in working with key members of Congress to ensure that increases in severe mental illness research keep pace with all other diseases, and that funding decisions are based on promising science and the public health burden of disease.

Since becoming Director of NIMH in early 1996, Dr. Hyman also pushed hard to change the focus of NIMH toward higher scientific standards for research and for integrating advances in neuroscience and genetics with clinical practice. In addition, Dr. Hyman's tenure saw more focus in the NIMH research portfolio on severe mental illness research. In recent years NIMH has undertaken the STEP-BD program, which is the largest study of real-world treatment of bipolar disorder ever undertaken. This important study, is examining both primary treatments and at adjunctive or add-on treatments to determine the best clinical approach in situations where the best approach is currently unknown.

Surgeon General Satcher's Leaving A Big Loss To Mental Health Community

Staff Writer
Mental Health News

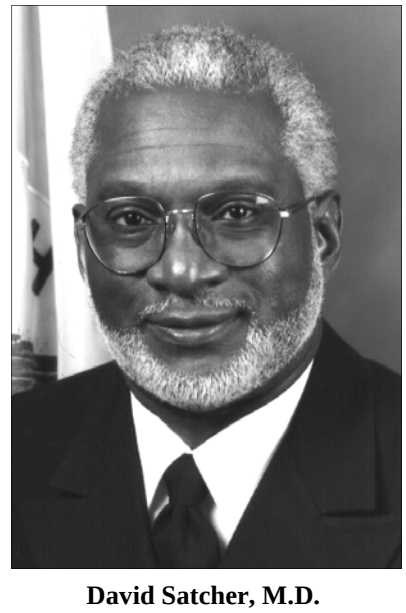
At the end of his four-year term on February 13th, Surgeon General David Satcher will leave the post he has held since his appointment by the Clinton Administration.

Satcher drew sharp criticism by political conservatives when he released a report last summer which found that there was no evidence showing that teaching sexual abstinence in schools was successful. The report went on to call for schools to encourage abstinence among students but to also teach birth control techniques—a reflection of scientific research rather than politics according to Satcher.

Dr. Satcher will be sorely missed by the entire Mental Health Community for his active leadership in mental health education and breaking down barriers to the discrimination caused by stigma.

Dr. Satcher will be remembered by many in the mental health community as the first surgeon general to release a comprehensive report on mental illness. He made the issues of suicide awareness and prevention a battle cry for the nation and urged the nation and the rest of the world to better understand and care for persons with mental illness. He led the call for adopting the disease model for mental illness and how the insurance industry was harming millions of mental illness victims by not placing the disease of mental illness on an equal par with any other medical disease such as cancer or diabetes.

The mental health community has lost a valued champion of the causes and issues it holds dear, and will keep a close eye on who President Bush will appoint to fill Dr. Satchers shoes.



David Satcher, M.D.

NEWSDESK: TOP STORIES

The Fate of the Mental Illness Parity Fight Looms Heavy on the Hearts & Minds of Advocates

Staff Writer
Mental Health News

On October 30, the Senate passed S. 543, the Mental Health Equitable Treatment Act as an amendment to the fiscal year 2002 appropriations bill for the Departments of Labor, Health and Human Services and Education (H.R. 3061). This important legislation provides in-network parity for group health plans sponsored by employers of more than 50 employees. If enacted, it would eliminate discriminatory limits on inpatient days and outpatient sessions, maximum out-of-pocket limits, co-payments and deductibles.

The bill will now be considered in the House and Senate Labor-HHS-Education appropriations conference committee, which is expected to conclude its work and send the bill to the President for signature in less than two weeks.

Robert Pear, in his November 6, 2001 New York Times piece, *Furious Lobbying Is Set Off by Bill on Mental Health,* did an excellent review of the issues. Pear writes that "Supporters and opponents of "mental health parity" say the lobbying is intense because the proposal stands a greater chance of enactment now than at any other time in the last decade. The drive for parity has gained momentum with the discovery that many mental illnesses have a biological basis and can be treated with drugs. At present, people who are treated for mental illnesses like schizophrenia or depression often face higher co-payments and deductibles than they would have to pay if they were being treated for physical ailments, like diabetes or cancer. Likewise, many insurance plans cover fewer visits to a doctor, and fewer days of hospital care, when patients are treated for mental illness.

Senator Paul Wellstone

Senator Pete Domenici

Pear's New York Times article goes on to report that: "Mr. Domenici, who has a daughter with schizophrenia, and Mr. Wellstone, whose brother has severe mental illness, have been tenacious advocates, lining up 65 senators as co-sponsors of their proposal. The two authors have also worked with lobbyists from groups like the National Alliance for the Mentally Ill, the National Mental Health Association, the American Psychiatric Association and the American Medical Association. After meeting with advocates for the mentally ill, Mr. Domenici sounded confident. "We're on our way now," he said in an interview. "There's a real opportunity to change the entire landscape with reference to mental illness and to put more money into research, more money into facilities. If there's insurance coverage, there's going to be a lot of assets following these sick people around, just as there have been over time huge amounts of resources for other diseases because insurance companies covered them." Further, Senator Wellstone said broader coverage of mental health care would save money in the long run, by increasing the productivity of workers, reducing their absenteeism and lowering the level of crime committed by people with mental illness."

Mental Health News wishes to commend Robert Pear and the New York Times for it's accurate and compassionate coverage of the parity issue which the entire mental health community hopes will finally win passage and improve mental health care.

Commissioner Cohen Submits Testimony To US Senate Committee on Trauma and Terrorism

Mental Health News
E-news Reprint

New York City Department of Mental Health, Mental Retardation & Alcoholism Services - Department of Mental Health Continues Assistance For Victim's Families. At the request of the U.S. Senate Committee on Health, Education, Labor and Pensions, Mental Health and Health Commissioner Neal L. Cohen, M.D., submitted testimony on September 20 to a Senate Hearing on Psychological Trauma and Terrorism. Dr. Cohen's testimony focused on the emerging mental health needs of New Yorkers that have resulted from the recent disaster, and the strategies the City has been putting into place to assist those who were directly and indirectly affected by the terrorist attack at the World Trade Center.

In the past two weeks, NYC Department of Mental Health, Mental Retardation and Alcoholism (DMH) staff, and other mental health professionals have provided assistance at Ground Zero, the Emergency Operations Center, the Family Assistance Center, mental health hotlines and at community-based mental health agencies. They have helped families, rescue workers, and the general public cope with feelings of grief, confusion and anger, and have encouraged people to continue performing the critical tasks of daily living.

Dr. Cohen acknowledged these efforts but cautioned that in the future, "the task before us is enormous. We face the possibility of a sharp increase in chronic and disabling mental health problems including post traumatic stress disorders, depression and the exacerbation of existing mental health problems. We are also concerned about the potential for more drug and alcohol abuse, domestic violence and relationship difficulties. Virtually every New Yorker is experiencing high levels of stress. That creates the potential for increased verbal and physical violence.

Dr. Cohen also announced that to help address these issues, the DMH is working with the State Office of Mental Health (SOMH) to apply for Federal Emergency Management Agency (FEMA) funds. Titled "Project Liberty," this grant application is for New York City and its seven surrounding counties. The State will also file an application for longer term aid from FEMA. In his testimony, Dr. Cohen outlined some of the City's future plans for its mental health system which includes disaster training for mental health providers, mental health promotion efforts and strengthening the City's array of mental health services. He focused on the City's efforts on behalf of children and adolescents which includes expanding school-based mental health services, and working closely with the Board of Education and the City's Administration for Children's. He also expressed concern for the elderly, a disproportionate number of whom are isolated and already suffer from depression and efforts to work closely with organizations that serve older adults.

Dr. Cohen said, "We will ask mental health providers to reach into their communities and to offer assistance at places where people live, shop, play, pray, work and congregate. Mental health providers will need to coordinate their efforts with other local social service agencies, schools, businesses, health providers, religious institutions and community leaders."

The DMH's core mission is to attend to the needs of those with severe and persistent mental illness, those with substance abuse problems, and those with mental retardation and developmental disabilities. DMH oversees a provider network of 230 agencies that offer a total of 988 mental health programs. Together, these agencies serve almost 300,000 people annually.

The full text of Commissioner Cohen's testimony is available on the Department's Web site at nyc.gov/dmh.

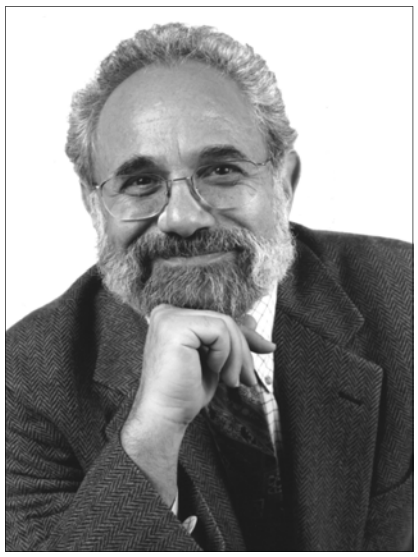
"We face the possibility of a sharp increase in chronic and disabling mental health problems"

Neal L. Cohen, M.D., Commissioner
NYC Department of Mental Health

NEWSDESK: TOP STORIES

Mental Health Advocacy: Tough Challenges For 2002

By Michael B. Friedman, CSW



Michael B. Friedman, C.S.W.

Mental health advocates in New York State will face very tough challenges in the coming year, and to meet these challenges we will have to press for new funds for mental health at both the federal and state levels. That is probably the only chance we have to prevent a sacrifice of the priorities we have pursued over the past decade to the priority which has emerged since September 11.

Terrorism has engendered new mental health needs. Many people are experiencing levels of fear and distress which create significant personal suffering, strain family life, and have dreadful social and economic consequences. The rise in bigotry towards Muslims is fueled by fear; the rise in unemployment is caused by loss of business, which is fueled by fear; the loss of consumer confidence, which leads to declines in purchasing, is fueled by fear. In addition, research from prior incidents of terrorism--particularly in Oklahoma City--makes it clear that over the next year there will be a significant rise in mental illnesses--especially post-traumatic stress disorders. Responding to these needs is a clear public responsibility, and public mental health authorities at the federal, state, and local level have responded by making it the central mental health priority.

But the old mental health needs, the needs that have defined the main mental health agenda for the past decade or more, have not disappeared. Children and adolescents with serious emotional disturbance who could not get the service they needed before September 11, still cannot get what they need. Adults with psychiatric disabilities waiting for decent housing are still waiting. The community mental health infrastructure which was eroding because of lack of funding to keep pace with inflation is still eroding. The principle of reinvesting savings from reductions of inpatient services in state hospitals, which got lost in the budget battles of 2001, still needs to be re-established. People with psychiatric disabilities who want to work still cannot because they would lose their health coverage. And people with serious mental illnesses who reject traditional mental health services still need innovative outreach programs to engage them in services which they will accept.

Mental health advocacy agendas this year will need to reflect a balance between the urgent needs created by terrorism and the chronic needs which have continued unmet for many years. Not either-or, but both-and.

But how do we realistically pursue a "both-and", balanced agenda in the context of an economic recession? Governor Pataki has announced a multi-billion dollar shortfall for this year and for the coming year. Mayor Giuliani has called for a 15% cut from almost every New York City department, including mental health. The County Executive in Westchester has called for a tax increase so as to preserve services. Who knows whether he'll get it? Nassau County faces the double whammy of years of fiscal excess and an economic downturn.

Even though 2002 is a state election year--when we'd ordinarily expect a very rich budget, this is going to be a very tough year except for a very few of the highest *political* priorities.

The best hope of being able to respond both to the mental health needs engendered by terrorism and the mental health needs which have been a serious and persistent problem in New York State is for the federal government to take full responsibility for the response to terrorism. This is not an idle fantasy. The Federal Emergency Management Agency (FEMA) has already provided $23.1 million for the first two months of Project Liberty, the state's program to provide outreach, crisis counseling, and mental health education to people experiencing emotional distress in reaction to terrorism. And the state has recently requested $132 million for the next nine months of the project. If that money comes through, it will be a big help. (We should know by the time this is in print.)

But it will not be enough to meet all the mental health needs engendered by terrorism because FEMA funds can only be used to provide crisis counseling and education to people suffering emotional distress. It cannot be used to provide treatment or rehabilitation for people who have developed diagnosable mental illness due to terrorism--as many will.

Who will pay for treatment and rehabilitation? A substantial portion will be covered by the private sector because it is likely that the majority of the people who develop mental illnesses will have health insurance through work. But there still will be a substantial cost to the public sector. The good news is that the Federal government has announced its intention to provide funds for services for both adults and children who develop mental illnesses due to terrorism. The bad news is that the amounts committed so far are not nearly enough.

Mental health advocates have to focus, therefore, on pushing the federal government to cover the costs of terrorism. It was an attack on the United States, not just on New York City. And, if the main goal of terrorism is to create psychological reactions which disrupt a society, then overcoming the psychological consequences must be a critical component of the war on terrorism--clearly a federal responsibility.

At the same time mental health advocates have to work to remind a nation now dominated by the need to reduce the risks of terrorism that social needs that were paramount before September 11 are still paramount today. More specifically we need to remind the leadership of New York State that the state has a responsibility to adults with psychiatric disabilities and children with serious emotional disturbances which is rooted in American social history and still is one of the primary responsibilities of state government.

Michael B. Friedman is the Public Policy Consultant for The Mental Health Associations of New York City and of Westchester County. The opinions expressed in this essay are his own and do not necessarily reflect the positions of the Mental Health Associations.

Senator Spano Honored at Arts Show

Staff Reporter
Mental Health News

NYS Senator Nicholas Spano inaugurated "Vision 2001", an exhibition of area mental health clients by the Westchester Arts Council in Mamaroneck.

A recognized leader in the field of mental health, Senator Spano continues to fight to eliminate the stigmas associated with mental illness. "It is very important to give individuals with mental issues the opportunity to share their talents with the public. An event like this demonstrates that artists with mental disabilities have positive contributions to make to the community."

The exhibit was sponsored by Rockland Psychiatric Center, The Guidance Center and The Center for Career Freedom.

Irene Milliken, of the Rockland Psychiatric Center in White Plains explained that "For many, creating a unique visual concept of the world in any medium is a way to enhance self-esteem and hopefully provide income as well."

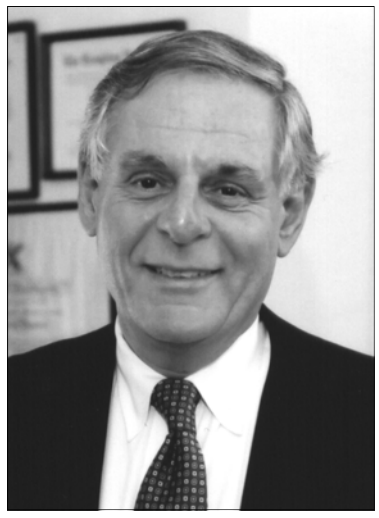
The exhibition is a collaboration between the Arts Council and the Westchester County Department of Community Mental Health. The Westchester Arts Council arranges artist residencies to twenty-two Community Mental Health sites throughout the County, including Rockland Psychiatric Center/White Plains, The Guidance Center and The Center for Career Freedom.

The Arts Council hopes to host one exhibition a year featuring art works by mental health clients and would like to acknowledge the support and encouragement of Commissioner Steven Friedman.

La Ruth Gray, Marge Klein, Senator Nicholas Spano, Jennifer Schaffer, Patricia Hamill, and Don Fitch

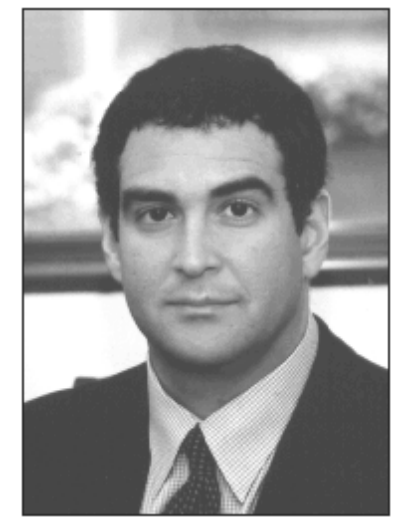
Where Do We Go From Here?

A Conversation with Doctors from St. Vincent's Hospital Westchester



"It has been both a privilege and an honor to serve our community in this time of tremendous need."
Richard D. Milone, M.D.
Medical Director

"People are wondering how to adjust to living in a world that feels less safe than it once did."
Steven Shainmark, M.D.
Chief of Adult Services



"Now, more than ever, we need to reassure children that the world is safe and that they will be taken care of."
Carlos Sotolongo, M.D.
Chief of Outpatient Child and Adolescent Services

Since September 11, words like "credible threat," "bio-terrorism" and "post traumatic stress" have entered our everyday vocabulary. The events of that tragic day have had a profound effect on our nation. In the weeks since the terrorist attacks, mental health professionals from around the country have used their clinical expertise to help a stunned nation grieve and cope with unimaginable loss.

St. Vincent's Hospital Westchester reacted quickly in the face of this disaster, offering walk in services, a crisis hotline, a public lecture and a crisis counseling support group. St. Vincent's clinicians volunteered their time to aid family members of the dead and missing, counseled people who had been at the scene or escaped from the area and addressed children and adults at area schools, churches and community groups to help them talk about the events. "It has been both a privilege and an honor to serve our community in this time of tremendous need," says Medical Director Richard D. Milone, M.D.

These have been difficult months for all of us. "Although not all of us have post-traumatic stress disorder," observes Steven Shainmark, M.D., Chief of Adult Services, "we have all been affected by current events. In this heightened state of alarm, we are prepared to see lots of things as threatening, whether they are or not." People are wondering how to adjust to living in a world that feels less safe than it once did. Dr. Shainmark offers the following advice. "It is important," he says, "to question the quality of the threat we are experiencing and to

see *Where Do We Go* on page 9

Looking Back

By Timothy Sullivan, M.D., Chief of Services for the Seriously Mentally Ill, St. Vincent's Hospital Westchester

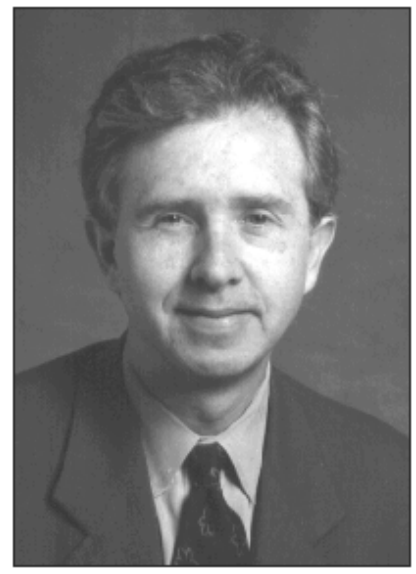
As I write, September 11, though its intensity dims into a chaos of pained and surreal imagery, still dominates my, and our, awareness, as did once those two great towers press the sky, powerful and monumental. What can we say of our mourning for those lost, of our efforts to help those still suffering, or of our struggle to recover?

We have witnessed brutality, and sorrow, beyond our desire to understand and accept. We endure, and grieve, along as many paths of grieving, as there are grievers. We worry, plan, watch and listen, distracted and effortful in our determination to carry on our lives. Can we find a way to make the world a better, safer place, or must we countenance more pain, more misery? When will we know peace?

So many searing images rose in the first days of smoke and darkness, distilled attention and disoriented time. Families searching for the missing, counting promise in days, numb, and struggling to find other eyes that would greet and renew their hope; witnesses reeling, sifting, retelling a story that yearned for an ending; children at improvised memorial sites, placing messages for missing parents, their words simple and suffused with heartbreaking poignancy that made me want to shout and stop time; rescue workers, ironmongers, police and firemen, volunteers, gritty and drained and resolved, lifting ashened hands and rough smiles, as long lines of well-wishers holding placards, water bottles, and food cheered them along their trudge homeward from their grim, perilous work.

I have, in the course of my life and work these last weeks, listened to many tales of loss, of friends and family and colleagues, of young persons fresh and vigorous in their nascent independence, of fathers of newlyweds awaiting the arrival of grandchildren, of couples busy planning futures, until this horror ended future for them. I have heard of fear-fraught escapes, swift glimpses of mercy and sacrifice and heroism, and luck. And I have attended those traumatized at distances near and remote, some simply from the idea of the act, and the images, evil and unimaginable, until now.

Although many facets of our lives have regained a reassuring, familiar hue, we do not have to look hard to recognize the deformity occasioned by our changed circumstances. People tell me of offices of relocated workers, where still the survivor-witnesses talk of little else than their memories of that day, or of its



Timothy Sullivan, M.D.

aftermath. They scour the internet hourly in search of news, and trouble over the safety of the everyday. Many start suddenly at the sound of a siren, go to lunch in groups, avoid the subway. Some will walk across the street to avoid passing beneath a tall building, and hold their breath as they race through Grand Central Terminal. Those who still must travel to work downtown, near to Ground Zero, daily rationalize their risk – believing the surviving structures of the Financial District remain possible targets of further terrorism – and all know colleagues who have left their jobs, out of fear or deference to the fears of loved ones. Vacations, air travel, sporting events, all are tagged with a separate and unaccustomed calculation. Many are out of work, and wonder about their futures, while those who have not faced layoffs wonder if their business, or industry, is vulnerable.

In those days, and since, we have as well been multiply inspired, by acts historical and quotidian. Some events are striking, singular, and indelible: the transcendent sacrifice of the passengers of Flight 93, who willingly brought down their own plane rather than risk others' lives; by the unhesitating heroism of the firefighters, and police, who rushed into what they surely knew was nearly certain death, imbued with duty, honor, and purest charity; by the generosity, patriotism and tenderness of our community, here in New York, and throughout our great nation. Communities, churches, and charitable groups have organized and extended themselves with unprecedented energy and commitment. Good may come, good may yet come, but, oh, at what a cost!

I travel, often, into the City, with my family. There are many places and

see *Looking Back* on page 9

Where Do We Go **from page 8**

allow a little skepticism to factor into our thinking."

Reassuring children and providing them with a sense of safety and security remains a concern among mental health professionals. Carlos Sotolongo, M.D., Chief of Outpatient Child and Adolescent Services says, "Now, more than ever, we need to reassure children that the world is safe and that they will be taken care of." Dr. Sotolongo recommends that parents have their children evaluated if they seem overly clingy, angry or disorganized, as these could all be symptoms of post-traumatic stress. "In general," Dr. Sotolongo observes, "parents seem to be particularly vigilant about how much news coverage their children are being exposed to." He notes that children who have not experienced a direct loss as a result of the tragedy are actually dealing with the current crisis quite well. Children take their cues from the adults around them. While it is important to be truthful, Dr. Sotolongo says, it is also important for adults to monitor their own responses to anxiety and to give children information that is age-appropriate.

What role will mental health professionals have in the coming months? Dr. Shainmark believes that mental health professionals will play an important role in the days ahead, as we grapple with this latest national crisis. Dr. Shainmark says, "One of the most important things mental health professionals can do now is to help people assess whether their responses are an illness or a natural worry. To do this, we need to realize that each of us has a past that informs our current sense of security; experiences we have had earlier in our lives may predispose some people to feeling unsafe more readily than others, faced with the same events. As mental health professionals, it is our job to help people separate past factors that could color or distort our reaction to the present." He adds "perhaps we can say that one of the only good things to come out of this is that it has enabled people to take care of their emotional health who otherwise might not have. The events have, in a sense, given us, collectively, permission to talk about our mental health care needs."

Andrew Adler, Ph.D., who ran the crisis support groups offered by St. Vincent's following the tragedy agrees. "In the coming months," he says, "I suspect we will continue to see an increase in the number of people with anxiety, worrying about whether they are safe going about their regular, every day lives." Dr. Adler, who directs the Partial Hospital at St. Vincent's also believes that the events had an impact on those already in treatment for mental illness. "For patients with mental illness," he adds, "the events exacerbated many of their symptoms. As mental health professionals, we need to be particularly attuned to how this traumatic experience has impacted our patients' difficulties."

St. Vincent's is continuing to see individuals with post traumatic symptoms. For more information about treatment services at St. Vincent's, please call 914-925-5320. St. Vincent's is part of Saint Vincent Catholic Medical Centers, now one of the largest behavioral health care providers in the Northeast.

Looking Back **from page 8**

neighborhoods we enjoy. We often eat lunch or dinner in Greenwich Village, old haunts for both my wife and I. And, in the last few years, we had, as a family, discovered downtown. My daughters, and son, liked to run on the promenade at Battery Park City, and, after, we would often see a movie at a theater there with big screens and short lines. As we waited in the foyer, we looked out the large windows, and there, shadowing us, were the World Trade Center Towers, immense, vast and powerful, prying exclamations of praise from three little girls who never imagined anything that tall, giants' staffs, columns securing the sky.

When we told them about the tragedy, gently, and with as much reassurance as we could muster, they were quiet. A little while later, the youngest of the girls, just exuberantly entering kindergarten, asked, "Why are they trying to kill the City?"

We determined to take them into the City that first weekend after the attacks, subdued and sparsely traveled as we knew it would be, to show them the City was still alive. We went as far down as Greenwich Village, and had dinner at one of the several small restaurants we love along the stretch of Hudson Street north of Christopher, pampered by a grateful maitre'd. We walked in the early evening along the blocks, past dinnergoers repopulating the sidewalk tables. The air was faintly acrid, and looking downtown along Hudson Street you could see the emergency lights of police cars blocking the streets below Canal, and further, the strangely suspended still plume of smoke, glowing with reflected floodlight, that marked the center of our sadness.

But our girls frolicked, and teased their baby brother, and petted patient dogs, and people smiled at them, and cooed at the toddler. The onlookers seemed glad of their presence and their unselfconscious joy. We were glad we went.

And so we find ourselves making history, personal and aggregate, as we tread through danger. Each of us finds our way of coping, and healing, the head of that path, when we accept we cannot walk it alone. We anchor ourselves, in one, or more, of the communities, in which we work, or live, or pray. We talk, about what has happened, and what we fear. We listen to others, each for the other, abiding pain and anger, offering nourishment when we can, stopping sometimes, as upon an outlook, where we can see where we have come along the path so far, and where we have yet to go.

Most importantly, fervently, most of all, we battle helplessness. We face uncertainty. We have been forced to contemplate death in a newly incorporated shape, sudden, unpredictable, enormous and undeserved. We remind ourselves that we cannot accept living in terror. We return to comforting rituals, traditions, diversions and festivities. We become, remain informed about the risks we face; become, remain involved through constructive action that will strengthen our communities. We live out tolerance in our acceptance of the varied responses, within our families and communities, to the terrors that we face. We demand justice, but not vengeance. We seek to find expressions of mercy and compassion for those suffering here, and in places where our hopes, visions and intentions are not yet understood. We know that we can greet the fear that has thrust its icy fingers into our hearts, and, in time, together, with help, we can bid it to be gone. We remember, and we honor. So we may, in imagining the peace toward which our path tends.

Parity Legislation Passage Imperative

Evelyn Roberts, Executive Director
NAMI - New York City Metro

Over the past several years, 32 of the 50 states have enacted some form of parity legislation—legislation that mandates health insurance coverage for treatment of mental illness at the same level as coverage for other illnesses. So far, New York State has not enacted a parity law, although various parity bills have been proposed in both the Assembly and Senate over the past few years, including this year. In New York State, resistance to parity legislation appears to reside mainly in the Senate, which has proposed parity bills that are much more limited in the scope and population covered (such as the newly introduced S.4209) than, for example, the more broadly comprehensive bill proposed by the Mental Health Committee's new chair, Martin Luster (A.4506).

Why are legislators in New York State and elsewhere reluctant to pass a comprehensive parity bill?

Perhaps they mistakenly believe that mental illnesses are untreatable. In fact, mental illnesses are more treatable than many other illnesses that are currently covered much more comprehensively by insurers. For example—while the treatment success rate for heart disease ranges from 41-52%, the treatment success rate is 60% for schizophrenia, 65%-70% for major depression, and 80% for bipolar disorder.

Evelyn Roberts

Perhaps they mistakenly believe that parity is too expensive to implement. In fact, implementing parity laws is not as expensive as earlier analyses—especially those provided by the insurance industry—have suggested. Evidence of the effects of recently passed parity laws, according to the Surgeon General, shows that "parity results in less than a 1 percent increase in total health care costs." Coopers & Lybrand's actuarial study prepared for the 1997 Vermont legislative session on mental health and substance abuse parity projected the percentage cost impact on employer claims to be an increase of 3.4%; after cost offsets, the expected employer contribution would be only 1.4%. In June 2000, the National Advisory Mental Health Council reported that parity results in only minimal increases in total health care costs, recently estimated at 1.4% in total health insurance premium costs; in one state studied, total health care costs actually *decreased* after parity was implemented.

The Bank One Corporation instituted parity for its 100,000 employees, and found that parity is not only good for employees, families, and communities but also good for business. After Bank One instituted parity, mental health benefits paid dropped from 15% to 6% of total costs—because of education, preventive services, worksite programs and health clinics, and enhanced mental health benefits. Other employers, including Black & Decker and Federal Express, have found that providing health insurance that covers mental illnesses is not only affordable but leads to increased productivity.

Perhaps our legislators are unaware of the terrible costs of not providing parity. Many Americans with mental disorders currently do not seek treatment, despite the availability of successful treatments—and untreated mental illnesses increase the burden of disability on individuals and on society and the economy. One-third of homeless people in the U.S. have a severe mental illness. Four times the number of people with mental illnesses who were in state mental hospitals in the U.S. were incarcerated in prisons and jails (in 1998). Prior to incarceration, mentally ill offenders have a higher rate of homelessness and unemployment than other inmates.

Individuals who do get treatment for mental illness can expect to have a much higher out-of-pocket burden than those being treated for other illnesses. Congresswoman Lynn Rivers of the U.S. House of Representatives reported that 50% of her family's take-home pay went to pay for her treatment for bipolar illness. A family with mental health treatment expenses of $35,000 a year, pays an average of $12,000 a year out-of-pocket, compared to only $1,500 out-of-pocket for non-mental-health medical/surgical treatment expenses.

The lack of parity clearly has a high cost for individuals and families afflicted with mental illnesses. Parity would alleviate this discriminatory burden on

see *Parity* on page 30

In The Aftermath - Reflections On Crises And Trauma

Richard Gallagher, M.D.
Medical Director - Westchester CPEP and Mobile Crisis Team

The whole country and especially our New York City metropolitan area may rightly be said to be in a "crisis" and convulsed with the "trauma" of the September 11th World Trade Center tragedy. It has even been reported that we live now in a "Post-Traumatic" era. Since these phrases are so widely bandied about as of late in the media and among the lay public both, it is useful to be more precise about use of these terms and concepts as they are generally and more specifically employed and addressed in the mental health field.

What sets apart the trauma of the September 11th terrorists, of course, was its sheer magnitude, both in terms of the thousands of deaths and massive destructiveness involved, as well as of its strong effect on so many of us not even directly involved or related to the victims. A Pew poll found, that seventy percent of Americans have felt "depressed" at times since the attacks and a full third reported difficulty sleeping.

But, of course, we have come to know that a history of trauma, to varying degrees, is a part of many people's lives, as is the possibility of going through an emotional or psychological crisis. How then are we to think most usefully about these two distinct, albeit related concepts?

Richard Gallagher, M.D.

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

Like the eighteen other crisis teams in New York State, the Westchester Mobile Crisis Team (MCT) based at the Behavioral Health Center of the Westchester Medical Center, specializes in the management and brief treatment of these crisis situations. It handles thousands of calls a year and makes over 2200 community visits for crisis-related episodes annually. While we have found that the route of a crisis, the "crisis pathway", is quite complex, there are some distinct patterns and generalizations about crises that bear emphasis.

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

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

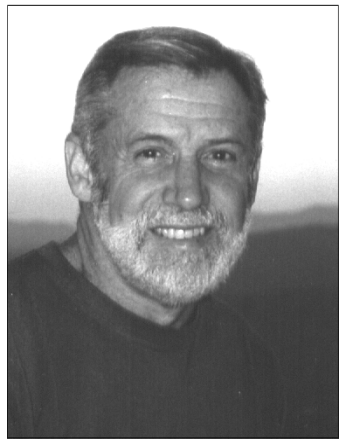
These typical cases examples should not prompt a "pathologizing" of the crisis situation. A crisis, brought on by any of multiple reasons – some commonplace - can be a growth opportunity, as well. Healthy individuals may have their own crisis proclivity, though generally recover without involvement of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

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

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

see *In The Aftermath* page 14

Setting Priorities In the Wake of September 11th



Lanny Berman, Ph.D., Executive Director, American Association of Suicidology (AAS), Washington, DC

"Two things were immediately apparent following the incidents of September 11th. One was the tremendous shared communal grief and experience that was actually protective of the immediate negative traumatic sequence of events.

That sense of sharing our grief and our experiences and the gathering of information through TV and News broadcasts, decreased our isolation from others and brought a sense of togetherness.

For some people September 11th reactivated early traumatic experiences and thereby heightened their terror, their generalized anxiety and other symptoms.

With regard to suicidality, I believe two things will also be apparent in time. One is in the short term: suicides and non fatal suicide behaviors *will decrease* – which occurs when there is an increased sense of communality among people. However in the longer run, if our experience after the Oklahoma City bombing is prototypic, we may well expect *an increase* in suicide rates and more suicidal behavior as we distance ourself from the immediacy of September 11th.

Clearly, we should be on alert for such possibilities and be keenly observant and ready to respond from a clinical perspective – and from our general human concern for others."

Jack Guastaferro, Executive Director Restoration Society, Inc. Club Houses - Buffalo, NY

"The priorities of our mental health system must include a greater focus on trauma and stress management related to 9/11 and subsequent terrorist attacks, but must not ignore nor decrease funding for ongoing community mental health efforts. Access to these services is critical, especially as folks try to cope with the terrorist attacks and return to "normal" lives and routines. We are not prepared to deal with ongoing terrorist attacks or bio-terror without a stronger trauma management strategy."

Chris Ashman, M.S., Commissioner Orange County Department of Mental Health, Goshen, NY

"The ripple effects of the events of September 11th, the fear of further terrorist acts, and the reality of our country going to war are being felt across Orange County. Our citizens affected directly and indirectly are receiving support from friends and neighbors, their clergy, their schools, and from professional mental health service providers when necessary.

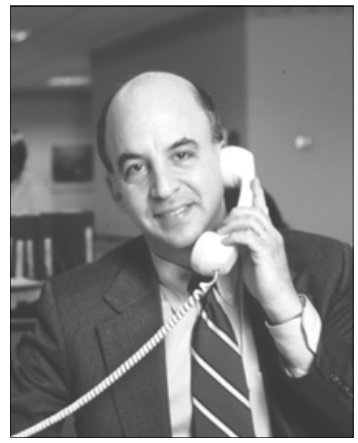
A well-integrated collaboration of community organizations is offering this support, as well as cash assistance, pro-bono legal counsel and pro-bono financial planning services. We are all in this for the long-term."

Rep. Nita Lowey (D-Westchester)

"September 11th was a traumatic event for all Americans, particularly New Yorkers. There are so many families for whom life will never be the same, and every American's sense of security has been threatened.

Access to mental health services for families who have lost loved ones is absolutely essential. In fact, services to help cope with the events of September 11th should be available to everyone.

However, many insurance companies do not offer equitable coverage for mental health services. That's why I'm a cosponsor of the Mental Health and Substance Abuse Parity Act of 2001 which would require insurance companies to provide the same treatment coverage for mental illness as physical illness. As New Yorkers work to recover from the attacks on our country, I will continue to fight for better mental health care for all Americans."



David W. Brody, M.D., Director, Behavioral Health Services, Arden Hill Hospital, Goshen, NY

"My sense is that the biggest priority remains public and professional education regarding anxiety/stress disorders and mood disorders. Although only a small percentage of individuals will develop symptoms requiring treatment, the large number of persons who were either directly affected or who witnessed the attack will mean that a significant number will need intervention. We know that most people with symptoms of psychiatric disorders do not present to psychiatrists or other behavioral health professionals; they present to other physicians and/or talk about their experiences and feelings with family, friends, clergy, employers, and such. So it is important to talk frequently and plainly to a wide audience—professional and lay—about the potential significance of symptoms such as withdrawal/avoidance, flashbacks or recurrent/intrusive thinking, sleep loss, depressed mood, and so on."

Diane Tresca, Associate Executive Director, Putnam Family & Community Services, Inc. Carmel, NY

"In the wake of September 11, 2001, all of our lives as we once knew them have changed. As mental health professionals, we need to continue to provide quality treatment services to those in need and to be supportive of our families, children, friends, colleagues and communities but most importantly take care of ourselves. We cannot go back to what we knew as normal. We must go forward into the future."

Constance Lieber, President, NARSAD The National Alliance for Research on Schizophrenia and Depression

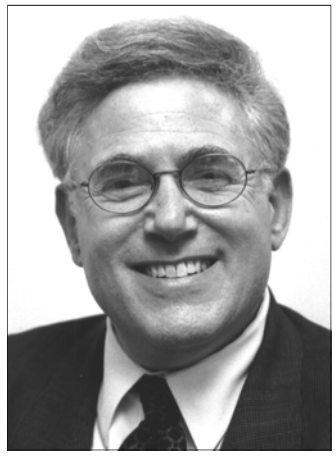
"The tragic events of September 11th and the threat of further destruction of life demand our best responses. The psychological trauma caused by these attacks emphasizes the need for effective understanding of the brain and behavior. We are challenged by the needs of the families of the victims, who bear the lifetime burdens of mourning, stress, anxiety and depression. We face a society that is suffering with new insecurities, disrupted lives and deep sense of hurt. NARSAD's Scientific Council has long emphasized the need to understand and overcome stress and crisis. NARSAD has funded numerous studies that provide greater understanding of the impact of trauma in all its forms. Our programs have supported more than 100 scientists studying how people react to stress, crisis and trauma. We hope that NARSAD can be a beacon in this crisis."

Nadia Allen, Executive Director Mental Health Association in Orange County, Goshen, NY

"The effects of the tragic occurrences of September 11th are being felt in our local community. Many Orange County residents work daily in New York City. Henceforth, many families have been affected directly or indirectly by the recent events.

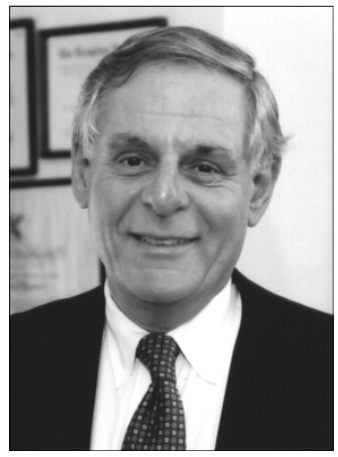
We strongly believe that individuals affected by the 9/11 attacks will continue to need to express their feelings about the events."

Setting Priorities In the Wake of September 11th



Alan B. Siskind, Ph.D., Executive Vice President, Jewish Board of Family and Children's Services, (JBFCS)

"We need to understand the work that needs to be done following the WTC attack within the context of our pre-existing work. The world has in some-ways changed and the demand for thoughtful and quality interventions on the part of the Mental Health community have and will continue to increase. At the same time, this is not the first time we feel vulnerable and anxious as a community (or as multiple communities) and we need not reinvent our relationships, or our understanding of our work or our relationships totally. To the degree we can borrow on our pre-existing knowledge and relationships is the degree to which we can provide continuity and thereby reassurance that we can and will help. To totally redefine our context, at this point, is unnecessary and probably unproductive"

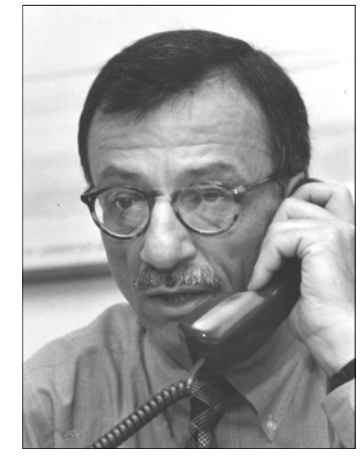


Richard D. Milone, M.D.
Medical Director
St. Vincent's Hospital Westchester

"In the difficult days since September 11, we have struggled to explain and understand events that before this we never really believed could occur. As mental health professionals, it is important for us to use our expertise to be service to others during this time of sadness and fear. We can offer the comfort to the grieving, and we can work hard to allay the pain of anxiety and fear. We can and should use our skills to help those in our community who are suffering from these events. In one form or another, we are all victims; our lives are changed forever. These events of the past several weeks have also given us an opportunity to educate the general public about grieving, depression, post traumatic stress disorder, panic disorder and other similar ills. In the months ahead, I hope that we will be able to further the public's understanding of and empathy for individuals who are suffering the trauma of these events, and that we can create an environment where more people feel comfortable seeking help."

Janet Z. Segal
Chief Operating Officer,
Four Winds Hospital, Katonah, NY

"What have we learned in the wake of the attacks on September 11th? The lessons have been profound! We have learned not only that tragedy has united us as a nation, but even more startling, that it has de-stigmatized mental health problems in the workplace, in schools, and in families. No longer is there shame attached to open anxiety, stress and grieving in the workplace. Corporate Managers, School Personnel and Parents have had to become instantly knowledgeable about the effects of stress and anxiety and simultaneously compassionate for those who suffer with these symptoms of trauma. A parallel process of human and humane care was systematically deployed to help those suffering with the effects of a trauma so pervasive and intense that it has affected an entire nation. The nation has been united in a myriad of ways – not the least of which is the issue of mental health."



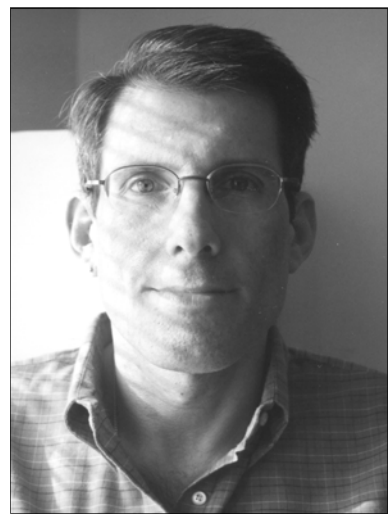
Phillip A. Saperia, Executive Director, The Coalition of Voluntary Mental Health Agencies

"The community mental health sector has been part and parcel of the rescue and relief effort in New York City-from Ground-0 to family centers to neighborhood venues. The outpouring of help from agencies and staff was spontaneous and unquestioning. And still we expect the demand for mental health services to increase. We expect it because the evidence tells us that it will and because people are facing the continuing threat of terror in all aspects of their daily lives. Yet no plans exist to shore up a system that before the disaster was facing staff turnover rates of 36-54%? Can we find the resources and the will to fund the system of essential community based care when energies and resources are focused on war and homeland defense? The fraying infrastructure of the community mental health system must be repaired and considered in planning for future disasters and to ensure a continuing mental health safety net for New Yorkers."

Karen A. Oates, D.S.W.
President & CEO, Mental Health Association Of Rockland County

"The Mental Health Association is involved in crisis intervention debriefing counseling, trauma counseling and mental health education with children and adults. What we have learned from September 11th is that people are resilient, that all of us can be impacted in our daily lives after such a traumatic event, and that services need to be available in the communities where people live and work. We have also, as clinicians, seen how people cope and the strategies they use to rebuild their lives in times of crisis.

As we move forward the mental health community will need to look towards working together to restore individual community health as we attempt to heal from this tragedy."

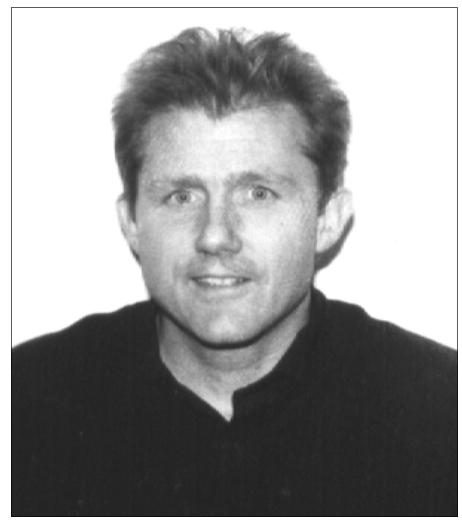


Josh Koerner, Executive Director
CHOICE
New Rochelle, NY

"Children whose fathers were crushed to dust can expect to be treated as enemies of the state if they become mentally ill. It happened to me, and it can happen to them unless we alter the agenda of our mental health system."

Barbara G. Melamed, Ph.D. ABPP
Professor - Division of Social and Behavioral Sciences, Mercy College

"At Mercy College we lost many family of our firefighters and police officers. One young policeman shared with me his outrage when he noted the ashes on the soles of his feet after serving at Ground Zero. Those were the souls of those lost. He could not throw those lives away. We have surveyed over one thousand students and faculty regarding needed services in the wake of the disaster and are continuing to find that optimism is not lost. The data will be available after the third month anniversary as we are continuing to survey on the black Tuesdays. I am predicting that except for those who lost relatives or were injured only 2% of the population will actually develop posttraumatic stress disorder. We are resilient. The best protection for stress is social relationships with folks who mean something to us."



Jim Killoran,
Executive Director
Habitat for Humanity of Westchester

"During this time of challenges, we cannot live with fear, but with faith of a better future. To that end, staying positive, getting involved and helping others will help the world change. Maybe September 11th will be remembered as the day we loved more as a society and changed the world for the better."

Setting Priorities In the Wake of September 11th

Michael J. Silverberg, Esq.
President
NAMI-NYC Metro

"We continue to need to have a steady stream of funding for supported community living and a broad spectrum approach to rehabilitation in which all aspects of a persons life is taken into consideration. It is not enough to *only* provide housing and medications to people with mental illness—we need to consider how best to help them regain a good job and relationships which will help reintegrate the person into the community. More efforts need to focus on Family Psycho-Education and the incorporation of ACT and PACT models of rehabilitation."

Julie A. Domonkos, Esq.
Executive Director
My Sisters' Place, White Plains, NY

"For people who have previously suffered trauma in their lives, a new trauma such as the terror attacks can revive the pain of the earlier crisis. Domestic violence victims sometimes feel more vulnerable and relive the pain and fear of their abuse as well as suffer from the current crisis. We are seeing this among the women who come to My Sisters' Place for help. We want abuse survivors to know that we are here for them. We also want women currently being abused to know that their abuse is no less important just because we all face a threat from terrorism. They have a right to live free of abuse and My Sisters' Place is here for them. Our 24-hour Hotline is 1-800-298-SAFE."

Rami Kaminski, M.D.
Medical Director of Operations
NYS Office of Mental Health

"In my opinion our priorities should stay the same, namely, unqualified help and support to the patients and their families. It is especially in times of great shift in public focus, that we have to stay focused on our mission. Obviously, we have to pay attention to the emotional needs of the population at large, but that has always been part of our mission. We might have to learn more about "communal PTSD" and how to best address it. But in essence, I believe we are well prepared to deal with the crisis whilst continue to adhere to our everyday responsibilities."

Virginia L. Susman, M.D., Associate
Medical Director, NY Presbyterian
Hospital, Westchester Division

"The tragedy of September 11, 2001 and the subsequent fear and uncertainty have established two sets of priorities for mental health. First, the trauma and loss caused by the terrorist attacks require mobilization of efforts to teach about the signs, symptoms and consequences of stress and trauma and to support and care for those suffering from these problems. Secondly, continuing concerns over further terrorism challenge mental health services to provide a balance of support, education, and acknowledgement that everyone is facing unprecedented personal and societal anxiety and that we will need to work together to find new ways to adapt."

Form-Link Revolutionizes Application Forms

Staff Writer
Mental Health News

A simple technological advance has just arrived, and it's introduction signifies a major solution to making life a bit easier for persons with disabilities.

FORM-LINK© is a CD-ROM which brings together over 70 application forms used to access social services. FORM-LINK© delivers more services in less time and less stress than the traditional referral model.

All but the most determined of technophobes would agree that information technology has improved our lives. It's brought us the paperless office, desktop publishing, sophisticated databases, and the Internet. Even the simplest of technical solutions can have a big impact on people's lives.

One good example of this is FORM-LINK©. FORM-LINK© is distributed to case managers employed by hospitals, community and government agencies, and other care and support organizations (all of whom pay a nominal $1 licensing fee). Once a case manager has assessed a client's needs, they can print out all the relevant forms from the Form-Link© CD.

Before FORM-LINK©, the needy (whether mentally or physically disabled, homeless, seniors, the addicted, etc.) had to go to various agencies – often miles apart – to pick up the forms they needed to apply for help. This resulted in people's already painful situations being made worse. Because FORM-LINK© brings all the social services forms together in one place, people now only have to go to one agency – cutting both the stress and the legwork.

The current scope of application forms includes most government agencies - Social Security Administration, Department of Social Services, Westchester Department of Community Mental Health, etc., as well as local community agencies which provide food, clothing, legal assistance, credit counseling, jobs, crisis services, etc. to qualified applicants.

Center For Career Freedom

FORM-LINK© was created by Don Fitch, M.S., Executive Director of The Center for Career Freedom, a not-for-profit organization based in White Plains, New York, that helps people with psychiatric disabilities re-enter the workplace.

Mr. Fitch explained how the idea for FORM-LINK© came about. "We'd been collecting application forms for some four years but it just didn't make any sense to copy them and hand out huge books to all the case managers at institutions in Westchester County. Coming from the business sector as I did, the obvious solution was to scan the forms and put them on a CD-ROM."

Help From the Business Sector

The only problem was Don didn't know anyone who could help him scan the forms. So when he saw a newspaper article about Data Conversion Laboratory, he called up the company's president, Mark Gross, to see if he could help. "When Don told me about FORM-LINK© I thought it was a great idea," recalls Gross. "And to help him get started, I told him we would do it at no charge."

The team at DCL duly scanned the application forms and converted them to PDF files, which can be read on any computer system in the free Adobe Acrobat Reader software, and printed when needed. The files were then put on CD-ROM.

"I'm very grateful to Mark and the DCL team," says Fitch. "Without their help, it would have taken many more months to make Form-Link© operational. We simply don't have that kind of equipment or budget."

Fitch plans to take FORM-LINK© a step further in 2002 and make it available online from the Center for Career Freedom website (Freecenter.org). This will make it even easier for case managers and institutions to access and deliver the gamut of forms needed by people applying for social services.

FORM-LINK© is Unique

To people in the business world, scanning application forms and putting them together in one place on CD-ROM or on the Web, might sound like the obvious thing to do. But apparently no one thought of it before.

"We believe Form-Link© is unique in that it begins with the client's needs and approaches service delivery from the consumer's point of view, not from the agency perspective." "The not-for-profit sector spends money. They don't make it, so they're not generally used to looking for ways to deliver better services at less cost." "Because I came from the commercial sector (Fitch was in marketing at Pepsi Cola), I was able to more readily apply a business solution to a not-for-profit challenge".

Worldwide Appeal

Although FORM-LINK© is currently distributed to community agencies in New York State, it will likely get picked up in other parts of the U.S. and even other parts of the world; such is the strength of the idea. Not only is this relatively low-tech solution making life easier for the needy, it also improving the efficiency and cutting the cost of delivering social services – a fact that we believe will not go unnoticed by those holding the purse strings of public funds worldwide.

For more information on how your agency can obtain FORM-LINK© contact Don Fitch at the Center (914)288-9763 or by E-mail at DonFitch@Freecenter.org

In The Aftermath **from page 10**

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

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

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

Fortunately, like most crisis teams around the state, ours has a number of psychiatrists directly involved who can arrange hospitalization when necessary. We have 12 full-time, and a number of part-time, psychiatrists distributed over three sites in the county, in addition to about thirty other licensed clinicians who are also able to facilitate hospital referrals, if needed. The presence of psychiatrists, nurses, and physician assistants is indispensable when the situation warrants, for instance, when there is a role for immediate, adjunctive medication. Pharmacotherapy can help the crisis patient through their most troubling, acute symptoms, such as pain, psychosis, or severe depression. Severe crises can at times involve the failure to control one's impulsivity or outright self-destructiveness. Crisis clinicians, while respecting autonomy, must also be prepared, therefore, to be decisive when warranted in securing safety, always consistent with the responsibility and commitment to use the least restrictive alternatives possible.

When turning from crisis treatment to "trauma work" per se, one is struck by both the overlap and the differences. Though not the rule, as already noted, a crisis can, of course, be precipitated by traumatic events. Recently our own crisis team has been consulted on numerous occasions by individuals desirous of learning about trauma, coping directly with the Manhattan attacks, or suffering the grief of having lost someone close to them. Traumas cannot be said, however, to have the potentially positive impact that crises can sometimes eventually evoke. In discussing the estimated 10,000 children directly related to victims of the World Trade Center collapse, one local newsmagazine averred that these children might come out "stronger". The proposition seems reminiscent of a sentiment occasionally voiced in the older, psychoanalytic literature that incest might be salutary at times, now thankfully a thoroughly discredited notion. Trauma is destructive by its nature. We can only contain and

see *In The Aftermath* page 34

MIND MATTERS

You are Cordially Invited to attend a multi-faceted Major Event including an Art Exhibition, Symposium and Musical Performance designed to Raise Awareness, and Increase Public Support for Research Breakthroughs in Mental Health

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***Friday, January 18th 6pm-9pm: Gala Opening Night and Silent Art Auction** (admission $50)*
Reception catered by NOBU

***Saturday, January 19th 2pm - 5pm: Mental Illness Symposium** (free of charge)*
featuring lectures on the most recent advances in research and treatment of Schizophrenia, Depression, and Anxiety Disorder by leading scientists and doctors. In light of the recent 9/11 tragedy, the issues surrounding Post Traumatic Stress disorder will also be addressed.
Featured Speakers:
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Jack Gorman, M.D., Columbia University College of Physicians and Surgeons
Daniel Weinberger, M.D., National Institute of Mental Health
Andrew Solomon, author of The Noonday Demon - An Atlas of Depression

***7:30 pm - 8:30 pm: A Musical Performance by a Renowned Jazz Artist** (admission tbd)*
8:30 pm - 10:00 pm: Reception catered by Tribeca Grill

***Sunday, January 20th 10am - Noon: Art Lectures** (admission tbd)*
Lectures on the relationship of art and mental illness, as well as self-taught art and "outsider" art.
Opening Remarks by Robert Rindler, Dean of the School of Art, The Cooper Union
Rebecca Hoffberger, Director and Founder of the American Visionary Art Museum
Roger Ricco of the Ricco/Maresca Gallery

***2pm - 5pm: Related Lectures** (admission $25)*
Oliver Sacks, Neurologist and author of Awakenings and The Man Who Mistook His Wife for a Hat
Temple Grandin, Professor, lecturer and author of Thinking in Pictures

Mind Matters will feature artwork donated by organizations, artists and galleries that support artists with mental illness.
Participating Organizations: Anchor House, Art + Community, Artist Cares, Candee Hill Group Home for Autistic Adults, Community Access, Creative Growth, Creedmore Psychiatric Center, The Living Museum, Fountain House, Gateway Crafts, GRACE, NARSAD Artworks, NAMI, NIAD, Ricco/Maresca Gallery, Spindleworks, Studio-11, VSA, (list in formation)

All Artwork will remain on view through February 10th 2002

For Tickets & Information Call Kristy Dodson at NARSAD

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Guidance On Helping Bereaved Children Who Have Lost a Loved-One

By Cynthia R. Pfeiffer, M.D., Professor of Psychiatry, Director, Childhood Bereavement Program, Well Medical College of Cornell University, New York Presbyterian Hospital

The tragedies on September 11, 2001 when the World Trade Center and Pentagon were attacked and a hijacked airplane crashed in Pennsylvania began unprecedented experiences for thousands of children. There were those who lost a loved-one as a result of those events. Others were displaced from their homes, schools, and friends. Estimates indicate that approximately 6000 children suffered the death of a loved-one in the horrific events of September 11, 2001. Certainly, concerns about how children cope with loss and to what degree their development will be affected have become major concerns for parents and professionals, who work with children. Soon after these unfortunate events, people realized the significant need for answers to numerous questions about how children grieve and cope with the death of loved-ones. This article is written for parents and professionals, who work with children. It aims to provide guidance in understanding children's responses to the death of a loved-one. It is hoped that this article will present information that can aid parents and those who work with children to support the processes of children's bereavement and to promote their healthy adjustments.

Theories have been proposed about characteristics of bereavement; but most were based on clinical observations of adults. Sigmund Freud, among the seminal thinkers about bereavement, described adult's responses to death of loved-ones in terms of mourning or melancholia. Mourning involves expectable thoughts and behaviors after the death of a loved-one. These responses include intensive repeated preoccupations of the deceased, longing to be with the deceased, behaviors to maintain a sense of closeness with the deceased, such as going to places that involved the deceased and maintaining objects that belonged to the deceased. These were expected responses that involved features of mourning that are usually experienced after the death of a loved-one. In contrast, a problematic phenomenon is melancholia. This is a serious form of bereavement that is based on conflicted relationships with the deceased. It is most manifest as severe depression and it includes intense guilt about causing the death and surviving the death, depressive feelings, and problems with sleeping, eating, and other somatic complaints. Those with melancholia may experience severe impairments in daily functioning, withdrawal from activities, and loss of interest in pleasurable endeavors. Those with melancholia may experience intense wishes to die and suicidal thinking. Treatment of this condition is necessary.

While Freud described these bereavement responses in adults, he proposed that children were too immature to grieve and mourn. Others agreed with Freud's ideas about childhood bereavement. Subsequently, clinicians and researchers, deriving ideas from direct observations of bereaved children, suggested that children have the capacity to mourn and that bereavement is an expected response of children to the death of a loved-one.

Cynthia R. Pfeffer, M.D.

There has been relatively little systematic and reliable information gathered about children's bereavement after the death of a relative resulting from war-like events, such as the attack on New York City and the Pentagon. Kaufman and Eliza, working in Israel, reported on a study of children whose fathers died in combat. These children were followed from the time of their father's death to approximately four years after this event. The results of this study suggested that children who experienced the sudden, unexpected death of a parent in combat suffered from psychological problems for years. The types of problems these children exhibited included frequent crying and moodiness, anxiety, over-dependence on adults, separation problems, aggression, fears of injury, restlessness, poor concentration, and learning problems. Approximately, 50% of the children exhibited these problems four years after the death. Many required professional help to decrease their symptoms.

Characteristics of Children's Grief and Mourning

Children's responses to the death of a parent, sibling, or other close relative vary depending upon children's cognitive and emotional development. Some characteristics are listed below.

Infants and toddlers, age 0-2 years, respond to the death of a loved-one mostly in physical ways with increased crying, irritability, sleep disturbance, changes in appetite, and withdrawal. Infants react to changes they sense in the household, especially the mood of their parents. When language is more fully developed at approximately 2 years old, toddlers develop immature concepts of death. Toddlers consider death to be similar to brief separations, such as when the mother leaves the house to shop or when the child falls asleep. This occurs because toddlers do not have objective concepts of time. Brief separations from the caretakers may be felt as a permanent loss that is similar to someone dying.

Preschool children, age 3-5 years, who are grieving may experience intense anxiety and insecurity about separations and are very sensitive to the emotions of their caretakers. They may revert to past behaviors such as thumb sucking and bedwetting. They may be sad, fearful, cry more often, cling to others, and have difficulty sleeping. Because their vocabulary is limited, preschool children may have difficulty talking about their grief. Grieving preschool children usually consider death as temporary because their concepts of time are not mature. When a preschool child is told that someone has died, explanation about what has occurred is necessary. For example, a preschool child may be told that "Daddy is dead. He cannot breathe. He cannot eat. He cannot come home. He cannot be with us. Being dead means that daddy can no longer do these things." Statements, such as these, need to be repeated to preschool children. They may believe that they have magical powers that caused the death and that they can make the deceased return.

Young school age children, age 6-7 years, may ask many questions about the death of a close relative. Such children often say and act upon what they feel. They often will talk about missing the deceased, but they often will talk about them in a happy way. Young school age children feel comforted by thoughts that their dead relative is somewhere nearby and perhaps watching them. Some bereaved children may carry on imaginary conversations with the deceased. Some may talk about wanting to die and be with the deceased. Young school age children may feel very anxious about separating from the parent who is taking care of them. They worry about the health and safety if their surviving parent and will need comfort and reassurance. Grieving children may worry about who will help them with their homework, playing sports, going shopping, etc. They may feel guilty that they did something to cause the death. They may cry often, have temper tantrums, and show more irritability in their interactions with others. They may have headaches, stomachaches, eating problems, and difficulty sleeping. They can conceptualize that when someone dies, the deceased is not able to be with the family. However, young school age children do not have clear concepts that death is permanent. While they may say that the dead person or pet cannot come back, children of this age may have beliefs to the contrary and that in time the deceased will appear again.

Older school age children, age 8-9 years appear to show less expressions of grief. They may express emotions only sporadically. They may feel that it is important to be strong and brave for their surviving relatives. However, children of this age grieve. At this age, family is still the center of children's lives. They do not yet have the strong support of friends and classmates to talk with about their feelings. School age children may contain their feelings of sadness and loneliness. They may worry about the health of their surviving parents. Maintaining children's routines is very important. School age children appreciate rules and need to know what to expect most of the time. They take comfort in things remaining as they always have been. Children of this age may feel that an unknown force that takes people away causes death. School age children may be afraid of dying and have problems falling asleep for fear that they, too, may die.

Preteen children, age 10-12 years may show frequent mood changes after the death of their loved-one. Much of their behaviors and feelings are influenced by their entering adolescence although the biological changes of puberty may not be fully perceptible. Preteen children may show distinct irritability, crying episodes, and have problems falling asleep. They may exhibit oppositional behavior and increased arguments with their surviving parents. They may blame the surviving parents for the death of their relative. By the age of 12 years, most children have mature concepts of the permanency of death.

Young adolescents, age 13-15 years, wish to be more independent and are very interested in being with friends after the death of a loved-one. However, they also continue to seek guidance and support from their parents. Their responses to the death of a close relative may be expressed as emotional variability with withdrawal, resentment, and anger in their interactions with parents. They may test limits, be stubborn, and rebellious. They have more complex concepts of death that include its permanence and thoughts of an afterlife.

Older adolescents, age 16-18 years, who are bereaved by the death of a loved-one, may show sustained and profound sadness, crying, anger, bitterness, depressed mood with sleep disturbances, helplessness, and feelings of being overwhelmed. They begin to experience mourning in ways that resemble that of adults. They may consider the deceased to have been a role model and as someone who was important in helping them develop values and a sense of identity. They may feel distracted from school, sports, and other activities, and may experience a decline in these areas. They may begin to use drugs and alcohol, have

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bouts of anger, argue with parents, and test limits by demanding more time away from home. Some may volunteer to help at home while others may resent increased demands and responsibilities.

Complications in Children's Grief and Mourning

Children's grief and mourning may be complicated when the death of a relative is sudden, unexpected, and unnatural. For example, as a result of the events of September 11, 2001 some children may experience bereavement that is associated with signs of trauma. These signs may include experiencing severe anxiety or fear, nightmares, repeated thoughts of the scene of the death, distress over events that resemble or symbolize the death, lack of responsiveness and withdrawal from others, and increased startle or arousal that occur with intense emotional liability including crying and anxiety.

Another complicating factor for children's grief and mourning is if children have not received clear, truthful explanations of what happened regarding the death. Without such explanations, children may feel confused, anxious, be mistrustful, think there are secrets, and feel guilty that they caused the death. This may be associated with children having problems with their behavior evident as aggression, argumentativeness, intense anxiety, and beliefs that there are secrets about the death.

Other Factors that Influence Children's Grief and Mourning

The responses of the family to the death of a loved-one affect children's grieving. Specifically, the way the parents are coping, how the family communicates, and the degree of support from other relatives are important family influences on children's grief responses. Some children may feel worried and fearful in observing parents grieve. Children may withdraw and not want to talk to parents about the death because they fear that they will upset their parents. This may increase children's sense of isolation, confusion about what happened, and intensify their grief. Availability of other relatives who can involve children in activities and engage them in discussion about the death are helpful in decreasing the pain of the loss and enabling children to carry on with their usual routines, interests, and responsibilities in school and with friends.

Support within the community is essential to assist children cope with the death of a relative. Instrumental in this is the support from school professionals to facilitate children's conversing about their feelings and ideas regarding the death of a close relative. School professionals can organize a plan to enable bereaved children to interact with others and carry out academic tasks at a pace that is compatible with the children's capacity during the period of acute responses to the death of their relative. Time away form the grieving family may help children speak about their own concerns and return to their usual academic and social routines. It may decrease children's intense pain associated with the loss of their relative. Similarly, others who interact with children, such as those involved with children's after school activities including coaches, clergy, neighbors, and friends may provide support for children to speak about their concerns. They can help children to divert their attention to other involvements that can serve to lessen a focus on the loss. These supports may decrease some of the painful grief feelings and enable children to proceed with their usual involvements, interests, and activities.

Specific changes within the family subsequent to the death also affect children's grief. There may be a need to change the living arrangements and relocate the home. Parental caretaking may decrease because the intensity of parental grief may limit parents ability to be with their children as was usual. Finances may change and grieving parents may need to work. These changes lessen parental availability and may increase children's insecurity, worries, sadness, and sense of loss. It may intensify children's preoccupations with the death. To offset problems that could occur when such changes are evident, it is important that families seek assistance from other relatives or those in the community to provide support to the children.

Some children may have medical illness or psychological or learning difficulties prior to the death. These problems may intensify children's bereavement. For example, children who previously suffered from depression may have increased sadness and be at risk for increased depression. Children with attention deficit hyperactivity my show increased impulsive behaviors and have increased difficulty concentrating. Children with learning difficulties may have problems understanding the events and require more explanation of what happened. Children with medical illness may experience a recurrence of physical symptoms. Children with psychological and medical difficulties have special needs in coping with the death of a loved-one. They can benefit from the guidance of a trained professional to assist them and their families to plan ways of intervening to decrease difficulties that may be associated with bereavement.

Children who have prior experiences with death and separation may have renewed reactions about their prior losses and these may intensify children's current bereavement responses. It is important to consider seeking professional help if such children exhibit prolonged and intense grief.

Ways Parents Can Help Their Bereaved Children

Parents and others in the family and the community can assist children with their grief. Listed below are key issues to consider.

1. Encourage children to express their feelings. Understand what bereaved children try to say and enable them to communicate in ways that they are comfortable. Among such means of expression are through discussions, drawing, or writing in a journal.

2. Children may not want to talk and

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The Impact of September 11th on Older Adults

By Gregory A. Hinrichsen, Ph.D.
Geriatric Psychiatry &
Psychological Services
Hillside Hospital

The psychiatric and psychological effects of the World Trade Center and Pentagon attacks on people in the United States will be revealed in the coming months and years. Of special concern is the impact of these events on older adults, especially those personally affected by the attacks or who live within the New York and Washington metropolitan areas. Many members of what Tom Brokow calls "the greatest generation" know first-hand the reality of war and its radiating effects on civilian populations. Prior exposure to trauma is a risk factor for the development of post traumatic stress disorder (PTSD). Are older adults at greater risk for psychiatric consequences of the tragic events of September 11? Some subgroups of older adults may be at greater risk.

Among older adults, PTSD has been best studied among World War II veterans. Studies within the Department of Veterans Affairs medical centers suggest that fairly large numbers of WWII veterans have experienced or currently experience PTSD symptoms. Those veterans with more severe war related trauma (for example, being a prisoner of war) are more likely to evidence PTSD symptoms than other veterans. Further, older adults with histories of PTSD may be prone to exacerbation or reemergence of symptoms when facing traumatic events. Another group of older adults who have experienced early life trauma are Holocaust survivors and those who suffered from the marked social and political strife following World War II. Older adults who have experienced other kinds of trauma (for example, natural disasters, personal assault, motor vehicle accidents) may have a greater vulnerability to the emotional effects of a traumatic event like the World Trade Center attack.

Current or prior psychiatric disorder is another risk factor for the development of PTSD. I was curious to get a sense of whether the events of September 11 appeared to exacerbate psychiatric symptoms among patients residing in the New York metropolitan area who are treated by geriatric psychiatrists, psychologists, and social workers. I informally polled my colleagues and gained this general impression.

In the month or so following the September 11 events, most older patients with a range of psychiatric disorders expressed levels of concern or upset that are similar to those expressed by most Americans. There was an increased recall of World War II related experiences. On the whole there has not been an acute exacerbation of symptoms. My colleagues' older adult patients have coped with these difficulties -- for better or for worse -- in ways that they characteristically deal with other stresses in their lives. Some patients noted that they have coped with things far worse than recent events. Those few individuals who have evidenced an acute exacerbation of symptoms have been directly impacted by the World Trade Center attack because of the death of family or friends or who were within close proximity of the Trade Center after the attack. Comments by some geriatric psychology colleagues who provide services to older adults residing in New York area nursing homes were similar. One colleague suggested, however, that nursing homes may be a bit more insulated from recent events noting, "Nursing homes are little worlds unto themselves."

Although the mental health effects of September 11 on older people will not be clear until years from now, informal observations suggest that psychiatrically impaired older adults not personally affected by recent events appear to be adequately coping with them. Clinicians need to be vigilant about assessing older people with prior experiences of trauma or past history of PTSD who may be most vulnerable to the emergence or reemergence of psychiatric symptoms.

***Issues* from page 5**

Access - Overall, 2.3 million persons were under care and 5.5 million persons were admitted during 1997 to specialty mental health inpatient, residential, and less than 24-hour mental health care programs. More males than females were treated in inpatient and residential programs, while both genders were fairly evenly represented in less than 24-hour settings. Although persons categorized as White comprised the preponderance of persons receiving services in 1997, American Indians/ Alaska Natives and African Americans showed higher rates of care relative to their numbers in the population.

State Expenditures - State mental health agencies expended more than $16 billion for mental health services in 1997. Although this number reflects an overall increase over the $12.1 billion expended in 1990, when the expenditures are adjusted for inflation, actual expenditures decreased 7 percent between 1990 and 1997. Community-based services represented 56 percent of total expenditures in 1997, compared with 41 percent for State mental hospitals. State mental health agency funding came from State government tax revenue ($11.4 billion); the Federal Government, principally through Medicaid ($4 billion); first- and third-party payments ($822 million); and local government ($95 million). The Community Mental Health Services Block Grant has declined from 2.4 percent of expenditures to 1.5 percent of expenditures between 1990 and 1997.

Co-occurring Disorders - The current estimate of the prevalence of co-occurring mental health and addictive disorders is approximately 10 million persons. Although identification and characterization of persons with these disorders remains difficult, several key factors are known: Persons with co-occurring disorders are much more likely to seek mental health and substance abuse services, and persons with particular mental health disorders are more likely to develop substance abuse disorders at a later point. Achieving good outcomes is difficult. Over the past decade, research and professional consensus have converged on comprehensive, integrated care as the preferred method of treatment for people with co-occurring serious mental illness and substance abuse disorder.

Children and Adolescents - Approximately 8.2% of children and adolescents ages 5 to 17 have a psychiatric problem and/or a related significant behavioral impairment. Within this group, those with a significant behavioral impairment but no psychiatric problem total 2,230,000, Those with a psychiatric problem but no significant behavioral impairment total 529,000. And those with a psychiatric problem and a significant behavioral impairment total 1,347,000. As a result of their problems, about 40 percent experienced a limitation in school activities, and more than 12 percent missed one or more school days in the past 2 weeks. About 19 percent were currently seeing a mental health provider, and an additional 11 percent had received therapy services in the past 12 months.

Juvenile Justice - Of the 113,000 children and adolescents in residential placements on any given day, at least 20 percent have a serious emotional disturbance. Overall, 94 percent of the juvenile justice facilities provide access to at least one mental health service. Facilities generally are more likely to provide medication therapy and emergency mental health services than screening and evaluation. Approximately three out of five facilities provide access to a psychiatrist. Most work with outside organizations, such as community mental health centers and social service agencies, to provide the mental health services offered.

Special Needs of Refugees - Refugees are at particular risk for developing mental disorders and not receiving treatment for their illness. Risk factors for poor mental health include marginalization and minority status, social-economic disadvantage, poor physical health, starvation and malnutrition, head trauma and injuries, collapse of social supports, mental health trauma, and difficulty in adapting to host cultures.

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    (Phobia, Depression and Anxiety Disorder Clinics, Clozapine Clinic, ECT Therapy)

- Child and Adolescent Services
  - *Inpatient, Day Hospital and Outpatient programs*
  - *One-Site School programs*
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  - *Eating Disorder Program*
  - *Psychiatric evaluation for legal issues*

- Chemical Dependency Services
  - *Crisis, Screening and Intervention Services*
  - *Outpatient/Intensive Day Programs*
  - *Outpatient Detoxification*
  - *Methadone Maintenance Programs*
  - *Relapse Prevention and Family Support groups*

- Mental Retardation/Developmental Disabilities Service (MR/DD)
  - *Inpatient Unit*
  - *Diagnostic Evaluation*
  - *Medication Treatment and Behavioral Intervention*

Other services include community residence programs; the Sexuality Center; psychiatric home care; Drop-In Center; vocational and psychiatric rehabilitation; crisis intervention program; supportive living program, and strong linkages to self-help and advocacy groups.

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The Many Faces of Grief

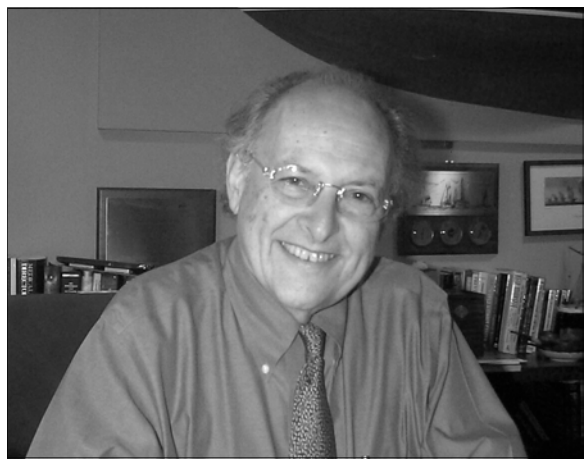
By Samuel C. Klagsbrun, M.D.
Executive Medical Director
Four Winds Hospital

It has been months since the evil catastrophe befell us at the World Trade Center, and yet to this day the mood in our streets, in our homes, in our work places continues to be heavy with sighs, shaking of the head and prolonged hand shakes.

Our grief has taken a different turn. It is more pervasive, more profound, longer lasting and it simply will not be shaken off. It's obviously not only the enormity of the loses, but it also has hit us in a way that only can be compared to when we suffer the sudden, unexpected tragic loss of someone close to us who by all accounts should not have died!

A child, a sibling, a colleague, a close friend…people who are part of our lives, healthy, active, vital, functioning – are not supposed to die! It's only the elderly, the people who have been sick for quite some time, the people who have been injured in some fashion and have not recovered, people who are in dangerous occupations – all of those, as sad as the loss may be, we understand if they die and therefore can work through our grief more quickly and more thoroughly. This one doesn't fit!

Is there anything we can use or borrow from our more predictable world of understandable and expected losses, which we could use to manage our present situation better? When a parent dies in the natural course of life, we have had a chance to prepare for such an event and can mourn our loss by crying, going through the ritual of the funeral and burial, by talking about the person and the meaning of the loss during wakes or while sitting Shiva. We can take our time and ease back to normality in a measured and relatively comfortable way. When the loss is of a younger person or someone whose death is totally unexpected, the shock of the news takes a longer time to absorb before we can get to a more ritualized and predictable way of mourning the loss. The shock of the unexpected delays our ability to get into the mourning phase for some period of time.



Samuel C. Klagsbrun, M.D.

If the loss of a person takes place while we ourselves are in the throes of difficulties, due to circumstances in our own lives that are profoundly unsettling, such a loss takes a much bigger toll on us than would otherwise be the case. In some cases, due to our own struggles, the ability to mourn this new loss is seriously curtailed because we are so caught up and busy in trying to manage our own affairs and have very little energy or ability left to focus on the new loss.

In the face of the World Trade Towers disaster, it's as if our grief reflects a situation which is closer to being overwhelmed than simply being grief stricken. The unexpected nature of the tragedy, the scope of it, the horror of the meaning behind it which clearly reflects a deliberate, well planned level of evil with all of us as the target of that evil…the clear message that this is a beginning as opposed to a single tragic evil event…all of those factors add up to having an impact on all of us which will not allow us to simply absorb this enormous loss but to demand a change in our view point of life. Our expectations for the future are now vastly different. We now have to adjust and adapt to facing and battling an insidious evil enemy who needs to be destroyed. None of this has anything to do with stages of grief as we've known them or with behavior patterns that can be recommended or suggested as a way of "getting over" the loss. There is nothing to "get over" here. There is in fact a need to keep the grief component in perspective as a reminder that we need to act in order to not allow this event to overwhelm us.

I took a walk in central park on a Sunday - October 14th. The sun was shining, the sky was as blue as it was the morning of Sept 11th. The grass was deeply green. People were playing ball on the great oval lawn and while staring at the beauty and peacefulness of the moment, I found myself filled with rage in thinking that a little over a month ago on just such a day, an evil enemy robbed us of the ability to drink in this moment without immediately comparing the sky, the sun and the beauty of the day, to what was taken away from us on exactly such a day over a month ago. My sense of grief had to do with a profound feeling of loss of having peacefulness, tranquility and the ability to take this for granted taken away from me, possibly forever.

Grief therefore, has many faces! The loss of a person (or in this case an enormous number of people), the loss of security, the enormous increase of vulnerability, the mourning over the loss of taking for granted safety and trust and the need to now always being on guard.

Getting back to normal means getting back to functioning including returning to the ability to laugh, to love, to play and to share. But, the usefulness of maintaining an awareness of the grief representing a major change in our lives, is what will help us adapt and focus on being realistic and appropriately aware of danger in the future for all of our sakes.

Four Winds Hospital is the leading specialized provider of child and adolescent mental health services in the Northeast. In addition to the Child and Adolescent Service, Four Winds also provides comprehensive inpatient and outpatient mental health treatment services for adults, including psychiatric and dual diagnosis treatment. As many of our colleagues in the mental health community have done in addressing the needs of the community after the tragedy of September 11th, Four Winds Hospital responded by establishing a Courtesy Crisis Counseling Center, as well as pro-bono clinical speaker services to area schools and agencies to assist educators, parents and children in processing the stress-inducing information in the aftermath of the crisis. These articles offer further information to help with the process of healing.

Critical Incident Stress

An Interview With
Herbert Nieburg, Ph.D.
Director of Behavioral Medicine
Four Winds Hospital

Q. What is Critical Incident Stress?

A. The definition of critical incident stress is any stressor that is above and beyond the realm of normal human experience.

These incidents can range from assault, such as rape or being mugged, to experiencing a major disaster/tragedy – which we collectively experienced as a nation on September 11th.

The characteristic that makes the event a critical incident is the overwhelming nature of it – the element of potential severe injury or loss of life. A critical incident is any event that has a stressful impact sufficient enough to overwhelm the usually effective coping skills of either an individual or a group.

Q. How can you manage this type of stress?

A. Expect reactions such as fear, confusion, anxieties or stronger emotions than you would typically experience as normal when you've experienced a critical incident.

Don't be afraid to talk about your feelings and emotions with your family, loved ones and co-workers. Give yourself time to get over the event – be extra kind to yourself, your spouse, your children, and allow yourself time to heal.

An unprecedented event such as that which occurred on September 11th can have devastating effects on the integrity of the family. Be especially aware of yourself and those around you, particularly your family. The rhythm of your life may have changed – that's OK.

What is important is that you recognize for yourself and your loved ones that the grief, anger, isolation, numbness, change in eating or sleeping habits should subside, and if they do not, you need to seek professional advice.

A trauma such as this shatters the illusion of invulnerability. Try to get back into your routine, be consistent and structured.

As we have said, critical incident stress is caused by the overwhelming nature of the event. The best way to deal with the stress is to know what is happening to you, and to take the most appropriate steps to continue moving forward.

Q. How Can Critical Incident Stress Debriefing Help?

A. In the case of the attack on American on September 11th, many families, individuals, and Emergency Service Workers were affected by the horrible trauma of that single day.

There is a technique, developed by Jeffrey T. Mitchell, Ph.D. called CISD, critical incident stress debriefing, which is an individual, or group meeting or discussion about a distressing critical incident.

Providing crisis intervention and education, the CISD meeting may reduce the impact of a critical incident. This has proven helpful in the past with people who make their livings by dealing with trauma, like EMS workers, and more recently with victims and families of the terrorist attacks of September 11th.

Critical Incident Stress Debriefing is not therapy or a substitute for therapy, but rather a group process of discussion designed to reduce stress and enhance recovery from stress. It is a sophisticated technique designed to accelerate the rate of 'normal recovery' in normal people who are having normal reactions to abnormal events.

Q. If You Have Had CISD and Are Still Experiencing Symptoms, What Should You Do?

A. Critical Incident Stress Debriefing is done immediately after a traumatic event. Given the brief time frame available in which this intervention and education process is ideally completed, all of the problems that have been presented may not be resolved.

Sometimes, it is necessary to refer individuals for further treatment after a debriefing.

Herbert Nieburg, Ph.D.

Dr. Nieburg concluded this interview by mentioning that the shock of September 11th had left many people emotionally confused due to the magnitude of the trauma and that mental health professionals are watchful for delayed reactions and mindful that interventions, like the immediacy of the Critical Incident Stress Debriefing Technique, typically used for EMS workers, has been demonstrated to be helpful when applied in generalized circumstances of global trauma.

A Word on Coping

By Janet Z. Segal, Chief Operating Officer
Four Winds Hospital

There have been decades of violence, horror and wars, all occurring far away from our shores. Some of us remember air raid drills, Spam sandwiches, reserves of canned food, bottled water, and yellow and black air raid shelter signs. But we were spared until September 11th! Suddenly, thousands of people were killed and our tallest buildings crumbled before our eyes. It all seemed beyond comprehension. It was unimaginable that our safe haven of freedom and democracy were so violently invaded. Our enemy is elusive and shadowy. Children and Adults alike wonder, "Why do they hate us so much?" The world, our world, has drastically changed.

Facing this change, and incorporating it into our lives, is our challenge. How we accomplish this will depend very much on who we are. We all deal with stress and change as differently as we sign our names. This is a period of adjustment, as any major change requires time to be absorbed. Patience and understanding of oneself and others is needed during this time. Routine and structure always gives a sense of safety and control. Knowledge and information is essential in a time like this, as it will prevent panic and irrational behavior. Some will seek help in the way of advice, counsel or therapy. Others will move closer to family and friends for support and help. Some will need time to be alone to try to sort it out. Denial will help others gain time to absorb the shock, and diversions will work for some. But most importantly, helping others is a way of helping ourselves.

In coping with any significant trauma - the loss of a loved one, the crisis of September 11th, or any other frightening, unpredictable event – the goal is not to 'get over it', but working together, you can, and will, get through it.

Janet Z. Segal

Outpatient Treatment Services
1-800-528-6624

Child Partial Hospitalization Program
- Ages 5-12
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- On-site school
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Adolescent Partial Hospitalization Program
- Ages 13-17
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- 24 hour crisis intervention
- Flexible full or half-day scheduling
- Weekly multi-family group
- On-site school
- 5 days a week (9:00 am - 3:00 pm)

Adult Partial Hospitalization Program
- Ages 18 years of age and older
- Treatment alternative to inpatient care
- 24 hour crisis intervention
- Flexible full or half-day scheduling
- Specialized treatment tracks
- Individual case management
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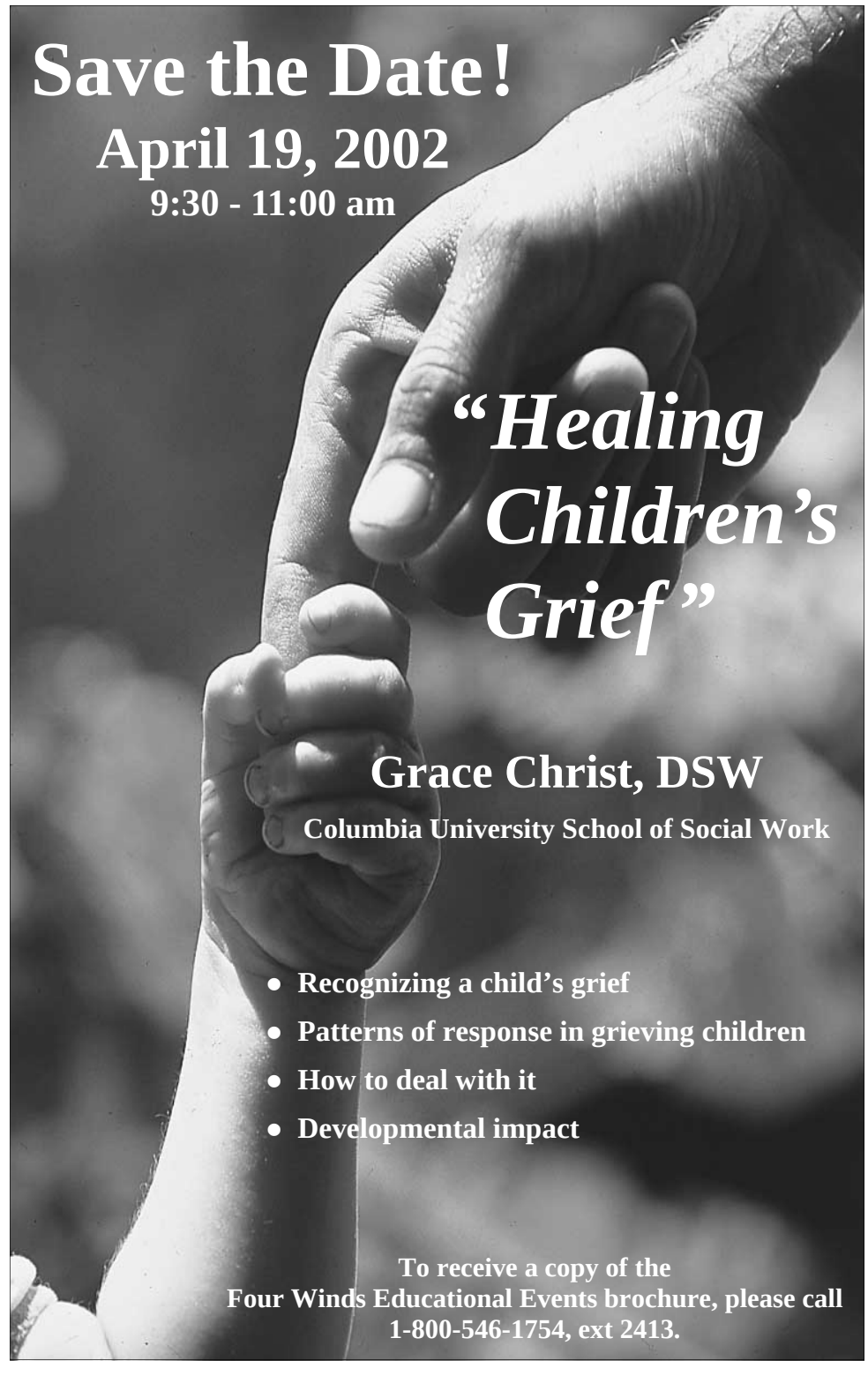
- Acupuncture for Detoxification

Adult Ambulatory Detoxification Program

A medically supervised 24 hour, 7 day a week program in which all substances can be detoxed. 23-hour crisis bed available.

Visit our website at www.fourwindshospital.com for a photo tour and further information about inpatient and outpatient services.



Keeping our Children Emotionally Safe In the Wake of Terrorism in our Nation

By Alan V. Tepp, Ph.D.
Child and Adolescent Psychologist
Director, Consultations and Evaluations, Four Winds Hospital

We are all certainly pained and shaken by the horror and tragedy of the events of September 11th, 2001. How can we keep our children emotionally safe so they can grow and develop optimally in the aftermath of something so frightening, so unpredictable? Let's take a look at three things:

1) Coming to understand and know if our children are feeling unsafe, particularly in situations where they do not directly tell us.
2) Knowing what to say to our children about the September 11th tragedy, and also what to say about future events which may affect our nation.
3) Concrete suggestions to help our children cope with these stressors to enable them to move forward in their lives.

What Stress Looks Like

First, let's take a look at those children who may be struggling with feelings of anxiety, stress, and fear, but who are not actively seeking us out to tell us that the terrorist tragedy has affected them. With these children, watch for a variety of different ways in which their stress might be affecting them, like regression - a return to earlier behavior such as thumb sucking, or possibly bed wetting in the younger children. You may also see increased clingy behavior, which might manifest itself as a reluctance to go to bed, or to sleep alone. There may be increased crying or school refusal. You also may see academic problems with some children showing an inability to concentrate.

The response of school-aged children can be divided into five areas: (1) Performance decline (school, intellectual, sports, or hobbies), (2) Compensatory behaviors (revenge in their play, denial), (3) Discrepancy of mood. i.e., inappropriate moods, crying, rages, (4) Behavior changes or problems (regression, attention seeking behavior, or getting into trouble), and (5) Psychosomatic complaints (headaches, stomach aches, nausea)

Children, who suffer with a response to the terrorist tragedy but do not talk about it, are often times experiencing anxieties and fears. They may be on edge, easily startled, overly alert, or feeling scattered because of the chronic anxiety with which they are suffering, but about which they are not necessarily consciously aware.

Certainly, children's reactions will depend upon their developmental age. It is the 5 and 6 year old who will refuse to attend school or exhibit regressive behaviors, while elementary and middle school age children may minimize their concerns and actually be much more argumentative, and show significant academic declines.

If you do see crying, bed-wetting, thumb sucking, nightmares, clingy behavior, increased aggression, withdrawal, isolation, headaches, increased phobic reactions or an inability to concentrate…*you'll want to pay attention*. These symptoms might be a reaction to the increased stressors with which we are all living.

Sleep problems can affect any age child and this is something which can be particularly problematic. Children and adults are alone in the middle of the night. As such, we experience increased feelings of vulnerability that can make us feel particularly upset. This should be addressed. Insomnia, or the lack of a 'good nights sleep' can significantly affect the way someone gets through their day.

What and How Much Do We Tell Our Children?

Let me turn now to what we can say to our children about the frightening events of September 11th, and about what the future may hold. First, be reminded of the very different ways in which we want to talk with pre-school and primary school age children, versus intermediate school age children, and how this contrasts with middle school versus high school students.

First, I would ask all of us as parents, to think about our own understanding of what happened, as difficult as that might be. We need to understand whether we experience this as fanaticism, or possibly evil, or possibly a worldwide struggle between fundamentalism and western secularism. What do we know about the images that we see on the media and what do we know about the belief systems of those people who seem to harbor hatred towards us? Sometimes discussions within ourselves, of our faith and our morality, and how evil coexists with good in the world, is something that we should talk about with our children, only after we come to some understanding about all of this, with ourselves.

With very young children, often asking them to speak with their drawings and their toys, is most appropriate. If we can shield very young children from the events around them, this is usually best. But so often, children hear from older siblings, or TV programs, what is going on.

We do need to immerse ourselves into the world of the child, wherein play is their language and toys are their words. For these young children, hugging them, and touching them in a comforting way, is oftentimes the best way to "talk" to them about the September 11th tragedy. Using words can be fine with young children, but we must be careful to use *their* words, and avoid hearing only our interpretations of their words. Be a careful listener and respond to what they are saying.

In general, *we* don't bring up what is going on in our post September 11th world to children, as much as we look for them to talk about their concerns with us…..either in their words or in their behavior. *We must always be focused on the child's needs.* This is what guides us in what to tell our children about the September 11th tragedy and the world in which we now live.

How Do We Help Children To Deal With The Stress?

Let us now turn to what we can do to help our children. First, keep in mind that our goal is to be supportive and non-judgmental, regardless of what things our children tell us. Providing factual information can sometimes help our children. By simply giving them the facts, we can help our children sort out that which they think they know, from what they don't know. Always allow children time to experience their feelings before offering advice.

One thing to keep in mind, is our own need to stay strong and do things for ourselves. Physical exercise can be very important to help us relieve stress. We should be eating well and getting plenty of rest. Remember that if we are feeling stressed, we are probably raising the stress level within our own families.

In general, giving our children some space and more tolerance, and particularly more hugs, can be very useful. Engaging in family rituals - things that reaffirm family bonds is often also helpful.

I would also urge you to reassure your child more frequently than you normally would. Specifically, reassure them that you are safe and together as a family, and emphasize the safety of the family unit. Tell your children that they can feel a sense of safety at all times, by keeping a feeling of family in their hearts at all times.

Spend extra time with your child at bedtime. This is a very difficult time and is something to which we really need to pay attention, because of the vulnerability that (particularly young) children feel during bedtime.

For very young children in pre-school through second grade, we want to emphasize routine (consistency) as it conveys security. Be careful not to tell very young children more than they need to know. Young children need to be protected more than they need to be informed. In the second through fifth grade, relaxing performance demands can sometimes be helpful initially. A child's self esteem is tied to their feelings about their performance, and this is a good time to make sure everyone is feeling successful.

Sometimes asking the children to put themselves in the shoes of another, e.g., a second grader whose parent is fighting the war, or who possibly lost a parent on September 11th can be helpful. Your child can feel like they're doing something to help another child by communicating their understanding of that child's loss.

I would encourage you to talk with your children about what to do if another disaster strikes. Let them know exactly what you are going to do if something bad happens again. Review safety procedures that are in place in your house. Develop ways to help your child to feel a sense of safety when they are with you or without you in school. Teach your child how and when to call for help. They should know what 911 is, and even young children need to be taught how to call for emergency assistance.

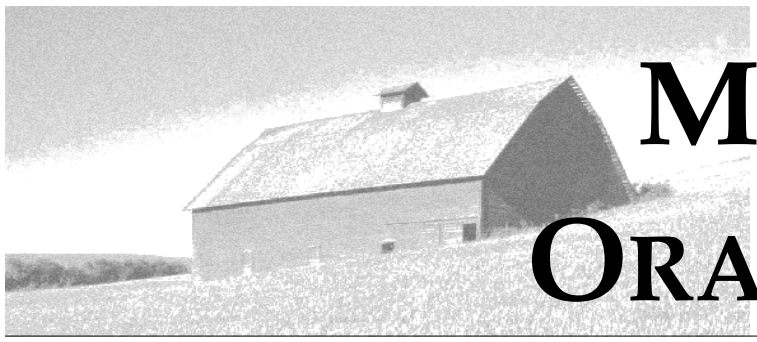
Alan V. Tepp, Ph.D.

Of utmost importance is the development of our own courage. We know that Anthrax is not contagious, but we also must remember that fear is. We as parents very much need to look into our own hearts, and find our own courage. We must not succumb to fear, at least in part because it is so contagious to our children.

When we talk with our child it is very important not to lecture. If we spend 10 minutes talking with our child, most of the time we want to be asking questions and having our child do more of the talking. Always use the child's level of language when talking with them – don't 'talk over their heads.'

Although the circumstances of recent months have been extraordinary, life is filled with stressors. Children will face stress in their lives, and these stressors will grow as they do. As such, we as parents must use the day-to-day experiences in our children's lives to help them confront stress, deal with these stressors (initially less effectively, but hopefully more effectively as time goes on) and then as they face increasing stressors, gain "immune responses" to stress. In this way, as our children develop, they do not view stress as something that they must avoid, but rather, as something that they have been taught skills to effectively and appropriately deal with. There is no better time to start than now.

In closing, allow me to say that this horror with which we have all suffered, needs to be infected with the hope, commitment, and courage that many of us are beginning to feel, and it is in our embracing this posture that we will be able to best help our children feel emotionally safe.



MENTAL HEALTH NEWS
ORANGE COUNTY SECTION

Information, Education and Advocacy News from Orange County, New York

MHA of Orange County Responds to Crisis

By Nadia Allen
Executive Director, Mental Health Association in Orange County

The effects of the tragic occurrences of September 11th are being felt in our local community. Many Orange County residents work daily in New York City. Henceforth, many families have been affected directly or indirectly by the recent events.

MHA in Orange County worked closely with the Orange County Department of Mental Health, Orange County United Way and other community agencies in order to coordinate a county-wide response to provide the immediate support needed by Orange County residents and to plan for the long term help that will promote community healing. The results of this collaboration led to the successful development of a Community Mental Health Response Plan, which has been highly effective. MHA's Orange County Helpline number 1-800-832-1200 was widely distributed as part of the Mental Health Resources in Orange County. In addition, our web site, www.mhaorangeny.com was updated with many tips and resources to help persons affected by the September 11th tragedy.

One of the unique web site resources offered is the confidential on-line Depression Screening Program. At the end of the screening the individual receives an immediate printable result. Furthermore, the individual is encouraged to call our Helpline to schedule a follow-up meeting with a health professional, which will include a confidential discussion of screening results and available resources.

One of our main priorities is to continue to promote our Helpline, which provides 24-hour, 7 days per week telephone support, crisis intervention, listening/problem solving, information and referral.

We strongly believe that individuals affected by the September 11th attacks need to express their feelings about the events. Furthermore, Helpline listeners are trained on the early warning signs of serious mental conditions (such as clinical depression, post-traumatic stress disorder, etc.). Therefore, they are able to provide callers with appropriate referrals and information as necessary.

Since the crisis, MHA has worked concurrently with Orange County Department of Mental Health and other community partners in order to establish and operate a crisis counseling program as defined by the Center for Mental Health Services (CMHS) Emergency Service and Disaster Relief Branch. Services provided will include support, short-term intervention, connection to needed resources, and encouragement to use individual, family, and community strengths to undertake the recovery and healing process. Specifically, the services provided include : individual and group crisis counseling, referrals, outreach and education.

Nadia Allen

We are optimistic, that the above planned enhanced services will be funded with available state and/or federal aid. Orange County has requested funding from the Federal Emergency Management Agency (FEMA) to implement the proposed crisis counseling program.

Although it may be too premature to evaluate, it has been our impression that, to date, the September 11th tragedy did not trigger an overt mental health crisis as we had originally anticipated. Many Orange County residents, directly or indirectly affected by the atrocities are reacting to the fear and loss of this catastrophic event and may have been traumatized to the extent of requiring mental health services. Conversely, many people do not see themselves as needing mental health services following a disaster. The proposed crisis counseling center will provide outreach efforts which will be reflective of all individuals in the community and services will be responsive to individual/cultural needs. The purpose of the outreach efforts is to assist individuals in coping with the psychological aftermath of the disaster, mitigate additional stress or psychological harm and to promote the development of understanding and coping strategies that individuals may be able to call upon in the future. It is designed to serve people responding normally to an abnormal experience.

We strongly believe that the crisis counseling program, proposed to be called *Project Liberty-Orange County Community Support Program*, will be equipped to address existing mental health needs and will supplement services currently in place to support the Orange County community in the weeks and months ahead.

Our residents appear to feel a new sense of vulnerability. However, this feeling must not be mistaken with powerlessness or psychological fragility.

The Orange County region has been galvanized, inspired and encouraged to unite as a community. Our Community Mental Health Response Plan and Project Liberty has focused on necessary mental health services as well as strength, bravery and an optimistic attitude—which is what our county and country seems to need at this time.

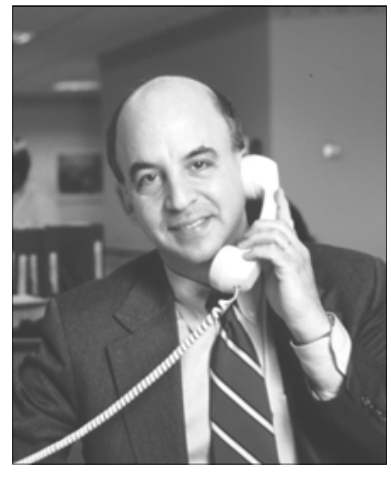
The Arden Hill Behavioral Health Center

By David W. Brody, M.D., Director
Behavioral Health Services
Arden Hill Hospital

Behavioral health services at Arden Hill Hospital - Horton Medical Center (AHH-HMC) include inpatient treatment, crisis intervention/rapid evaluation, partial hospitalization, inpatient consultation, ECT, and outpatient clinic services for psychiatric and substance use disorders. The inpatient service, located at AHH, offers specialty treatment for elderly patients, a separate treatment track for combined psychiatric and substance use disorders, and short-term, acute hospital treatment for most psychiatric emergencies. The inpatient unit admits adults over 18 years.

Crisis intervention and rapid evaluation services are available at AHH round the clock. Patients are first assessed to rule out acute medical problems and then evaluated and treated by a staff psychiatrist. Admission or referral to AHH or other inpatient psychiatric services is available. Children and adolescents needing admission are typically referred to an appropriate facility in the region.

AHH operates Pathway, a partial hospital program for adults 18 and over, in Goshen. Pathway provides intensive, outpatient treatment in a highly structured program weekdays, 9 AM - 3 PM. All program staff -- psychiatrist, nurse, social worker, and activity therapist -- meet daily with patients who are typically referred to Pathway immediately following discharge from inpatient care or who are attempting to avoid inpatient admission. Pathway is open to the community and accepts a wide range of insurance plans, including Medicaid and Medicare.



David W. Brody, M.D.

Patients admitted to the medical/surgical services at AHH or HMC can receive psychiatric consultation by a staff psychiatrist. ECT is also available to patients hospitalized at either facility or on an outpatient basis. The Arden Hill Behavioral Health Center (BHC), located in Goshen, provides outpatient assessment and treatment for all ages. A psychiatrist Board-certified in Child and Adolescent Psychiatry is on staff at the BHC and psychotherapy -- brief and longer-term, individual, family, and group -- is also available. The Horton Family Program for Alcoholism and Substance Use Disorders (HFPA), located in Middletown, provides evaluation and intensive outpatient treatment. HFPA is licensed by the New York State Office of Alcoholism and Substance Abuse Services and has specialized programs for adolescents, adults, and families. Both BHC and HFPA accept a wide range of insurance, including Medicaid and Medicare.

DEPARTMENT OF MENTAL HEALTH
ORANGE COUNTY COMMUNITY MENTAL HEALTH CENTER

Chris Ashman, M.S.
Commissioner

Arthur J. Gloeckler, M.S.
Deputy Commissioner

Joseph G. Rampe
County Executive

30 Harriman Drive
Goshen, New York 10924-2410
Tel (845) 291-2600 · Fax (845) 291-2628

The effects of September 11th's tragic events are increasingly being felt in our Orange County communities. As part of the County-wide action plan directed through the Office of Emergency Management, the Orange County Department of Mental Health is coordinating the Community Mental Health Response which will support individuals and families who were directly or indirectly affected by the disaster. As part of our Plan, the following information is being widely distributed across the County so that potential contact points for persons in need of support or counseling will have correct and comprehensive information to offer.

MENTAL HEALTH RESOURCES IN ORANGE COUNTY

Mental Health Services Hotline

(888) 750-2266

- 24 hrs/day, 7 days/week
- toll free
- direct services & referral to other community service locations
- home visits available

HELPLINE

(845) 294-9355 or
(800) 832-1200

- 24 hrs/day, 7 days/week
- phone support
- information
- referral to other community service locations

Grief & Bereavement Counseling

(845) 561-6111

- Children's Grieving Center
- Support Groups

United Way of Orange County

(845) 294-5100

- Coordination of volunteers who have skills or services to offer
- Missing Persons Hotline 845-364-8976

Licensed Outpatient Clinics

Goshen - 294-7931
- 294-5888

Middletown - 343-6686
- 343-7675
- 342-5941

Newburgh - 562-7326
- 568-5260
- 562-8255
- 561-5783

Port Jervis - 858-1456
- 856-6344

Walden - 778-5628

Monroe - 782-0295
- 782-6600

or toll free for appointments in Middletown, Goshen & Newburgh
1-888-750-2266

- Phone support
- Immediate appointment

Community Hospital Mental Health Services

Goshen - 294-2155
Cornwall - 534-7711
Port Jervis - 858-7121

- Walk in evaluations

Local Clergy

- Spiritual Support
- Counseling

Local School Districts

- Supportive counseling
- Referral information
- Student Assistance Services

Orange County Department of Mental Health

(845) 291-2600

- General Information
- Problem Solving
- Local Coordination of Services
- Updated Information via the Internet

Updates to this information will be posted on the Department of Mental Health's website: http://govt.co.orange.ny.us

NARSAD Honors Nobel Laureates Awarded for Outstanding Research at Annual Dinner

Staff Writer
Mental Health News

An extraordinary "meeting of the minds" took place at the annual benefit gala of the National Alliance for Research on Schizophrenia and Depression (NARSAD). The Alliance devoted the evening to honoring some of the most renowned neuroscience researchers worldwide. The event, which raised $1.1 million for research in schizophrenia, affective disorders, and other psychiatric illnesses, took place at the Pierre Hotel in New York.

NARSAD awarded its first Julius Axelrod Neuroscience Award to the three scientists who shared last year's Nobel Prize in Medicine or Physiology. The award is named for Dr. Axelrod, who received the 1970 Nobel Prize in Medicine for his discovery of the actions of neurotransmitters in regulating the metabolism of the nervous system. Dr. Axelrod is currently honorary chairman of NARSAD's Scientific Council.

Arvid Emil Carlsson, M.D., of the University of Gothenburg, Sweden; Paul Greengard, Ph.D., of Rockefeller University; and Eric R. Kandel, M.D., of Columbia University, received the NARSAD Neuroscience Award. The research of these brilliant scientists has focused on the brain and its billions of nerve cells, including groundbreaking studies that have elucidated the mechanisms by which these cells communicate with each other. Their research has contributed tremendously to our knowledge of brain function and has led to the development of new drugs to treat neurological and psychiatric diseases.

In addition to the Julius Axelrod Neuroscience Award, NARSAD awarded its annual Lieber Prize for Schizophrenia Research, the Nola Maddox Falcone Prize for Affective Disorders Research and the Ruane Prize for Childhood and Adolescent Psychiatric Research. Each of these prizes carries a cash award of $50,000.

This year, the award for schizophrenia research went to Solomon H. Snyder, M.D., Director of the Department of Neuroscience and Distinguished Service Professor of Neuroscience, Pharmacology and Psychiatry at Johns Hopkins University. Dr. Snyder has made significant contributions to the understanding of neurotransmission in the brain. Over the years, he has discovered novel neurotransmitters and numerous receptors, increasing our knowledge of how medications affect the brain. His findings and techniques have helped to accelerate the pace of drug development.

The affective disorders research prize was awarded to two outstanding scientists: Hagop S. Akiskal, M.D., and William E. Bunney, Jr., M.D.

Dr. Akiskal is Professor of Psychiatry and Director of the International Mood Center at the University of California at San Diego. Over the years, Dr. Akiskal has made enduring contributions to the understanding and management of mood disorders, especially bipolar illness. Early in his career, Dr. Akiskal conducted the definitive clinical and sleep-EEG studies that helped establish dysthymic and chronic depression as valid and treatable mood disorders. His subsequent research challenged many assumptions about the nature of personality disorders and paved the way for understanding the childhood variants and precursors of bipolar disorder.

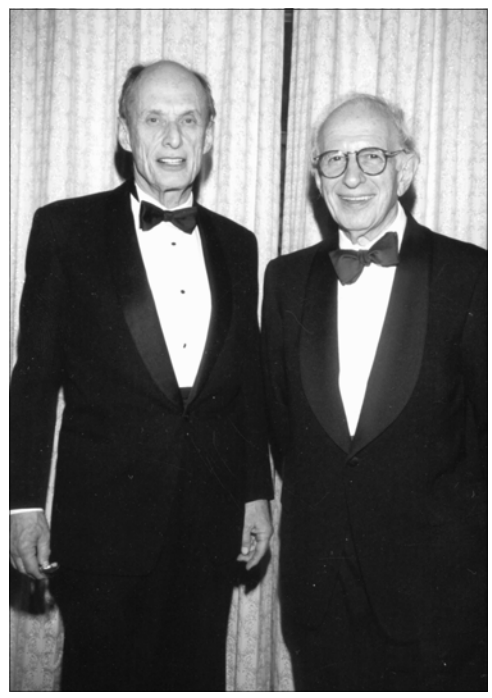
Dr. William E. Bunney is Distinguished Professor and Della Martin Chair of Psychiatry at the College of Medicine at the University of California-Irvine. Dr. Bunney is renowned for his research exploring the fundamental role of neurotransmitters in the major psychoses, particularly bipolar illness and schizophrenia. Among his many contributions, Dr. Bunney demonstrated that the stress hormone cortisol is involved in suicidal behavior. He also published one of the first double-blind studies of lithium for the treatment of depression and studied the mechanism of action of this drug. Dr. Bunney currently heads a large group of researchers who utilize a new, powerful technology called microarrays to search for the genes that cause severe depressive illness.

The Ruane Prize for outstanding research in child and adolescent psychiatry went to Donald J. Cohen, M.D., who, sadly, passed away before the award ceremony. Dr. Cohen was Sterling Professor of Child Psychiatry at Yale University and director of the Yale Child Study Center at the School of Medicine. His research focused on discovering how stress, child poverty and other environmental factors interact with genetic and biological influences to cause neuropsychiatric disorders. Dr. James Leckman of Yale University accepted the award in Dr. Cohen's place.

"The groundbreaking contributions of these brilliant scientists have advanced the field of neuropsychiatric research and opened new doors," said Constance Lieber, President of NARSAD. "Through their vision, determination and tireless work, they are leading the quest for better treatments and a cure."

NARSAD is the leading donor-supported organization funding research in brain disorders. Since 1987, NARSAD has awarded $115.9 million in grants to 1,372 scientists at 175 leading universities and research centers worldwide. Grantees are chosen by NARSAD's Scientific Review Council, which is composed of 72 prominent scientists and academic leaders in all phases of neurobiological and psychiatric research. The American Institute of Philanthropy, which rates charities nationwide, has awarded NARSAD an A+ for financial efficiency. For more information, visit the NARSAD website at www.narsad.org.

Constance Lieber, Drs. Kandel & Pardes



Drs. Greengard & Kandel

Nola M. Falcone, Drs. Bunney & Pardes

Nola M. Falcone, Drs. Akiskal & Pardes

Constance Lieber, Drs. Snyder & Pardes

HEALING THE TRAUMA OF TERROR

Leading the Search for Better Treatments and Cures for Brain and Behavior Disorders

The tragic events of September 11th and the threat of further destruction of life demand our best responses. The psychological trauma caused by these attacks emphasizes the need for effective understanding of the brain and behavior. We are challenged by the needs of the families of the victims, who bear the lifetime burdens of mourning, stress, anxiety and depression. We face a society which is suffering with new insecurities, disrupted lives and a deep sense of hurt.

The **NARSAD** Scientific Council has long emphasized the need to understand and overcome stress and crisis. **NARSAD** has funded numerous studies which provide greater understanding of the impact of trauma in all its forms: on the brain, the body, and behavior.

NARSAD's research programs have supported over 100 scientists studying the reactions to stress, crisis and trauma.

The following research grants illustrate our commitment:

- **A Genetic Approach to Anxiety States** — $100,000 one-year grant to Eric R. Kandel, M.D., (winner of the 2000 Nobel Prize in Medicine or Physiology) at Columbia University
- **Neurobiological Changes Following Stressful Event: The Effects on the Development of Affective and Anxiety Disorders** — $60,000 two-year grant to Israel Liberzon, M.D., at the University of Michigan
- **Brain Function in Children and Adolescents with Post-Traumatic Stress Disorder** — $60,000 two-year grant to Victor G. Carrion, M.D., at Stanford University
- **Adrenal Sensitivity in Post-Traumatic Stress Disorder** — $60,000 two-year grant to Evan D. Kanter, M.D., at the University of Washington
- **PET Study of Hippocampal Function in Post-Traumatic Stress Disorder** — $60,000 two-year grant to Lisa M. Shin, Ph.D., at Harvard University
- **Nocturnal Activity and Sleep Maintenance in Depressed and Traumatized Adolescents** — $60,000 two-year grant to Carol A. Glod, Ph.D., at Northeastern University
- **Psychosocial Risk Factors for Youth Suicidal Acts** — $100,000 one-year grant to Cynthia R. Pfeffer, M.D., at Cornell University
- **A Molecular Genetic Approach to Studying the Effects of Stress on Hippocampal Neuronal Remodeling and Death** — $100,000 one-year grant to Bruce S. McEwen, Ph.D., at Rockefeller University
- **Group IPT (Interpersonal Therapy) for Depressed Adolescents** — $100,000 two-year grant to Laura H. Mufson, Ph.D., at Columbia University
- **Functional Magnetic Imaging Studies to Provide Information About Brain Functions Aimed at Medications for Post-Traumatic Stress Syndrome and Depression** — $100,000 two-year grant to Jennifer Vasterling, Ph.D., at Tulane University

NARSAD is the largest public contribution-supported funder of psychiatric research in the world.

All of **NARSAD's** administrative and fund-raising costs are paid for by two family foundations allowing ***100% of your donation to go directly to Research.***

Through 2001, NARSAD has given a total of 2,533 grants to 1,372 scientists at 175 universities and medical centers in the United States and 17 other countries, for a total of $115.9 million since its inception in 1987.

NARSAD provides funds for all the pyschiatric disorders, from anxiety and affective disorders to schizophrenia.

The Scientific Council consists of 72 members, all of whom are recognized as leading specialists in key areas of basic brain science and clinical research. The Scientific Council was organized in 1986 with Herbert Pardes, M.D., as President, and Nobel Prize winner Julius Axelrod, Ph.D., as Honorary Chairman.

NARSAD is a top-rated charity. The American Institute of Philanthropy, an agency which rates charitable organizations nationwide, has awarded **NARSAD** an A+ for financial efficiency.

"Now I think that there is no organization in the United States that is doing a better job of dealing with the gap between our nation's real and profound public health needs, and our ability to fund research, than NARSAD. What they have done is to fund Young Investigators, the source of our innovation and our new ideas, in a really generous way over the past years, which is exactly what this country needs if we are going to have a cadre of effective mental health researchers to meet this enormous public health need."

Steven E. Hyman, M.D.
Director, NIMH

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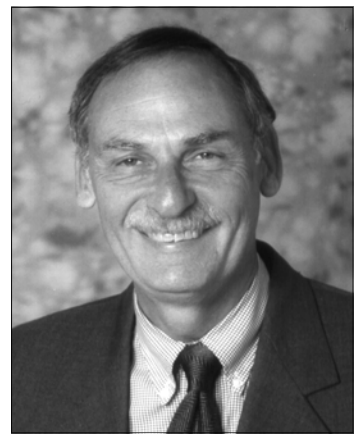
Mental Health and September 11th

By Arthur B. Zelman, M.D.
Associate Medical Director
The Center for Preventive Psychiatry

It is difficult to imagine any American who was not profoundly affected by the events of September 11.The high-jacked airplanes not only destroyed the World Trade Center buildings and part of the Pentagon, they temporarily destroyed our sense of the world as a benign place which we can control. In short we have all been traumatized.

Yet we have not all been traumatized in the same way and to the same degree. How and to what degree we are affected depends on many factors. The most obvious factor is our distance from "ground zero." In roughly descending order of psychological trauma, for example are: those who lost family members; survivors who had to flee for their lives; people who watched the events unfold from neighboring buildings or streets; rescue workers; people watching on television in real time as the second World Trade Center building was hit and as the buildings collapsed; and people who later watched the many repetitions of the events on the media.

The impact on a mother of young children, living in Manhattan, whose husband died in the attack is obviously of a different order of magnitude than another mother from a distant part of the country who knew no direct victims. Yet the chances are that the latter's distress was profound owing to her capacity for identification and empathy with another in similar life circumstances. Beyond that, the destruction and damage to such landmarks as the World Trade Center and the Pentagon, symbolizing as they do our country itself is something we all share, no matter what our distance from "ground zero."



Arthur B. Zelman, M.D.

Other factors that are affecting and shaping our individual reactions to the events include our personal histories (e.g. previous traumas and losses), individual differences in coping styles, and our present circumstances and support systems.

Granted that these differences exist, what are some of the potential reactions, symptoms and syndromes that might manifest themselves? They can be grouped into three categories according to whether they are primarily responses to trauma, loss, or loss of self-esteem.

Trauma in the clinical sense occurs when we are sufficiently unprotected physically and psychologically for an event such that the intensity of our anxiety precludes our ability to integrate the event. Instead, we resort to such psychological mechanisms as avoidance, denial, numbing and distancing ourselves from feeling.

Insofar as these mechanisms take us farther from the cause of the anxiety they leave us vulnerable to its manifestations. Sleep disturbances are common as are frightening dreams- sometimes disguised, at other times depicting the anxiety-provoking events themselves. The day-time equivalent of these latter dreams are involuntary flashbacks of any or all aspects of the events (though most frequently visual, they can involve any of the senses).

Since anxiety is the driving force behind these symptoms, they may express themselves in the form of other anxiety syndromes, including phobias, a heightened level of general anxiety, panic reactions and agoraphobia.

Depending on circumstances it is not always easy to determine the degree to which some of these reactions are "normal" or "rational" on the one hand or "pathological" or "maladaptive" on the other. For example a fear of airplanes or skyscrapers may well be realistic in view of ongoing terrorist threats to do more of the same. Yet the odds of harm are extremely low and ironically, due to our heightened level of vigilance, significantly lower, we now know, than they were on September 10.

The second group of reactions includes variants of bereavement secondary to loss. On one end of this spectrum are conscious feelings of sadness, on the other, apathy ("what's the point"), hopelessness, and extreme passivity. Reactions to loss are by no means limited to people who have lost family members, friends or acquaintances. Many describe sadness and tears at the disappearance of the Twin Towers. As in clinical depression, there can be somatic manifestations of distress, including loss of appetite or overeating, fatigue, irritability, change in sleep patterns, loss of interest in sex or compulsive sexuality, and a general decrease in the ability to experience pleasure. Reinforcing the latter can be a sense of guilt that one has survived or hasn't suffered as much as others.

A third group of reactions may be linked to a threat to self-esteem and attendant feelings of humiliation.

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***Parity* from page 10**

individuals and families, it would help reduce the population of mentally ill among the homeless and incarcerated, and would, most likely, reduce the socio-economic costs of disability and loss of productivity.

Perhaps our legislators believe that eliminating the discrimination against mental health treatment is a minor issue? The incidence of mental illness is pervasive. Mental illnesses are among the leading causes of disability, both worldwide and in the United States: of the 10 leading causes of disability worldwide, 4 are psychiatric conditions. One in every five families is affected by a severe mental illness; mental illnesses are more common than cancer, diabetes, or heart disease. Twenty-three percent of American adults (age 18 or older) have a mental disorder in any given year, while 5.4% have a serious mental illness. Fifteen percent of the adult population use some form of mental health service during any one year; and 21% of children ages 9-17 receive mental health services in any one year.

We know our legislators believe it is wrong to discriminate against people with mental illness. Most of our legislators have publicly stated that health insurance coverage should be fair and should not discriminate against people with mental illnesses. No one would argue that insurance that covers treatment for heart disease need not cover treatment for liver disease. Parity is a matter of simple fairness—limiting treatment for mental illnesses in ways that treatments for other illnesses are not, is discriminatory.

However, whatever legislators might say, they are as likely as anyone else to be uninformed about mental illness—to see it as a "character flaw," for example, rather than a medical condition. They may be pressured by lobbyists from the insurance industry, who are telling them that parity would be too expensive—that it might even destroy the health insurance business. Legislators may be involved in political battles within the legislature or in their districts that distract them from the importance of parity legislation, or that turn parity legislation into yet another "political football."

What can we do to get comprehensive parity legislation passed? Aggressive grassroots lobbying is our best tool for making it clear to our legislators in Albany that parity is important to the citizens of New York State—the people who elected them. Contact your assemblyperson and senator and urge them to support comprehensive parity legislation (as outlined in Assembly bill A4506, rather in the much more limited Senate bill S4209). To find out who your representatives are and how to contact them:

- *Go to our website: http://naminyc.nami.org/senators.htm and http://naminyc.nami.org/assembly.htm;* ***OR***
- *Go to the "Who Represents Me? (NYC)" website at: http://www.cmap.nypirg.org/webmaps/MyGovernmentNYC.htm and enter your address;* ***OR***
- *Call the New York State Legislature*
  - *Senate: 518-455-2800 (general); 518-455-3216 (public information); 800-342-9860 (bill status hotline)*
  - *Assembly: 518-455-4100 (general); 518-455-4218 (public information); 800-342-9860 (bill status hotline)*

A Firefighter and His Partner

By Adriene Iasoni, CSW
Mental Health Association
of Westchester

I was en route to work the morning of September 11th, when I listened in disbelief to a radio report that planes had struck the World Trade Center. Disbelief turned to horror as I listened to the events unfolding that morning. Before reaching my office, I was paged by my husband, a New York City Firefighter and told that all firefighters had been recalled to duty. When we said goodbye, neither of us knew where he was reporting to and it was several days before I spoke with him again.

The utter devastation I saw in the images on television were mirrored on my husband's face as he recounted his experience at "Ground Zero" and as he spoke of the victims including hundreds of fellow firefighters. With as much emotion as I believe I have ever seen my husband display, he talked about what he saw and the individuals he knew that were accounted for and those that were missing.

As quickly as that emotional window had opened, it closed and it was back to the tasks at hand. In retrospect, I see that as being a window of opportunity to grieve at a time when so many, including my husband feel there is no time for grief.

In the days and weeks following the terrorist attacks on September 11th, rescue workers spend their days at "Ground Zero", fighting fires, and burying and memorializing friends, "brothers" as they call themselves.

At a recent memorial I attended, I spoke to several firefighters who not surprisingly described themselves as "completely numb". It appeared as though they were fearful of the emotion they anticipated would strike when they have "time to grieve." One friend told me he had been to so many memorial services, in so many locations, he wasn't sure where he had left his uniform.

The men I spoke with contend that given the magnitude of not only what occurred on September 11th, but also the events that continue to unfold, they do not have the time to "stop and grieve." Yet as mental health providers, we know that grief is a process rather than a single event. The emotions expressed by these firefighters are natural responses and part of this process.

Memorial services, so devastatingly frequent these days, are an opportunity not only to collectively mourn heroes lost, but to share personal experiences and as unlikely as it may sound reaffirm life. The tremendous support gained by sharing common experiences and mourning together is certainly true not only for rescue workers, but as we have seen among victim's families and all those touched directly or indirectly by the events of September 11th.

While "we stand together", grief is ultimately a unique and personal process. Unfortunately, misconceptions about the grieving process may have negative implications for many individuals. The expectation that there is a time frame after which an individual should "get over it" is not only unrealistic, but also extremely damaging.

I fear that for some the impact of recent events will manifest in insidious ways, such as interpersonal problems, mental health issues, and self-medicating through substance abuse. Although some individuals will seek out professional intervention, many will not. Hopefully for those individuals who do not seek out professional assistance, their existing support network including family members, friends, neighbors and co-workers will provide the support needed to the survivors. For this reason and so many others I believe that as mental health providers, we are "rescue workers" in our own right whose "recovery efforts" will become so critical in the days, months and years ahead.

JBFCS' Loss and Bereavement Program Responds to Trauma - Aids Victims of Recent Disasters

A therapeutic model designed to assist grief-stricken youngsters through the mourning process is at the heart of the Loss and Bereavement Program for Children and Adolescents, a program in the Center for Trauma Program Innovation (CTPI) at the Jewish Board of Family and Children's Services (JBFCS).

Developed in 1989 by Dr. Nina Koh, the program initially served bereaved children and families primarily in Manhattan. Staffed by professionals trained in loss and bereavement, the program includes group therapy for children and adolescents as well as a concurrent group for surviving parents and caregivers.

Representational artwork and the group process are used to assist children and adolescents through the grieving process. Adult groups help surviving caregivers focus on understanding children's reactions and behaviors. Accepting a death, integrating and maintaining memories of the deceased, and moving forward represent important goals in therapy.

Over the years the program has grown tremendously and today, loss and bereavement services are offered at a eleven JBFCS locations, including outpatient clinics, day treatment centers and residential treatment programs across all five boroughs of New York City. In addition, since guidance counselors, classroom teachers, and school principals are often the first to notice the behavioral, academic and emotional changes that occur after a youngster has sustained the loss of a caregiver, some services are even based within community high schools.

The JBFCS program has always put a high priority on prompt intervention. This lessens the risk for a child developing more severe mental health disorders later in life such as depression, anxiety and post-traumatic stress disorder (PTSD), which may occur in a child who has witnessed a violent death.

Because of its past experience with issues of trauma and loss, the Loss and Bereavement program team was able to provide early guidance and intervention within JBFCS following the terrorist attacks on 9/11. The varied supports that the program provided to the agency in the early days following the attacks in turn facilitated the development of a comprehensive and effective agency-wide response.

The expertise of the L&B team was disseminated to the senior clinical staff and then to the rest of the mental health professional staff in an organized and systematic way through a series of trainings and workshops, which are still ongoing. Through these trainings, a curriculum has been established to give mental health providers within the agency the tools to help both established clients and new clients either directly or indirectly affected by the disaster.

L&B's expertise in the area of trauma and loss is one of the significant factors which allowed JBFCS as a whole to respond to a vast array of requests from all over the city. JBFCS has responded to over 175 requests from corporations, agencies, schools and other organizations. Responses have been geared to serve the community in three distinct ways. During the acute post-disaster period, senior clinicians from within the agency worked with groups of family members of the victims from companies that occupied space in the Twin Towers. Then, as other agencies began to define their needs, JBFCS CTPI staff members responded accordingly, providing services ranging from critical incident debriefing sessions to workshops to increase the capacity of those agencies in implementing effective trauma intervention modalities. Finally, JBFCS mental health professionals have been providing specialized treatment for traumatic grief reactions, including the implementation of a modified Loss and Bereavement group model specifically designed to help children and their surviving caregivers cope with traumatic grief, which is a newly proposed diagnostic classification.

As a consequence of its preparations in the wake of the WTC disaster, JBFCS was able to mobilize instantly when news of the tragic crash of American Airlines Flight 587 came to light. One JBFCS clinic in the Washington Heights area was well positioned to use the training and experience gained since the WTC disaster to help families and individuals who experienced loss or adverse effects resulting from the plane crash.

JBFCS continues to respond to the needs of the community by providing training and workshops to audiences ranging from teachers and mental health professionals to parents and varied groups from the community. In addition, it offers direct trauma treatment to around the city. Finally, it has become an integral member of various partnerships and coalitions to ensure that disaster response capacity is effectively developed, implemented and maintained.

The Loss and Bereavement Program is also expanding its capacity to respond to the interaction of trauma and loss. The Program is modifying its existing group therapy model for bereaved children and caregivers so that it can effectively support clients who are dealing with the complex and difficult issues surrounding traumatic bereavement. Once finalized, the revised model will be taught to agency personnel and hopefully to other interested mental health professionals in the New York area. The consolidation of a comprehensive training manual will ensure that the experience of the JBFCS L&B team will become a tangible and useful addition to the body of literature on trauma and loss.

Loss and Bereavement Program for Children and Adolescents

A program of the Jewish Board of Family and Children's Services

For children of all ages, the loss of a loved one can be frightening and confusing

Loss of Interest in School — Withdrawal
Angry Outbursts — Nightmares

These are just some of the signs that indicate that a grieving child needs help
Helping children grieve *now* can help prevent problems in the future.

The Loss and Bereavement Program for Children and Adolescents offers services for children, families and professionals dealing with a death in the home, school or community

Services for Children & Families…

- **12 week bereavement groups for children throughout New York City**
- **Concurrent group program for parents and caregivers**

...and for Professionals:

- **Presentations and workshops following a death in the family, school or community**
- **Workshops on recognizing the signs of grief; talking about death with children; and services available to grieving children**

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United Way of New York City
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limit its impact, not eliminate its deleterious effect entirely.

Our burgeoning knowledge about the biology, prevalence, and treatment of the consequences of trauma, however, has allowed us to combat some of its devastation. Unfortunately, however, traumatic stress disorders turn out to be more common than previously believed – surprisingly up to 8% of the general population over a life-time in recent surveys.

The effects of the trauma of the World Trade Center will not only be massive, they will also be unusually heterogeneous and complex, as well. There is operative what is known as a powerful "ripple" effect, owing to the sheer magnitude, politically frightening implications and enormous, ongoing media coverage, understandable as the latter is. Those injured and fleeing the World Trade Center are likely to suffer the most severe consequences. Only slightly less traumatized, however, will be those in the vicinity at the time and those related to, and grieving, the victims. Unusually so historically, mental health professionals have also reported a widespread impact of this event on our clients at large. One common response to this event among psychotherapy clients has been to trivialize or denigrate their own distress. Finally, as the Pew poll reveals, the impact, to a lesser degree, on the public seems staggering.

In considering all these groups, it's been predicted that the most common overall response will not be traumatic stress disorders per se, but rather severe grief and serious depressions. Other diagnosable anxiety disorders and, more obviously, lesser levels of demoralization and panic are being seen and are further expected, especially given the ongoing threats of bioterrorism and military action. Psychiatric testimony before Congress, including that by the New York Medical College's Dr. Spencer Eth, has underscored that the psychological devastation will last for years.

More classical stress disorders are beginning, of course, to appear in record numbers. Typical of such situations, those most directly affected will generally develop the worst variants of the disorder. But, as with most psychiatric conditions, all levels of severity will be seen – from the incapacitating to the milder, "subsyndromal" varieties - in ways impossible to predict beforehand. The latter patients, we are learning, also appear to benefit from treatment.

An early job of the mental health community has been to help victims and the public differentiate between what is somewhat schematically now classified as: normal stress, Acute Stress Disorder (ASD), and (the more prolonged or delayed) classic Post-Traumatic Stress Disorder (PTSD).

A certain amount of anxiety and sadness is not only normative, but probably appropriate under such tragic circumstances. We on the MCT have found ourselves reassuring many clients and co-workers from the outset that their preoccupation, dysphoria, and even nightmares are perfectly expectable. We advise this group to turn to one's personal supports, to talk to one another about their stress, and to maintain a balance between physical activity, work, and leisure. Turning off the television from time-to-time might not hurt, we've added. Children especially need to be protected from being overly saturated by the non-stop media coverage. Parents, naturally concerned about their children's safety, also will need to find a suitable way to encourage caution without overprotectiveness – what's been called "teaching our kids to keep both their chins and their guards up".

More serious, immediate reactions include those suffering a higher level of general symptomatology as well as exhibiting the various dissociative mechanisms common to 25% to 50% of severe trauma victims. This combination at present is conceptualized in DSM-IV as "Acute Stress Disorder", by current definition a condition lasting for a minimum of 2 days and a maximum of 4 weeks. The patient staring into space for hours and unable to talk about the event is a good example. This categorizing allows for an earlier version of the classic PTSD syndrome complex that, one hopes, lasts briefly.

ASD frequently is prodromal, however, to the better recognized Post-Traumatic Stress Disorder that, by definition, consists of at least month-long symptoms. PTSD may develop right away or be delayed by many months. Its longitidunal course is similarly highly variable: the complex may rapidly ameliorate or may last a lifetime, and it is seen at all intervals in between. It may be, but as a rule is not, totally disruptive to a normal life. Many war veterans have lived with symptoms like nightmares and startle reactions all their lives, while functioning reasonably well, albeit with varying levels of distress.

Neither early preventative efforts nor longterm treatments are entirely satisfactory, but we have made advances. A major challenge is to deliver such therapies widely and rapidly; we are already weeks out now and the demand for skilled clinicians in the World Trade Center aftermath far exceeds fully trained personnel.

Recent experience with early prophylactic medication, such as beta-blockers, has been disappointing. Some intensive, cognitive-behavioral models of acute treatment have proven track records, however, such as Edna Foa's manualized approach, originally developed to help victims of rape. These therapies generally involve an initial educative focus and then intense exposure in the form of detailed recounting or "imaginal" techniques. These re-creations are accompanied by stress reduction or relaxation training to facilitate the successful integration of the fragmented and otherwise toxic memories without overwhelming the personality. Homework assignments and reinforcement are critical elements of such therapies, as well.

Such approaches do not preclude the value of other forms of help. Many psychodynamic practitioners will see families of victims or others with varying degrees of distress from the event, and

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may need quiet time alone. Respect this and recognize that it may be helpful in filtering out the intensity of painful feelings.

3. Maintain usual routines in the home and at school. Bereaved children wish that their lives can continue as before the death. They find it comforting to engage in usual activities. In doing this, be aware that bereaved children may have more limited capacities to perform as usual. Therefore, relax expectations for school achievement and social activities.

4. Seek assistance from other relatives and friends who can help plan and participate in activities with the bereaved children and parents. Other relatives and friends are instrumental to enable communication about grief and continuation of some usual activities and routines.

5. Encourage children to plan and teenagers to socialize. Engagement with others offsets the pain of grief and enables children to renew and fulfill their life needs.

6. Reassure bereaved children that they will be taken care of and that they are safe. Children who lose a parent, sibling, or other close relative worry about their well-being and their grieving parents.

7. Provide opportunities for remembering the deceased by sharing stories, looking at pictures, or creating a memory book.

8. Recognize parents' own grief responses. Bereaved parents need time for themselves to grieve and take care of their personal needs. They should seek support from others and allow others to assist them with their children.

When and How to Seek Help

Bereaved parents and children may benefit from speaking to a professional if children show problematic behaviors that are intense or persistent. Professional help is indicated if children:

- stop playing or socializing with other children;
- become afraid to go to school;
- have severe decline in school performance;
- have persistent physical complaints including head or stomach aches;
- have difficulty sleeping or recurrent nightmares;
- have marked change in eating;
- display severe anxiety, fear, or panic attacks;
- have aggressive behavior towards people, toys, or other objects;
- have increased irritability or agitation;
- have intense preoccupations with the way the death occurred;
- talk or think about wanting to die or kill themselves;
- begin to use drugs or alcohol.

Bereaved parents should not neglect their own needs for help. Professional assistance is warranted if parents are overwhelmed with their feelings, are unable to carry out usual activities at home, work, or with others, if they have complaints of disrupted sleeping, eating, concentration, or withdrawal. If a parent has thoughts of wanting to die, professional assistance is indicated.

There are numerous people in the community from whom bereaved parents can seek some assistance for their children. The level of expertise will vary depending on the professional training in issues of childhood bereavement. Professionals that may assist with aspects of children's bereavement include school psychologists, guidance counselors, teachers, pediatricians, clergy, and child and adolescent psychiatrists. It is important to recognize that a consultation enables questions to be addressed and guidance in ways to help bereaved children. It can offer suggestions about how children are coping with their loss and identify needs for intervention and the types of intervention to utilize.

Programs that offer specific bereavement education, evaluations, and interventions may benefit children by providing a place for children to express their feelings and gain support. Such programs may offer interventions to decrease complications in children's bereavement. For example, the Childhood Bereavement Program at Weill Medical College of Cornell University at New York Presbyterian Hospital in White Plains and New York City offers educational programs for children and parents about bereavement, individual evaluations of bereaved children's and parents' needs, and interventions in individual and group formats for bereaved children and parents. Additionally, psychiatric interventions for children and parents, including medication treatment, are available in this program. Information about this program can be obtained by calling 914-997-5849.

Many questions persist about the long term effects on children's development that are associated with the death of children's parents, siblings, or other close relatives. Since the among of reliable information is limited, systematic gathering of information about factors that influence bereaved children's development, emotions, and behavior are essential to clarify such issues and to identify effective ways of helping bereaved children and their families. To accomplish this, research is needed. Such research requires direct participation of bereaved children and their parents. It also requires nonbereaved children and parents to participate as comparisons of the development of bereaved children. When death of children's close relatives occurs in a community, an important community response is to support and participate in research endeavors.

Finally, the tragic events of September 11, 2001 are unforgettable. This article aims to offer sympathy, support, and education to those who lost a loved-one. It is hoped that the family and community pain generated by this tragedy may be lessened and that understanding and supporting the needs of bereaved children and their families will be ongoing.

***In The Aftermath* form page 34**

can modulate reconstructive with supportive interventions of their own. Medications have a useful, adjunctive role. We formerly used the tricycline antidepressants to help with sleep disruption and to ameliorate nightmares and startle responses, but the Selective Serotonin Re-uptake Inhibitor (SSRI) antidepressants have emerged in the last decade or so as the better choice. Interestingly, empirical studies have shown the SSRI's (fluoxetine, sertraline and paroxetine are the best studied) as having a positive impact on all three symptoms clusters: the re-experiencing, the avoidant, and the hyper-arousal.

As with all work with traumatized patients, timing and overall judgment are critical. The Salvation Army's maxim used to be: "feed the body before saving the soul". Similarly, the astute clinician must help to ensure that essential needs are met first and promote initial conditions of safety. Victims' families may need to receive sufficient resources to prevent acute financial distress before any more focused treatment is even feasible. Suicidal, severely depressed, or substance abusing individuals may require their problems first be addressed in more conventional treatments, including hospitalization, as needed. Comorbidity with traumatic stress disorders is the rule, rather than the exception, another striking rationale for making sure that qualified practitioners are supported and made available.

The sequencing of indicated interventions has traditionally been called "staging" with trauma victims. Education and security first, then direct processing, and eventually an emphasis on re-integrating back into the interpersonal world and the community are the appropriate guidelines, with different permutations appropriate as one proceeds.

This schema over the long run seems especially relevant to those individuals with prolonged longstanding histories of severe traumatic distress, often the result of earlier abuse. Sometimes called "Complex Post-Traumatic Stress Disorder", this condition manifests itself in associated identity and serious relationship problems, as well as in high risks of self-harm and re-victimization. This variant not only requires increased length of treatment but considerable experience and dedication on the clinician's part. A subtype of borderline personality, heavily impacted by multiple abusive experiences, serves as a good example.

Conceptualization of PTSD has undergone somewhat of a shift over the years. Originally it was thought a discrete but relatively rare symptom cluster seen primarily in war veterans and other subjects of direct violence; it was believed almost predictable in severity by level of magnitude of the stressor. More modern research has emphasized its diverse etiology from a variety of sources and the "subjective" and individualized elements involved.

Certain people do not develop PTSD even under horrifying conditions. Conversely, other individuals may be subject to a diathesis to traumatic stress disorders rather readily. Vulnerability factors are now better appreciated. Pre-existing conditions, lack of emotional support, certain personality variables, and biological susceptibilities are all part of the picture.

Both perspectives – the normative and the subjective – jointly shed light upon what we are now likely to expect in the World Trade Center aftermath. There will be significant distress from even the healthiest subjects and their families, while others will appear relatively unscathed. Less involved but more sensitive subjects, as in a study by Sam Perry of burn patients, may well appear among the most affected. Here, too, as with crisis patients, there is no cookbook; each case is an individual and each treatment must be tailored specifically for that unique person.

This complexity of the topics of "crisis" and "trauma" and the consequent need for individualized assessments and treatments underscore why work with such patients necessitates expert skills and experience. The comprehensive nature of the ideal response required – careful diagnoses, ongoing evaluations, well studied interventions, and medication and hospitalization, as indicated – argues strongly that our public health system be supported and strengthened, for future potential crises, as well. It is time for the public to recognize that, as with the growing bioterrorism threat, the best insurance against catastrophes is a thriving public health infrastructure – be it outpatient clinics, hospital emergency rooms, or local crisis services.

If handled well, a less baneful result of this horrible tragedy could also be for us all – as a profession and as a society – the chance to study rigorously the mental health ramifications of such catastrophic events – both upon those most directly affected and upon public perceptions, as well. This effort, too, will undoubtedly require both government and private support for serious research follow-up. As former American Psychiatric Association President Dr. Joseph English has commented to me, "It would surely be a shame if this unprecedented opportunity to learn from this disaster – right here in the midst of the most distinguished medical centers in the world – were not properly picked up by our field".

One hopes, as well, that one consequence of the recent attacks might be similar to that of military psychiatry's influence and impact on the U.S. after World War II. Americans then came to realize how significant is the psychiatric dimension to the overall health and strength of a nation. A humane and caring society owes its citizens of today and its mental health practitioners no less support and recognition.

Dr. Richard Gallagher is Medical Director of the Westchester CPEP (Comprehensive Psychiatric Emergency Program) and Mobile Crisis Team, based at the Behavioral Health Center of the Westchester Medical Center. He is an Associate Professor at New York Medical College and a faculty member at the Columbia Psychoanalytic Center.

***Mental Health* from page 30**

We are not ordinarily aware of how much our experience of who we are depends on our sense of belonging to extra-familial entities such as churches, schools, towns, and finally country, which are held in high regard. Any challenge to the integrity of these institutions therefore threatens our self-esteem. Reactions to such threats are perhaps the most difficult to control because we cannot live without self-esteem. Threats to self-esteem can lead to shame and anger in addition to reinforcing anxiety and despair. These reactions if out of control, are the ones most likely to put self and others at risk.

Precisely because anger is a necessary and even biologically determined ("fight or flight" mechanism) response we are less prone to question it—particularly when directed at the enemy. It can be alarming when it erupts, seemingly inexplicably, when directed at loved ones. Last week, for example, I spoke to a mother who was feeling badly because she had yelled at her child after watching a news program concerning the WTC attacks and the U.S. military response.

Of the three groups of responses that I have described, rage reactions are obviously the most dangerous. On the afternoon of September 11th I passed a man on the street saying on his cell phone "let's nuke them." Because our anger and indignation are so understandable we are apt to underestimate the irrationality to which it can lead.

Rage may also be the least predictable emotion, making it all the more important that we pay attention to its early signs, e.g. irritability so that we can prevent it from escalating. The intense feelings of solidarity that most Americans have experienced in the weeks following Sept. 11, have probably served to reduce and contain much anger. As time passes however, especially if, as is likely, the threat of terrorism persists, we may experience more of these feelings.

How are we to cope with these extra burdens of anxiety, despair, and rage? I think most of us know the answers as well as the "experts." We should remember first that both in our individual and collective histories we have demonstrated the ability to cope, sometimes in extraordinary ways, with adverse circumstances.

Perhaps the most powerful antidote to our distress is social support and solidarity. We have been witnessing this in all its myriad forms. Thousands of people, throughout the nation as well as New York and Washington have given their direct and financial support to victims, rescue workers and their families, both direct and indirect. The media has stressed and reinforced these activities as well as forgoing advertising revenues for the public good.

Families have been reuniting and spending more time together. Countless memorial services have been held, many attended by people who did not know the victim personally. And finally meetings and discussions in schools, churches, synagogues and mosques and other community institutions, have given people an opportunity to give expression to their common concerns.

Most of us are also aware of the value of constructive action to reduce our sense of helplessness and reassert our sense of control over our lives. This is true whether we are engaged in activities directly related to the events or pursuing our private activities as before.

The first casualty when we are overwhelmed by our feelings is the loss of our ability to reason. Yet it is reason that allows us to establish perspective, make sound judgments, discern choices and find solutions. Paradoxically, however, if reason is to gain sway over emotion, we must give the latter its due. It is important to feel free in the right circumstances, for example with friends and family, to express our fears, feelings and fantasies, so that we can separate fact from fantasy, and subjective experience from objective reality. Finally, there is the challenge of making positive use of the tragedy in order to live better and more positive lives in the future. Perhaps Sept. 11 will continue to help us distinguish what is truly important and valuable in our lives from what isn't. Perhaps also, the suffering of so many of our peers, friends, colleagues, and countrymen, as well as our heightened awareness of our vulnerability may bring us closer to the suffering of others, in our country and elsewhere and intensify our efforts to change the world for the better. Surely such efforts not only protect mental health- they are manifestations of it.

Helping Children

Understandably much attention has been given to the question of how to help our children cope with September 11 and its aftermath. A basic assumption underlying the answer to this question is that children are not little adults. They have a different sense of time and a different sense of the world than do adults. To a four-year old child, for example, the "world" is his family, his nursery school, and perhaps his street. If that world remains intact the child will continue to feel secure. He has different needs for nurture and protection, a different attention span, and different understanding.

Because of his different sense of time, the young child does not understand the implications of death. If he mourns, he mourns differently than does the adult.

We should not expect, therefore, our children to have the same fears and feelings as we do. To their parents surprise and not infrequent consternation, for example, a five-year old child who has been told about the imminent death of a parent will often respond by asking who will take care of her. Once reassured, she will give little indication of distress and ask no further questions.

Children want to know if the "world" on which they depend is intact. This means that parents and other caretakers can continue to care for and protect them. The answer to that question, however, is not only communicated in words. If caretakers say one thing and indicate something else by their behavior the child will not be reassured. Therefore caretakers have to attend to their feelings and behavior as well as to what they say.

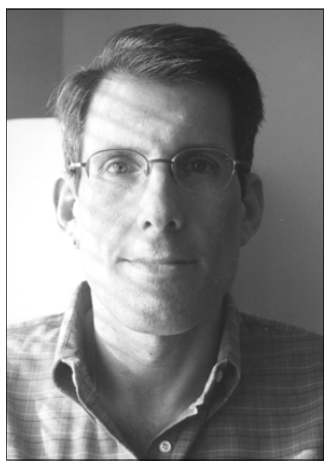
Often parents and teachers are not sure what to say for fear of giving information that the child can't handle. Three principles are worth keeping in mind here. First, children can cope with almost anything a trusted person tells them so long as that person is in control of their own feelings and is communicating out of a wish to help the child. Secondly, children let us know how much they need or want to know if we pay attention. Thirdly, children do not need to be told that the world is perfect or be protected from the knowledge of sad realities. Their own dreams and fears have already made them all to aware of frightening "realities." Instead they are reassured by appropriate discussions of those realities, including what is being done to cope with them. It is we adults who need the most help, for it is we who understand the tragic consequences and frightening implications for our "world" of the events of Sept. 11.

In My Opinion, we are Enemies of the State

By Joshua Koerner
Executive Director, CHOICE

I recall as if it were yesterday the bright clear morning my father went to work and never came home. The collapse of the World Trade Center brought that morning back more vividly than I ever would have expected. Not only did I feel shock, grief and hopelessness; I felt them as if I were thirteen years old. I had to cope, go to work and carry on. At the same time I was falling apart. But who I am today has understanding and compassion for the young man whose father died on the streets of New York City, even though back then I went on to make some ugly, self-destructive choices.

As a teenager I suffered crushing depression, enormous rage, and tortuous, obsessive thoughts about what my father's last seconds on Earth might have been like. I finally found solace in drugs. Many drugs, and many different types of drugs. Add to that a genetic predisposition to mental illness -- my grandfather was suicidal by the time he was fourteen – and it's no surprise that by my twenties I was acutely sick. Nor is it surprising that I came to believe I had messianic powers. I didn't want to believe, even after a decade, that my father wasn't coming home. I wanted to believe I could the raise dead.



Joshua Koerner

Dragged into the mental health system, my life was reduced to police reports, commitment protocols and diagnoses. I was treated like a dangerous, drug-abusing psychotic, and the last thing anyone cared about was my fragile sense of self. Imagine how it felt to be handcuffed, locked on a psychiatric ward and jumped in the middle of the night by hypodermic-wielding orderlies. There were less dramatic abuses: callow resident doctors got their shot at me. I was psychiatrically poked and prodded for educational purposes, interviewed, tested and hung out to dry in case conferences during which I was put on display for rooms full of strangers.

Now imagine the same thing, and worse, happening to the survivors of September 11th. The mental health system in New York State is not more compassionate now than it was I first entered it. It is demonstrably less so. Now we have involuntary outpatient commitment as well as inpatient commitment. The state has made clear its abiding dedication to the use of forced electroshock. The rift between the delivery of mental health services and substance abuse services remains. Insurance companies continue to discriminate, withholding mental health services with impunity.

Children whose fathers were crushed to dust can expect to be treated as enemies of the state if they become mentally ill. It happened to me, and it can happen to them unless we alter the agenda of our mental health system.

Now more than ever we need to remove the element of force and coercion from treatment. We need to recognize that mental illness is more than biology, and treatment is more than medicine. We need to recognize the benefits of services that value rehabilitation, recovery and rights, and to reallocate funding to reflect the importance of those services. We need to improve the linkages between substance abuse services and mental health services, and to restructure funding to enhance those linkages. We need to pass laws making discrimination by insurance companies illegal.

In other words, we need to do all the same things we needed to do before September 11th. It's just that now even more people will suffer if we don't.

Sidran Foundation Releases New Manual On Starting Effective Peer Support Trauma Groups

The Essence of Getting Real
Risking Honesty, Connection and Hope with Peer Survivors

By Jennifer Wilkerson
Sidran Traumatic Stress Foundation

A grassroots peer support group is a powerful force promoting community, connection, and hope in the lives of survivors of traumatic stress. ***The Essence of Getting Real*** presents a new approach to creating, facilitating, and maintaining a peer support program for people who have experienced traumatic events. Many people who experienced the events of September 11 will find it useful. But it will particularly resonate with those who have histories of psychiatric illness, trauma, and other vulnerabilities who have been "shaken" in their recovery work by the recent events.

Whether you are interested in starting a new group or adding to an existing one, this approach can help guide the discussions you have about the effects of traumatic experiences and the path to healing. The goal of this manual is to provide you with a deeper understanding of the effects of trauma, particularly within the context of relationships, in order to create long-lasting and meaningful change.

The Essence of Getting Real is about **you** and your relationship with yourself and others. It is about being honest about where you are in life and what you need from others, when honesty is the biggest risk you could take. Some of the issues and questions we address include:

- How can I distinguish who I am from what I have been through?
- Reclaiming a sense of identity that is not trauma-based
- How can I be real with myself and others when I don't feel like I even know myself?
- How can trauma inhibit my ability to connect and be authentic?
- How do I relate to the person, not the behavior?
- What role do I play in group settings?
- Where has trauma stopped me in my tracks?
- What needs do I meet at the expense of my boundaries?
- How does my attitude change when I think of symptoms as adaptations?

This manual is about being real in the midst of painful circumstances, knowing that what you have experienced does not define who you are. This approach is about hope and the power of connection. Ask anyone who has struggled with something painful what gave them hope, and they'll tell you it was the knowledge that others made it through a similar experience. Sometimes hope comes in the form of just showing up and being real, even if you doubt that you have anything to offer. Too often, we are taught that we have to offer more than ourselves to be acceptable. This manual supports the notion that you are an amazing gift all by yourself.

Effective peer support relies heavily on the power of hope, and on the belief that every person who has experienced trauma can do more than merely survive it. There has been a tendency, in trauma groups, to take an inventory of pain more readily than to assess what is already working, what has already healed, what is already strong in a person's life. In peer support groups, you can support each other in the weak places by using the strength and hope that has allowed you to come this far.

There is no secret formula for making a peer support group successful, just as there is no perfect equation for a friendship or a partnership. I believe the one variable that makes the difference is simply this: you must be willing to risk being real. Your ability to be honest about who you are, where you are, and what you need, are all part of being real. Connecting to others helps you get there. That is the ***Essence of Getting Real***.

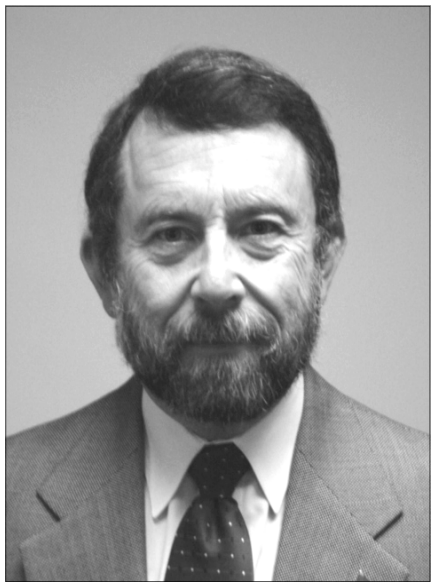
The manual for *The Essence of Getting Real* will be available from Sidran in January, 2002. It can be pre-ordered at www.sidran.org, or at 1-888-825-8249. The Sidran Traumatic Stress Foundation provides an in-house or on-site training for the ***Getting Real*** model. To discuss a ***Getting Real*** training program that meets your needs, contact Jennifer Wilkerson at jen@sidran.org, or call 410-825-8888.

Sidran
TRAUMATIC STRESS FOUNDATION

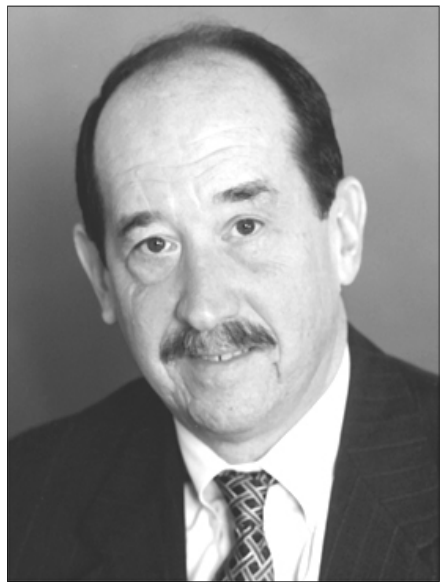
Project Liberty
"Feel free to feel better."
September 11th
Community Support Team

Westchester

Governor George Pataki Launches Project Liberty
New York State Office of Mental Health Commands Regional Effort
Westchester DCMH Spearheads The September 11th Community Support Team
The Westchester Family Response Center Opens



Steven J. Friedman, Commissioner
Westchester County
Department of Community Mental Health



James L. Stone, MSW, CSW
Commissioner
New York State Office of Mental Health

George E. Pataki
Governor
New York State

Andrew J. Spano
County Executive
Westchester County, New York

Governor George E. Pataki has launched New York State's Project Liberty, a program to provide free crisis counseling services to individuals in the New York City area who are having difficulty coping with the events of Sept. 11.

"The events of Sept. 11 have caused extraordinary stress on many Americans and in particular New Yorkers whose lives have been forever altered," Governor Pataki said. "Project Liberty is in place to help individuals who may need assistance returning to their pre-disaster lives."

State Mental Health Commissioner James L. Stone said, "Project Liberty offers skilled counseling to individuals at work, in school, at home, wherever they are most comfortable."

Westchester County Commissioner of Mental Health Steven J. Friedman said, "I would like to express my gratitude and appreciation to all those who are part of the system of services in Westchester County for their quick response to the needs of our community on September 11th and on the days that followed. I am proud of how quickly and competently we came together. The immediate response was comprehensive and well integrated. During this emergency, individual clinicians, professional societies, provider agencies and hospitals worked closely with the Department of Community Mental Health, offering crisis counseling and identifying the future needs of our residents.

I also wish to thank Commissioner Stone for the quick response by the State Office of Mental Health to this tragedy and his immediate inclusion of Westchester in this effort. Services are now available to our residents through Project Liberty-Westchester, the September 11th Community Support Team. Project Liberty will work closely within our existing system. Project staff is here to help the residents of Westchester during this difficult time, and I am confident that individuals and families will be well served. I invite you to use the assistance that is available through Project Liberty. Their telephone number is 686-6803.

I would now like to share with you a very special letter from our County Executive Andy Spano:

Several weeks after the World Trade Center disaster, I had the opportunity to visit Ground Zero as part of a delegation of elected officials and other dignitaries. Despite all the images I had seen on television and the media, I was not prepared for the immensity of the devastation. It was a jolting sight.

Three months after the initial event, we are all still feeling the aftershocks of Sept. 11. You don't need to have lost a loved one, a friend or a job to have been affected by the World Trade Center tragedy. Millions of people across this country are feeling the weight of these events, and they need to reach out to others for solace.

To help people recognize and cope with these feelings, the Federal Emergency Management Agency has made funds available to us to provide assistance.

In a pamphlet developed by our Department of Community Mental Health, you will learn that reactions you may be having -- feelings of hopelessness, impatience, difficulty sleeping -- are all normal under the circumstances. You will also learn about what you can do to relieve some of these feelings, and where to get help if they begin to disrupt your life.

Just remember, we are all in this together. The sooner we share our feelings, the sooner we can get back to normal and sleep better at night.

Andy Spano, Westchester County Executive"

The crisis counseling program, funded by a $22.7 million grant from the Federal Emergency Management Agency (FEMA), is a collaboration involving the New York State Office of Mental Health (OMH), local governments and providers of crisis counseling services.

The grant makes services of Project Liberty available through local mental health agencies to residents of New York City, Nassau, Suffolk, Westchester, Orange, Rockland, Dutchess, Putnam, Delaware, Sullivan and Ulster Counties.

In consultation with the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, OMH has contracted with individuals who have special expertise in disaster recovery and trauma in terrorist incidents to act as advisors and trainers. In addition, OMH is coordinating specialized training sessions for mental health providers participating in Project Liberty.

OMH is also collaborating with the New York City Department of Mental Health to track the delivery of crisis counseling services.

For more information about Project Liberty, or to arrange for services, individuals can call 1-800-LIFENET, go online to visit the statewide Project Liberty web site at www.projectliberty.state.ny.us or call the The September 11th Community Support Team at (914) 686-6803, located at 150 Grand Street in White Plains, New York.

Project Liberty
"Feel free to feel better."
September 11th
Community Support Team

Westchester

How Can I Cope With Disaster?

By Project Liberty-Westchester
Sept. 11 Community Outreach Team

HOW CAN I COPE IN A DISASTER?

A certain amount of stress is present in your everyday life, but it can become more intense during a disaster. Experiencing stress is normal and expected in these types of situations. You may find answers to the following questions helpful.

HOW AM I AFFECTED BY STRESS DURING A DISASTER?

You may experience physical symptoms associated with stress such as headaches, upset stomach, diarrhea, or have poor concentration, and feeling of irritability and restlessness.

WHAT CAN I DO TO MINIMIZE THE STRESS OF A DISASTER?

- Talk to family and friends about your feelings about the disaster.
- Try to get regular exercise consistent with your physical condition. Do things that help you relax such as listening to music, running, reading a good book, or taking a hot bath.
- Get enough sleep and eat regular meals. Try to avoid foods high in sugar, fat and sodium, such as donuts and fast foods. Take a good vitamin and mineral supplement to be sure your body is getting the nutrients it needs.
- Avoid excessive use of alcohol and coffee. Caffeine is a stimulant and should also be used in moderation as it affects the nervous system, making you more nervous and edgy.
- Although you need time alone, you should also spend time with friends and family. Talk about things (home, friends, family, hobbies) other than the disaster.
- Participate in individual and group social activities (movie, dinner, volleyball, picnic).
- Humor helps ease the tension.

HELPING CHILDREN HANDLE DISASTER-RELATED ANXIETY
(From the Mental Health Association of Westchester County)

Children sense the anxiety and tension in adults around them. And, like adults, children experience the same feelings of helplessness and lack of control that disaster-related stress can bring about.

Unlike adults, however, children have little experience to help them place their current situation into perspective.

Each child responds differently to disasters, depending on his or her understanding and maturity, but it's easy to see how an event like this can create a great deal of anxiety in children of a all ages because they will interpret the disaster as a personal danger to themselves and those they care about.

Whatever the child's age or relationship to the damage caused by disaster, it's important that you be open about the consequences for your family, and that you encourage him or her to talk about it.

QUICK TIPS FOR PARENTS

- Children need comforting and frequent reassurance that they're safe -- make sure they get it.
- Be honest and open about the disaster.
- Encourage children to express their feelings through talking, drawing or playing.
- Try to maintain your daily routines as much as possible.

Pre-School Age Children

Behavior such as bed-wetting, thumb sucking, baby talk, or a fear of sleeping alone may intensify in some younger children, or reappear in children who had previously outgrown them. They may complain of very real stomach cramps or headaches, and be reluctant to go to school. It's important to remember that these children are not "being bad" --they're afraid. Here are some suggestions to help them cope with their fears:

- **Reassure young children that they're safe.** Provide extra comfort and contact by discussing the child's fears at night, by telephoning during the day and with extra physical comforting.
- **Get a better understanding of a child's feelings about the disaster.** Discuss the disaster with them and find out each child's particular fears and concerns. Answer all questions they may ask and provide them loving comfort and care. You can work to structure children's play so that it remains constructive, serving as an outlet for them to express fear or anger.

Grade-School Age Children

Children this age may ask many questions about the disaster, and it's important that you try to answer them in clear and simple language.

If a child is concerned about a parent who is distressed, don't tell a child not to worry--doing so will just make him or her worry more.

Here are several important things to remember with school-age children:

- **False reassurance does not help this age group.** Don't say disasters will never affect your family again; children will know this isn't true. Instead, say, "You're safe now and I'll always try to protect you,-- or--Adults are working very hard to make things safe." Remind children that disasters are very rare. Children's fears often get worse around bedtime, so you might want to stick around until the child falls asleep in order to make him or her feel protected.
- **Monitor children's media viewing.** Images of the disaster and the damage are extremely frightening to children, so consider limiting the amount of media coverage they see. A good way to do this without calling attention to your own concern is to regularly schedule an activity--story reading, drawing, movies, or letter writing, for example--during news shows.
- **Allow them to express themselves through play or drawing.** As with younger children, school-age children sometimes find comfort in expressing themselves through playing games or drawing scenes of the disaster. Allowing them to do so, and then talking about it, gives you the chance to "re-tell" the ending of the game or the story they have expressed in pictures with an emphasis on personal safety.
- **Don't be afraid to say, "I don't know."** Part of keeping discussion of the disaster open and honest is not being afraid to say you don't know how to answer a child's question. When such an occasion arises, explain to your child that disasters are extremely rare, and they cause feelings that even adults have trouble dealing with. Temper this by explaining that, even so, adults will always work very hard to keep children safe and secure.

Adolescents

Encourage these youth to work out their concerns about the disaster. Adolescents may try to down-play their worries. It is generally a good idea to talk about these issues, keeping the lines of communication open and remaining honest about the financial, physical and emotional impact of the disaster on your family. When adolescents are frightened, they may express their fear through acting out or regressing to younger habits.

- Children with existing emotional problems such as depression may require careful supervision and additional support.
- Monitor their media exposure to the event and information they receive on the Internet.
- Adolescents may turn to their friends for support. Encourage friends and families to get together and discuss the event to allay fears.

If more assistance is needed contact: **Project Liberty-Westchester at 686-6803.**

The September 11th Community Support Team
150 Grand Street, Terrace Level
White Plains, New York, 10601

Our 24-hour, 7-day crisis hotline number is:

(914) 686-6803

Monday through Friday, 9:00 am until 8:00 pm
All services are free and confidential. Se habla Espańol.

In response to the events of September 11, 2001 the Westchester County Department of Community Mental Health's Project Liberty-Westchester has been mobilized to provide disaster-related interventions that include outreach, crisis counseling and education for disaster survivors, their families, local government, rescuers, disaster service workers, business owners, religious and civic groups and other special populations.

Project Liberty
"Feel free to feel better."
September 11th
Community Support Team

Westchester

A Community of Caring & Support

In response to the events of September 11, 2001 the Westchester County Department of Community Mental Health (DCMH) has worked in close cooperation with the New York State Office of Mental Health (OMH) and the Federal Emergency Management Agency (FEMA) to implement Project Liberty-Westchester. Project Liberty-Westchester provides disaster-related interventions that include outreach, crisis counseling and education for disaster survivors, their families, local government, rescuers, disaster service workers, business owners, religious and civic groups and other special populations. Crisis counseling services are geared toward assisting in coping with the extraordinary stress caused by the disaster. Services provided are short-term interventions with individuals and groups experiencing psychological reactions to a major disaster and its aftermath. Outreach is the primary method of delivering service and consists primarily of face-to-face contact with individuals in their natural environments (home, places of worship, schools).

Project Liberty-Westchester also provides education and training services in Westchester County. This includes the development, distribution and presentation of information on the project and crisis counseling-related topics. Educational information is provided through brochures and posters placed in public areas, mailings and training to human service personnel. Project Liberty-Westchester is available to present psycho-educational information (e.g. How Can I Cope in a Disaster) to community groups.

In most disasters/crisis situations, a majority of individuals have needs that can be met by short-term, relatively informal interventions. In some circumstances, individuals may need long-term, more formal mental health services that are beyond the scope of Project Liberty-Westchester. In this situation, an individual will be referred to a contract agency of the Westchester County Department of Community Mental Health.

for more information or to request assistance contact:

Project Liberty-Westchester
The September 11th
Community Support Team

150 Grand Street, Terrace Level
White Plains, New York, 10601

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September 11
The Westchester Family Response Center
for individuals and families affected

At this Center, representatives from several organizations will be available to help eligible individuals and families secure financial assistance counseling and other special services through a simplified application process

Please call weekdays to make an appointment and find out what information you may need to bring with you:

(914) 995-3916
English/Spanish

Open Tuesdays/Thursdays,
10:00 a.m. to 3:00 p.m.
143 Grand Street, White Plains, NY

The Westchester Family Response Center is sponsored by the Westchester September 11 Coordinating Committee:

American Red Cross in Westchester County • Catholic Charities
The Salvation Army • United Way of Westchester and Putnam
Victims Assistance Services/WestCOP • Westchester Community Foundation
Westchester County Department of Community Mental Health/Project Liberty
Westchester One-Stop Employment Center

MENTAL HEALTH NEWS™
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SUBSCRIPTION CATEGORIES *(four quarterly issues)*:

❒ Consumer/Survivor/Ex-Patient $15 ❒ Student $25 ❒ Individual $35

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❒ Business Card (three issues) $180 ❒ Eighth Page $245

❒ Quarter Page $395 ❒ Half Page $545

❒ Full Page $825 ❒ Back Page $1,000

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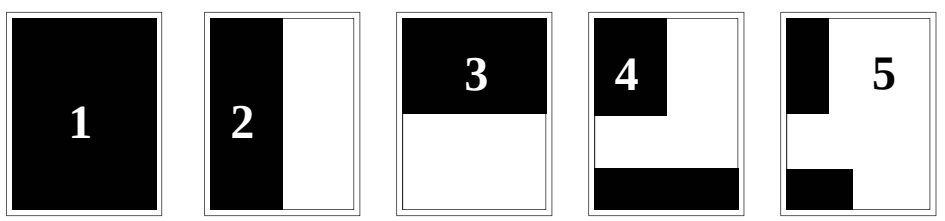
Deadline Calendar, Rates & Ad Size Specifications

Deadline	Release Date
February 1, 2002	April 2002 (spring issue)
May 1, 2002	July 2002 (summer issue)
August 1, 2002	October 2002 (fall issue)
November 1, 2002	January 2003 (winter issue)



Full Page $825 | Half Vertical $545 | Half Horizontal $545 | Quarter V & H $395 | Eighth V & H $245

Ad Size Chart

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

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