

# MENTAL HEALTH NEWS™

YOUR TRUSTED SOURCE OF INFORMATION, EDUCATION, ADVOCACY AND RESOURCES  
WINTER 2003 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 5 NO. 1

## *Mental Health News Salutes NAMI*

# The National Alliance for the Mentally Ill

**T**he National Alliance for the Mentally Ill (NAMI) is a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses, such as schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, and anxiety disorders.

NAMI is dedicated to the eradication of mental illnesses

and to the improvement of the quality of life for all whose lives are affected by these diseases.

Founded in 1979, NAMI has more than 220,000 family members and consumers who seek equitable services for people with severe mental illnesses, which are known to be physical brain disorders. Working on the national, state, and local levels, NAMI provides education about severe brain disorders, supports

increased funding for research, and advocates for adequate health insurance, housing, rehabilitation, and jobs for people with serious psychiatric illnesses.

In addition to 1,200 state and local affiliates in the United States, NAMI has affiliates in the District of Columbia, Puerto Rico, Canada, and American Samoa, and has helped start sister organizations in Australia, Japan, and the Ukraine.

Mental Health News is proud to salute NAMI and to bring this organization's vital mission to the attention of our readers. Please consult our table of contents for the full story in our NAMI tribute.



## *Mental Health News Launches All New*

# New York City Section - Premier Issue

**T**hanks to the efforts of many of New York City's leading mental health organizations, Mental Health News is pleased to announce the premier of an exciting new section of the newspaper devoted to the New York City area.

Almost a year in development, the *all new* New York City Section

will focus on the vital need to provide a free and readily available source of mental health education to thousands of individuals and families who live in Manhattan, the Bronx, Queens, Brooklyn and Staten Island.

According to Ira H. Minot, founder and publisher of Mental Health News, "We now know that one of the key components in the recovery process is to offer people mental health education and the ability to make informed choices and access to the wide array of

community mental health supports and services around them. Having a resource like Mental Health News provides a beacon of hope to countless individuals and families who desperately need a helping hand."

The roll-out of the New York City Section comes at a critical time to the Metro NYC region, which is still coming to grips with the mental health challenges posed in the aftermath of 9/11.

See pages 31 thru 47 for all of the exciting contents.



New York City Section

Mental Health News  
Recipient of the  
NAMI-NYS 2002 Media Award  
and The Guidance Center  
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2002 Award

Also in this issue of

**MENTAL HEALTH NEWS**

- **Senator Paul David Wellstone - Memorial Tribute**
- **The NARSAD Report - A New Research Column**
- **Zen Answers To Your Mental Health Questions**
- **The Four Winds Hospital Winter 2003 Supplement**

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Ira H. Minot, C.S.W., President, Founder & Publisher  
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Wishes to Express Its Sincere  
Gratitude And Appreciation  
To The Members Of Our  
Advisory Council And To The  
Organizations and Supporters Who  
Make This Publication Possible***

# The Publisher's Desk

## "One Voice"

**Preparing for Tomorrow  
By Uniting Behind our Vital Issues  
A Primer For Future Legislation**

**By Ira Minot, CSW, Founder & Publisher, Mental Health News**

First let me wish everyone a Happy and Healthy New Year. My heart is soaring with pride from the many achievements Mental Health News has made in bringing its message of hope to more and more people during the past year.

I am deeply thankful to you all for your continued support and participation, which has fueled the newspaper's success.

As I write this page, we have just made it thru the November Election. It has been hard to bear the onslaught of speeches, sound-bites, political advertisements, and promises made over the past seven months.

As a person with mental illness, I feel used and abused over the fact that our issues are so much grist for the political mill during election time—only to be diminished during terms of office, year after year.

So our good friends at NAMI-NYS have put all of our vital issues on paper. This is a fitting example of why I am so honored to have had the opportunity to pay tribute to the essential and energetic achievements of the entire NAMI organization in this issue of Mental Health News.

I hope you enjoy this issue's salute to NAMI and are as excited as we are about the premier of our new New York City Section. We will be tackling the subject of *Housing for People With Mental Illness* in our Spring Issue and then take a look at *Employment Issues* this Summer.

Best Wishes  
Ira H. Minot

## **The Mental Health System: What Voters and Legislators Should Know**

**By NAMI-New York State**

### **A Good Investment**

Mental illness is more common than cancer, diabetes or heart disease. Of the ten leading causes of disability worldwide, four are psychiatric conditions. Twenty-three percent of American adults have a mental disorder in any given year, while 5.4 percent have a serious mental illness.

Yet even the most serious mental illnesses are highly treatable, with a success rate that is better than many "physical" illnesses.

Properly implemented, mental health services are now highly effective in enabling individuals to recover and go on with their lives. Of course, restoring people as productive members of society has numerous economic benefits.

When mental health services are cut, the costs "snowball" throughout the system. Just ask anyone who is in charge of providing local services in the areas of health, public assistance, criminal justice, family services or education what the loss of mental health services means to their bottom lines. One ends up paying "from the same pants" but from (often several) different pockets, with a greater overall cost to taxpayers.

### **Displacement**

The closing of state psychiatric center beds without adequate community mental health services has not only caused a terrific strain on other human services but has displaced thousands of persons into jails, homeless shelters, adult homes and even special locked units of nursing homes.

Anywhere you go in New York State, the largest "psychiatric facility" will be the area's jail or prison. More than 10 percent of prison inmates and up to 20 percent of jail inmates have serious mental disorders, between eight thousand to eleven thousand persons. Rikers Island alone houses two thousand to three thousand persons with a mental illness.

It costs New York State an average of \$175 a day (in 1996) to provide a bed in Rikers Island; it costs the state an average of \$32.87 a day to provide a supportive housing (mental health transitional housing) bed in New York City.

Between 40 to 50 percent of the residents in New York City's homeless shelter system, 3,200 to 4,500 people, have a chronic mental illness. The average cost of homeless shelter bed in New York City in 1999 was \$68 a day. The stipend the state pays for a New York City supported housing (residential) bed averages about \$30 a day.

As many as 15,000 people with psychiatric disabilities are now housed in adult homes, many of whom were shunted out the back door of psychiatric centers as beds were closed. The neglect they have subsequently suffered in adult homes is a public scandal that will cost many millions to remedy.

An even more heinous scandal that has come to light only recently involves up to a thou-



**Ira Minot**

sand individuals who were transported from state psychiatric centers into locked nursing home units that are unlicensed and unregulated. These individuals, most of whom are in their '30s and '40s and physically healthy, are virtual prisoners, without rights or legal protections. This is very much like the Willowbrook scandal of the '80s.

### **Disappearing Care**

Despite considerable growth in the state's overall budget in the past decade, the budget for the Office of Mental Health, when adjusted for inflation, is no larger than it was eight years ago. The struggle to keep expenditures in line with a stagnant income has resulted in the sacrifice of care in the services the system does provide. Care is disappearing from the mental health care system.

Psychiatric centers, which are the only providers of intermediate and long-term care, will soon be at or below the bare minimum of beds required to serve the two percent of the state's mentally ill population that needs this care. Already, it often takes weeks and months of waiting to gain access to this care.

A bright spot in this picture is the state's promotion of Assertive Community Treatment (ACT) treatment and support they need) teams to maintain persons with serious mental illness in their communities, providing the medical treatment and support they need to stay out of the hospitals, homeless shelters, jails, etc. The ACT program needs support, however, both financial and political, for it to succeed in localities around the state.

Nowhere is the care crisis more critical than in the community services sector, however. Frozen funding levels year after

year, without "trends" or "adjustments," have created so much financial pressure, many community agencies are in danger of imploding.

Housing agencies are in the worst shape. Upstate, the average cost of rent alone is approaching the stipends provided by OMH to pay for all the costs associated with housing persons with mental illness. Precious little is left to pay for salaries, materials, contingencies, administration and overhead. In many areas downstate, the average cost of rent has already exceeded the entire stipend.

The lack of money to pay salaries has devastated any care these agencies have been able to give, and they are now competing with establishments like McDonald's for employees. Congregate care residences might have one staff person on duty for 40-50 residents, and that person, with only a high school diploma, may be in charge of dispensing hundreds of medications. More than half of the employees in the state's congregate care agencies leave every year. As the gaps in coverage increase, so do the tragedies that can so easily occur with this very vulnerable population.

The situation is so critical that many community housing agencies are at the point of going out of business because they simply can't cover their costs.

A three percent COLA, the first in many years, was approved this year for community mental health workers, to go into effect in December. This is an important but tiny first step, but much more support will be needed just to maintain the community housing services now available.

Meanwhile, the housing that is now available only serves 11.9 percent of the state's population with mental illness. This means a wait of many months, even years, for many people who need it. This is hard on everyone, including many families. Some 49% of individuals discharged from hospitals are discharged to their families, a practice that has been going on for generations. Many parents are now elderly and are desperate to find an appropriate housing environment for their children, whom they are no longer able to take care of.

It should be noted that the estimate of 3,200 to 4,500 persons in New York City's shelter system accounts for only about half of the total estimated number of the city's homeless who have a chronic mental illness. The rest are on the streets.

**see A Primer on page 51**

# MENTAL HEALTH NEWSDESK

## National News

### SSA Announces New Employment Initiatives HHS Announces Medicare Premium Rates For '03

#### SSA Announces New Employment Initiatives

Several new initiatives to assist people with disabilities who want to go to work have just been announced, which include the Disability Program Navigator, which will link people with disabilities who visit the Department of Labor's One-Stop Career Centers with employers and benefit planning assistance and outreach organizations. The Navigators, who will work in the One-Stops, will also provide information on Social Security's work incentives, employment networks and the Ticket to Work program.

The Ticket to Work program provides Social Security and Supplemental Security Income beneficiaries with more choices and expanded opportunities to help them go to work. Upon receiving a Ticket from Social Security, individuals may give it to an employment network to obtain free vocational rehabilitation, job training, and other support services. The Ticket program, launched in February 2002, will be available nationwide by January 2004.

As an offshoot of Ticket to Work, a new service has been developed with the Department of Labor to help employers locate

and recruit skilled employment candidates with disabilities. The service, "Ticket to Hire," is a free, national referral service for employers to recruit workers from the Ticket to Work program. "Ticket to Hire" specialists, available at 1-866-TTW-HIRE (1-866-889-4473), will answer questions about the Ticket to Work program.

Please visit [www.ssa.gov](http://www.ssa.gov) and [www.disabilityinfo.gov](http://www.disabilityinfo.gov) for more information.

#### HHS Announces Medicare Premium/Deductible '03 Rates

The Department of Health and Human Services (HHS) today announced the Medicare premium, deductible and coinsurance amounts to be paid by Medicare beneficiaries in 2003.

For Medicare Part A, which pays for inpatient hospital, skilled nursing facility, and some home health care, the deductible paid by the beneficiary will be \$840 in 2003, up 3.5 percent from this year's \$812 deductible. The monthly premium paid by beneficiaries enrolled in Medicare Part B, which covers physician services, outpatient hospital services, certain home health services, durable medical equipment and other items, will be \$58.70, an increase of 8.7 percent over

the \$54.00 premium for 2002.

All Medicare beneficiaries enrolled in Part B pay the monthly premium. The Part A deductible applies only to those enrolled in the original fee-for-service Medicare program. Those who enroll in private Medicare+Choice plans may not be affected by the Part A increase, and may receive additional benefits with different cost-sharing arrangements.

Most of Medicare's 40.4 million beneficiaries are enrolled in the optional Part B, which helps pay for physician services, hospital outpatient care, durable medical equipment and other services, including some home health care. Nearly 90 percent also have some form of supplemental coverage (such as Medigap, Medicaid, or Medicare+Choice) to help reduce out-of-pocket medical costs.

The Part A deductible is the beneficiary's only cost for up to 60 days of Medicare-covered inpatient hospital care. However, for extended Medicare-covered hospital stays, beneficiaries must pay an additional \$210 per day for days 61 through 90 in 2003, and \$420 per day for hospital stays beyond the 90th day in a benefit period. For 2002, per day payment for days 61 through 90 was \$203, and \$406 for beyond 90 days.

For beneficiaries in skilled nursing facilities, the daily coinsurance for days 21 through 100 will be \$105 in 2003, compared to \$101.50 in 2002.

Most Medicare beneficiaries do not pay a premium for Part A service. Seniors and persons under age 65 with disabilities may obtain Part A coverage even though they have fewer than 30 quarters of Medicare-covered employment, by paying a monthly premium set according to a formula in the Medicare statute at \$316 for 2003, a reduction of \$3 from 2002. Seniors and certain persons under age 65 with disabilities with 30 to 39 quarters of Medicare-covered employment are entitled to pay a reduced monthly premium of \$174. To be eligible for voluntary enrollment in Part A based on disability, the person must have lost disability benefits solely because earnings exceeded a certain amount.

States have programs that pay some or all of beneficiaries' premiums and coinsurance for certain people who have Medicare and a low income.

Information is available at 1-800-MEDICARE (1-800-633-4227) and, for further details on the Social Security Cost of Living increase for 2003 please visit [www.SSA.gov](http://www.SSA.gov) for more detailed information.

## National News

### National Disability Media Directory Released

#### National Telability Media Center, Columbia, MO

More than 1,400 mass media resources that serve people with disabilities are contained in the 2002-2003 edition of *America's Telability Media*, the nation's first disability media directory, published by the National Telability Media Center.

Charlie Winston, editor and NTMC Director, has added more than 60 new entries to this new eighth edition, which provides current information resources

that benefit the disability community and the rehabilitation industry.

The 370-page book is based on an annual nationwide survey, which collects data on the growth and development of telability media and offers the only national view of America's newest field of journalism.

Each directory entry contains a full description of the resource, along with complete contact information, including websites and e-mail addresses. Included are more than 1,200 magazines, newspapers and newsletters;

about 80 broadcast producers; about 20 newspaper columnists; more than 40 dial-in newspapers for the blind; and nearly 40 professional organizations.

"Our book," Winston said, "is a marketing tool for corporations and a thorough reference guide for libraries and service organizations."

Winston, who is blind, founded the NTMC in 1992 as a non-profit organization to support the growth and development of mass media for persons with disabilities. He holds a B.J. and M.A. degrees from the University

of Missouri-Columbia School of Journalism.

NTMC maintains one of the nation's largest library collections of disability media resources.

America's Telability Media is available in print or on disk in Word format. The price is \$50 in print and \$40 on disk. Mailing labels and other contact information may be purchased on disk or through e-mail. Checks or money orders should be made to Telability Media, P.O. Box 1488, Columbia, MO 65205-1488. You may telephone (573) 445-7656 for more information.

# MENTAL HEALTH NEWSDESK

New York News

## NYS Governor George Pataki Signs "Most Integrated Settings" Bill Into Law

**NYAPRS  
Mental Health E-News**

Capping several years of extraordinary effort by state advocates for New Yorkers with disabilities, including strong support by NYAPRS members and staff over the past week, Governor Pataki signed the 'Most Integrated Settings' bill into law Tuesday night.

The landmark new law will require the state to regularly demonstrate how it is maximizing efforts to provide alternatives to segregated, institutional settings like nursing homes or adult homes for New Yorkers with disabilities.

The law will require a number of prominent state agencies who help serve New Yorkers with disabilities to help develop and implement a statewide 'Olmstead plan,' in keeping with a recent Supreme Court ruling requiring states to demonstrate they are taking every available measure to provide services and supports

sufficient to allow their citizens with disabilities to live in the most independent setting possible.

A 'most integrated setting' defined by the new law as one that is "appropriate to the needs of the individual with a disability and enables the individual to interact with nondisabled persons to the fullest extent possible."

These agencies include the NYS Department of Health, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, Office of Alcoholism and Substance Abuse Services, Office for the Aging, Department of Transportation, Office of Children and Family Services, Department of Education and the Division of Housing and Community Renewal.

The agencies will be required to provide quarterly updates surrounding their efforts to promote community integration for New Yorkers with disabilities to a newly established Coordinating Council, comprised of represen-

tatives from the above agencies and of the state Office of the Advocate for the Disabled and the Commission on Quality of Care for the Mentally Disabled, as well as 3 consumers of services for individuals with disabilities, 3 individuals with experience in community services for people with disabilities and 3 individuals with in who are are recipients of services for seniors.

The new law was strongly championed by its author, Assemblyman Kevin Cahill, Chair of the Assembly Task Force on People with Disabilities and fellow sponsor Senator George Maziarz.

Several groups worked tirelessly to advance the bill including representatives from ADAPT, the NYS Independent Living Council, Disability Advocates, NYAPRS, the Alzheimers Association and several other organizations.

The new law represent the second major victory this year for this extraordinary cross-disability coalition, who achieved state

adoption of the Medicaid Buy-In work incentives program for New Yorkers with disabilities in January.



**NYS Governor George Pataki**

New York News

## Torch Passed To New Westchester Commissioner

**Staff Writer  
Mental Health News**

Deputy Commissioner Jennifer Schaffer has taken over the helm as head of the county's community mental health department as Commissioner Steven Friedman retired on Aug. 26, County Executive Andy Spano announced.

Schaffer, who has served as deputy commissioner for 12 years, said she is eager to take on her new responsibilities and hopes to see the department offer even more innovative treatment and rehabilitation programs in coming years.

Spano extended his congratulations to Schaffer as he expressed appreciation to Friedman for his efforts in creating a compassionate yet efficient department that shows how much can be accomplished with strong planning and determination.



**Jennifer Schaffer**

Friedman said that when he first joined the Department of Community Mental Health in 1973, he never thought he would



**Steven Friedman**

stay for 29 years. Serving as commissioner for the last fourteen years, he noted that the final years have been the best.

"Our system of services has grown, changed and adapted to the changing needs and expectations of Westchester's residents," he said. "The system understands its responsibility to first serve those most in need. I am very proud of what we have all accomplished through the cooperative efforts of county government, the offices of the state Department of Mental Hygiene, voluntary providers, families and consumers.

Schaffer, a Briarcliff Manor resident, has been deputy commissioner since 1990. She previously served as executive director of the Middletown Psychiatric Center and deputy director of a state Office of Mental Health regional office that included six state-run psychiatric centers. With a PhD in Applied Research in Psychology, she is also clinical assistant professor of psychology at New York Medical College.

# Mental Health Community Mourns Wellstone

## We Will Remember His Record As Advocacy Champion

Staff Writer  
Mental Health News



**Senator Paul David Wellstone**  
1944 - 2002

Senator Paul Wellstone's untimely passing has truly saddened the nation and has created a pervasive sense of deep loss within the mental health community.

The best way we felt to express our sadness and pay tribute to this champion for mental health rights is simply to cite just a few of the press releases which announced the many groundbreaking legislative initiatives and sentiments voiced by Senator Wellstone while in office.

For a complete anthology, please go to [http://wellstone.senate.gov/On\\_the\\_Record/Press\\_Releases/Mental\\_Health/mental\\_health.html](http://wellstone.senate.gov/On_the_Record/Press_Releases/Mental_Health/mental_health.html).

**June 6, 2002**

Wellstone Demands Mental Health Parity Now!

Bill to Provide Greater Parity in the Coverage of Mental Health Benefits

(Washington, D.C.) – Thousands of citizen advocates representing nearly 200 grassroots organizations came to the U.S. Capitol in Washington, D.C. today to rally with Senators Paul Wellstone (D-MN), Pete Domenici (R-NM) and Representatives Patrick Kennedy (D-RI) and Marge Roukema (R-NJ) for immediate passage of full mental health parity. Wellstone, Domenici, Kennedy and Roukema are the chief authors of the Mental Health Equitable Treatment Act of 2001, a bill to ensure health plans provide coverage for mental illness on par with their coverage of other medical illnesses. Wellstone and all the participants at the rally urged Congress to pass the bill and end the discrimination against those with mental illness.

The Wellstone-Domenici Mental Health Equitable Treatment Act of 2001 (S. 543) builds on the Senators' 1996 landmark legislation to ensure greater parity in the coverage of mental illness by prohibiting group health plans from treating mental health benefits differently from the

coverage of any other medical or surgical benefits. The bill provides full parity for all cost-related and access-related benefits for all categories of mental health conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV-TR), and is modeled after the mental health benefits provided through the Federal Employees Health Benefits Program (FEHBP). Like the 1996 law, the bill does not mandate the coverage of mental health benefits, but rather requires all insurance companies who list coverage of mental illness as a part of their benefit package to provide those services with the no greater cost or access limitation than are required for other medical illnesses. The bill has broad bi-partisan support in both the Senate and the House, and the President has endorsed the principle of full mental health parity.

"Mental health parity is an important and long overdue step in improving the health of our nation. Enacting full parity would achieve our bipartisan goal: that mental illness be treated like any other disease in health care coverage. Once and for all, we will no longer accept the stigma. We will no longer accept the discrimination. We want full mental health coverage for men, women and children in the United States of America," said Wellstone. "We can do better. We must act now!"

**May 30, 2002**

Sen. Wellstone, Rep. Kennedy Praise New Evidence Refuting Mental Health Parity Opponent's Claims

Non-partisan CBO Memo Clarifies Cost-Estimate for Bipartisan Measure

(Washington, D.C.) - Senator Paul Wellstone (D-MN) and Representative Patrick Kennedy (D-RI), chief sponsors along with Senator Pete Domenici (R-NM) and Representative Marge Roukema (R-CT) of the Mental Health Equitable Treatment Act (S.543 and H.R. 4066), today pointed to a new memo by the Congressional Budget Office clarifying the organization's cost estimate for the legislation as the latest proof that mental health parity is affordable.

The public memo, released by the CBO last week, punctures parity opponents' claims that the Domenici-Wellstone-Roukema-Kennedy bill would require insurers to pay for any mental health claim submitted. Rather, the memo explains, the plain text of the bill allows plans to deny payment for care that is not medically necessary and to otherwise manage benefits.

"Opponents of mental health parity have waged a very aggressive disinformation campaign for weeks," Wellstone said. "Clearly, the CBO's research proves the truth: that mental health parity is affordable, and that the legislation reflects a bipartisan concern for the needs of mentally ill people, the concerns of the business community, and the need for flexibility in our health care system. I am pleased that CBO has documented that the low cost of S. 543 is based on sound legislative language and the realities of the marketplace."

"Special interests know that they can't kill parity on the merits, so they are trying to kill it on myths," stated Kennedy. "The bill they describe I might not even support. Fortunately, that's not the bill we've introduced. CBO's memo is impartial confirmation that our bill is a reasonable, cost-effective approach to ending discrimination in medical care."

The recent CBO memo was written to clarify the agency's estimate last year that the provisions included in the Domenici-Wellstone-Roukema-Kennedy parity bill would increase health care costs by only 0.9 percent.

**December 18, 2001**

Wellstone Vows to Continue Fight for Fairness

Mental Health Parity Blocked by Republican Leaders, White House

(Washington, D.C.) -- Senator Paul Wellstone (D-MN) today vowed to continue his fight for full parity in health care coverage for Americans suffering from mental illness. After intense lobbying by big insurance companies, the White House, and House Republican Leadership, House Republican Appropriators stripped the Wellstone-sponsored mental health provisions from the Labor HHS spending bill, denying fairness in mental health care to millions of Americans. The provision was supported by a bipartisan majority of Senators and Members of Congress.

"Opponents of mental health parity have used a million excuses to block this bill, but the bottom line is that the big insurance companies do not want to provide this coverage," said Wellstone. "Though they may have won the day, this fight is far from over. Mental health parity is cost-effective civil rights legislation whose time has come. Mental illness must be treated like any other disease in health care coverage, and when Congress returns in January, I will return to this issue."

The mental health provision was based on S. 543, the Mental Health Equitable Treatment Act of 2001. The bill expands and improves the Wellstone-Domenici Mental Health Parity Act of 1996 by prohibiting group health plans offering mental health coverage from imposing treatment limitations or financial requirements on benefits for mental illnesses unless comparable limitations are imposed on medical and surgical benefits. Members of Congress and all 8 million federal employees already enjoy these very same benefits as a part of the Federal Employees Health Benefits Package.

"This is a blow to the extraordinary bipartisan support that led to this carefully crafted bill that both respected the needs of seriously ill people and the concerns of employers," Wellstone said. "But this fight is not over. This is just a step in the long history of struggle for decent medical care for people with mental illness, one that will not be over until full success."

**June 15, 1998**

REPORT: MENTAL HEALTH PARITY AFFORDABLE—Wellstone-Domenici Legislation Report Shows Serious Gaps in Access & Quality. "We Must Move For-

ward to Full Mental Health Parity," Wellstone says

Senator Paul Wellstone (D-Minn) and Senator Pete Domenici (R-N.M.) joined in unveiling a report today that shows that their mental health parity legislation, which became law in 1996, will make care for the mentally ill more affordable than originally expected. The report was authored by the National Advisory Mental Health Council of the National Institute of Mental Health.

"For those struggling with mental illness, and their families, the cost results of this study on mental health care insurance parity is good news," Sen. Wellstone said. "In 1996, when the Congress passed the Mental Health Parity Act authored by Senator Domenici and myself, it marked the first step toward ending the discrimination against the mentally ill in terms of health care coverage. This new study is yet another step forward in that effort. But it is clearly not enough -- other parts of the report revealed problems with access and quality which are very troubling."

The report, "Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access, and Quality," shows clearly that earlier concerns were unfounded regarding potentially high costs caused by requiring mental health insurance coverage on par with that offered for other serious physical ailments. The report also provided new information about reductions in access to treatment and the ways access is controlled by managed care companies.

Among the major conclusions in the report:

In systems already using managed care, implementing parity results in a minimal (less than one percent) increase in total health costs during a one-year period.

Parity alone does not guarantee improved access to mental health care because of the strong counteracting effect of managed care.

Considerable variability occurred in access and quality across managed behavioral health plans (HMOs), raising concerns about mental health care. In some cases in which access was limited, decreased work performance, increased absenteeism, and greater use of other medical services have been observed.

"The report provides further evidence that parity must be accompanied by accountability in order to ensure quality of mental health care. Those suffering from mental illness, or any disease, should not have to fight for the right to have treatment. This speaks to the heart and soul of the patient rights issue. We know now that mental health parity can be cost effective and, with accountability, can be of high quality. We must move forward now to full mental health parity." Sen. Wellstone said. "People with mental illness deserve nothing less."

# Mental Health News Interviews

## Dr. Richard C. Birkel, Executive Director of NAMI

Staff Writer  
Mental Health News



**Richard C. Birkel, Ph.D.**

**O**n April 23, 2001, Richard Birkel joined NAMI (National Alliance for the Mentally Ill) as the executive director. With more than 220,000 members, NAMI is the nation's leading grassroots advocacy organization solely dedicated to improving the lives of people with severe mental illnesses including schizophrenia, bipolar disorder (manic-depressive illness), major depression, obsessive-compulsive disorder, and severe anxiety disorders.

A psychologist by training, Birkel received his B.A. from Yale University and his M.A. and Ph.D. from the University of Virginia. He also received an M.A. in public administration from the University of Virginia. He has published or presented numerous academic papers and served as principal investigator for more than one dozen national research projects.

### Interview With Dr. Birkel

MHNews: How important is NAMI to consumers and families whose lives have been affected by mental illness?

Dr. Birkel: NAMI is one of the essential organizations on the scene today working to assure the development of treatment, support and recovery services for people with neuropsychiatric illnesses. NAMI is making headway in its twenty-year long campaign to change the way people understand so-called "mental illnesses" and to recognize that genetic vulnerability, trauma and stress, personality and coping style, and environmental assault and injury all contribute to the development of these illnesses. But, once neurotransmission is altered in a person's brain, that effect is biological in nature and must be treated as a serious medical condition.

NAMI is also a leader in pushing for the provision of holistic services; including supported employment and housing, income support and community integration. People who experience these ill-

nesses lose a part of their life, and NAMI helps them and their families gain it back. People come to NAMI for education, support and to gain skills in advocacy and community action. They learn about the variety of paths to recovery and are afforded opportunities for leadership in support groups, peer-run education, policy advocacy and community action. NAMI has been the pathway to local and national leadership for hundreds of the most effective advocates on the scene today.

NAMI is important enough to folks that our volunteers donate more than \$185 million dollars of time to NAMI every year, just for education and support. This doesn't count the time spent in governance and other activities.

MHNews: Is there a broader agenda that NAMI serves across the nation?

Dr. Birkel: NAMI's agenda is quite broad. We recognize that we are living through a scientific revolution in how we understand the brain, and that we have to make a political change commensurate with what we know about the brain and how it works. NAMI's agenda is ultimately about preparing and prompting our country, our government and our public health community to make that change. Our agenda includes the civil rights of people with neuropsychiatric conditions. We are champions of their right to access effective treatments and supports, about their right to hope for recovery for themselves and their children, about their right to equitable insurance, the right to be kept out of jails because of the lack of community-based treatment. We also support the rights of people with mental illness and their families to be protected against discrimination in housing and employment. In fact, NAMI members are continuously fighting the discrimination and misinformation that regularly flows to the public through our media.

I suppose our broadest mission is one of restoring dignity to millions of people who have been discriminated against and written off because they had the great misfortune to develop a so-called "mental illness."

Finally, our mission includes the challenge of reforming a fragmented, often ineffective mental healthcare system that was founded on broken promises, often is starved for money, and where those who are part of it—whether consumers, family members, providers, researchers, or administrators—all are diminished in the eyes of the public because of ignorance and prejudice.

The current system is an economic, social and moral catastrophe. In too many cases, neither consumers nor families ever get the help they really need. Since deinstitutionalization in the early 1970s, the nation has failed to invest in a seamless community-based system. We have abandoned 200,000 people with mental illness to the streets and more than a quarter million to jails or prisons. Thirty-thousand Americans commit suicide every year as a result of mental illness. Among teenagers and young adults, suicide is the third-leading cause of death today. Those kinds of statistics are a tragedy and a disgrace.

The lost human potential and economic productivity for the nation is enormous.

NAMI recently announced the launch of a "Campaign for the Mind of America." It will be a multi-year effort on many fronts to promote investment in recovery and to prevent the abandonment of yet another generation to neglect and hopelessness. Key elements of the campaign presently include:

Co-sponsorship of the National Forensic League's 2002-2003 Policy Debates involving 15,000 high school students from more than 1,000 schools nationwide, focused on the issue: Resolved that the federal government should substantially increase public health services for mental health care in the United States.

"Walks for the Mind of America" in a dozen communities around the nation in May 2003—in Delaware, Florida, Louisiana, Maine, Maryland, Missouri, New Hampshire, New Jersey, Ohio, Oklahoma, Oregon, and South Carolina. This is just the pilot project for what will be a much larger effort in the years to come.

We're expanding NAMI's "In Our Own Voice: Living With Mental Illness" antistigma education program in which people with mental illnesses speak directly to community groups about their experiences. The program has grown from six states in 2001 to 25 this year. Not only does it help overcome stigma; the program helps to empower consumer recovery.

We also have a Center for Research, Education & Practice (CREP), the NAMI Policy Research Institute (NPRI), a Child and Adolescent Action Center (CAAC) and Multicultural and International Outreach (MIO) Center. Each of them plays an important role in advocacy and outreach. Encourage your readers to check us out regularly on-line at [www.nami.org](http://www.nami.org). We also will be launching a new Website soon, that we hope will be a vital nerve center for our movement.

*The Campaign for the Mind of America* also isn't just about NAMI. We're all part of a broader movement. The name of the campaign defines our common challenge.

MHNews: What key areas in the mental health world has NAMI had an impact?

Dr. Birkel: NAMI will reach its 25<sup>th</sup> anniversary in 2004. During the "first generation" of its organizational life, NAMI made a significant contribution in helping to educate the general public about the science of the brain and specific mental illnesses. We have shifted the focus of thinking from a "psychodynamic" view, to a science-based view of what these disorders are. You'll also be reporting in this issue about NAMI's StigmaBusters program—that's another important area where we've achieved some significant victories.

In addition, NAMI helped define the importance of education and information for recovery and made it clear that consumers and family members were often the most effective providers of that education.

NAMI has been a training ground for a generation of family and consumer advocates—I am amazed to read the histories

of our NAMI affiliates and find out how many direct consumers have been leaders within NAMI since the beginning. All these leaders have made a positive difference in influencing government and the public health community at every level. We have demonstrated that a grass roots movement can be effective in the mental health arena.

Perhaps the culmination was the publication of the U.S. Surgeon General's Report in 1999. There also have been other solid achievements: such as parity legislation to promote equal health insurance coverage for mental illnesses, increased funding for scientific research, identification and dissemination of information about evidence-based treatment practices, and the enactment of the first national law to regulate the use of restraints or seclusion in psychiatric facilities, and NAMI's extraordinary outreach to veterans. Very few people realize that there are more than 700,000 veterans with serious mental illnesses.

We have also had impact on Social Security disability, Medicaid, housing, employment, and elimination of criminalization of consumers. Our grassroots network gives us a lot of clout in these areas.

MHNews: What is your proudest achievement as Executive Director?

Dr. Birkel: It's probably still in the future. What I am proudest about right now is the opportunity to serve and to be a part of NAMI and the broader movement of which it is a part. We all stand at a critical moment in history. We have an opportunity to make history, if we all work together and apply ourselves. I am pleased to be a part of an organization that has great passion and a readiness to work together at all levels and to be fully inclusive.

MHNews: What is your vision for the future—and are there any potential roadblocks that must be overcome in achieving that vision?

Dr. Birkel: My vision—NAMI's vision—is of a robust system of science-based services and treatments that work for everyone. We have a great deal of the knowledge and tools to help people recover from mental illnesses right now, and there will be greater breakthroughs in our ability to diagnose with accuracy and to treat with specificity. I envision a society in which neuropsychiatric illnesses are understood properly and where "stigma" has gone the way of the dinosaurs. NAMI's vision is of a comprehensive, efficient system of early identification and continuing treatment tailored to the individual; really no different than the treatment for any other illness.

The roadblocks are not insurmountable, but we need to address them. Stigma, of course, is number one. Second is inaction by those in leadership in government and in public health. Third is the continuing influence of psychodynamic training in psychiatry and the allied health professions. Finally, advocacy groups themselves (all of us) often fight too much when we need to hang together.

# Battling the Hurt and the Harm of Stigma

## NAMI StigmaBusters Champion Truth About Mental Illness

*A Mental Health News Interview  
With Stella March  
NAMI StigmaBusters Director*



**Stella March**

**Mental Health News:** What is the mission of StigmaBusters?

**Stella March:** NAMI StigmaBusters are a grassroots network of more than 10,000 consumer and family advocates dedicated to the elimination of ignorance, fear, prejudice and discrimination that creates stigma for mental illness. We want to change public attitudes to promote reintegration, community acceptance, understanding, and support. Every month, we publish electronically a newsletter—StigmaBuster Alerts—with targets, case studies, and other updates. Our advocates pursue two basic strategies:

- **PROTEST** prejudice and stereotypes in the news, entertainment, advertising and other media, which cross all boundaries of geography, race, culture and ethnicity worldwide.
- **PRAISE** accurate, fair sensitive reporting and depictions that improve public understanding of mental illness.

**MHNews:** How did StigmaBusters get started?

**March:** StigmaBusters started under NAMI's Campaign to End Discrimination (1995-2000). We kept receiving complaints about stigma situations in the media, in product names, or on TV shows that required tailored responses. I was asked to start a program to respond in November 1997. By NAMI's national convention in summer 1998, 650 people had signed up to receive the alerts and volunteer action. That's how it started. The network now extends around the world. Other stigma watch projects now are emerging in other countries. They contact us to share information and sometimes-coordinate efforts.

**MHNews:** Why did you get involved?

**March:** I have a son who was diagnosed with schizophrenia in the mid-1970s. At that time, there was no NAMI, and only sparse information existed about mental illness. Welcoming the promise of information, support and networking, I was one of the first persons to join NAMI locally and nationally in 1979. I have served in local, state and national leadership roles. I was an initial member of the California Mental Health Planning Council. I also served as NAMI's national vice-president for policy. Recognizing the personal hurt and social harm stigma imposes, especially as a barrier to consumers getting the help they need, I then was proud to accept the challenge of coordinating the NAMI StigmaBusters program.

**MHNews:** How does the process work? Is there a team of staffers that work with you?

**March:** I work closely with NAMI News Director Bob Carolla and Senior Communications Associate Anne Marie Chace. Based on set guidelines, we evaluate complaints, prioritize investigations, and decide on strategies in coordination with others in the national office and NAMI's state organizations or local affiliates. Complaints come from individuals on our StigmaBusters email list and from our affiliates. They are our eyes and ears.

We try to focus on high profile, national situations in media that have significant impact on public attitudes: movies, television programs, commercial products, magazine articles, and advertisements. We don't respond to the use of single words like "loony, wacky, nuts, or crazy," unless they specifically describe a person with mental illness or a situation involving mental illness. Then, we contact the offender. Those that dismiss our concerns are included in the Alerts to generate letters, emails, faxes and phone calls in protest. In other cases, praise. For newspaper reporters, editorial writers or television producers, it sometimes entails a risk to approach mental illness from a new or different angle, so it's important to reinforce their efforts as well as educate others. Numbers count in making an impression.

In some cases, we raise protests to higher profiles through news releases, contacting commercial sponsors, or other tactics. With NAMI's new Campaign for the Mind of America, the strategy also is shifting to start seeking deeper commitments to change. For offenders, apologies no longer will be enough. We want to convert them into "partners for recovery" by having them correct the balance—through internal policies directed at employees

and helping to sponsor antistigma campaigns in the communities they serve. If appropriate, we will consider legal actions and remedies.

I want to emphasize one point also. We aren't advocating censorship. We simply want the truth to be told and recognition that words—or labels—matter. Whenever StigmaBusters protest, they are exercising their own freedom of speech and trying to persuade professionals, a company or an institution to act responsibly. Sometimes that only can be achieved by focusing negative publicity on them, or to put it another way, by shining a bright light of public opinion to expose outrageous, offensive practices.

**MHNews:** What achievements are you most proud of?

**March:** My top three involve different types of media.

NAMI once melted one of Nestle's product lines: "Tasty Tanga Taffy" bars that were named Psycho Sam, Loony Jerry and Weird Wally with each name attached to an exaggerated, not very complimentary cartoon face. Nestle tried to defend the names as "rooted in a silly, playful humor" that "amuses children and gives personality to our cartoon characters." It took two Alerts, a letter and public statements from former First Lady Rosalyn Carter, and finally a news release to take our concern seriously. With an apology, they finally repackaged the candy under harmless new names.

A major battle—in some respects a turning point in the history of our movement—was "Wonderland," the ABC TV series set in a New York City psychiatric hospital. The story lines included a man with schizophrenia who shot up Times Square, graphic suicide, and patient characters who were used as the butt of jokes. It was a very narrow, distorted picture of consumers. None of the episodes that we previewed included any balance or conveyed a message that treatment works and recovery happens. We launched an intense campaign when it premiered. StigmaBusters flooded the commercial sponsors of the show with messages. We persuaded some ABC stations to stream warnings about the suicide scenes across the television screen. We organized a coalition of 17 other national mental health associations. ABC dropped the show after only two episodes. Low ratings contributed to the victory, but the protest and withdrawal of commercial sponsors made it an easy, quick decision for ABC. Some of the worst episodes we previewed were never shown. The U.S. Surgeon General applauded the decision.

A third victory involved "Me Myself and Irene," an outrageous movie

comedy that starred Jim Carrey as a motorcycle cop with schizophrenia—except that it completely misrepresented the nature of the illness, playing to stereotypes about split personality and violence. Ads for the movie—in newspapers, billboards and buses—depicted Carrey with a split head, with the tag-line "From gentle to mental." One billboard even was placed across the street from one of the biggest mental health centers in Los Angeles! One phone call to the movie distributor's vice president for public relations had that one removed. StigmaBuster messages overflowed and shut down the company executives' email boxes. The advertising campaign was quickly changed. Carrey's split head became whole, with the "gentle to mental" tag-line removed and his TV promotional interviews toned down so as not to even mention schizophrenia. The movie was still bad from a stigma perspective, but at least only people who paid the price of admission were exposed to it. Intense media coverage of the protest also helped set the record straight, featuring interviews with NAMI leaders with schizophrenia, like Fred Frese of Ohio and Moe Armstrong of Massachusetts. NAMI showed them the real face of mental illness, based on dignity and the hope of recovery.

**MHNews:** Has Stigma Busters changed the playing field in the fight against Stigma or are we just putting out fires that will continue to be started by an insensitive and uneducated society?

**March:** Change comes incrementally. We still need a revolution, but we have made progress.

We believe, for example, that the battles over "Wonderland" and "Me, Myself and Irene" helped open the way—by creating a new environment—for the movies "A Caveman's Valentine" and "A Beautiful Mind" to be made, which for the first time, showed individuals with schizophrenia not only sympathetically, but as heroes. The television show ER—which has had a mixed record—ultimately produced a special six-part series with actress Sally Field portraying a very realistic, sympathetic, poignant struggle with bipolar disorder. These kinds of developments in popular culture wield tremendous educational power.

I hope your readers will support NAMI's new campaign and as part of their commitment sign up to be StigmaBusters themselves.

They can do so by visiting the NAMI web site at [www.nami.org](http://www.nami.org) and scroll down to click on StigmaBusters Alert Listings. For more information, they can also contact me in Los Angeles by writing me to me by E-mail at [smarch@nami.org](mailto:smarch@nami.org).

# An Interview With Michael J. Silverberg President of NAMI-NYS & NAMI-NYC METRO

**Staff Writer  
Mental Health News**



**Michael J. Silverberg, J.D.**  
**November 2002**  
**Interview with MHNews**

**M**ental Health News (MHNews): How important is NAMI in NYS to consumers and families whose lives have been affected by mental illness?

Michael Silverberg: We are all aware that illness can strike us and our loved ones at any time, including serious illnesses like cancer. But most of us are totally unprepared for serious and persistent mental illness, know nothing about it and do not expect it in our own families. When it is brought home undeniably that a dearly loved family member is deeply psychotic and that serious symptoms are not likely to soon disappear, there are few places to turn for comfort or information. Many committed families and their loved ones struggling with these illnesses find their way to NAMI, where they begin to learn about the illness, treatments, medications and coping mechanisms, important matters that our doctors seldom teach us. NAMI brings comfort to thousands of families and their ill loved ones throughout New York State, teaches us to put aside unwarranted shame and gives us a means to advocate for much needed improvements in our system of mental health care.

As I write this, NAMI-NYS has just concluded its Annual Educational Conference, held this year in White Plains at the Crowne Plaza Hotel. This conference marked the 20th Anniversary of NAMI-NYS and as we looked about the crowded ballroom at our Saturday night celebration dinner, we could not help but feel

satisfaction at how far the organization had come. We often recall, as we did at the conference, that our organization began with a few families around a kitchen table 20 years ago. We now have 56 affiliates, a membership of thousands, and are able to make ourselves heard as New York's Voice on Mental Illness in all parts of the state.

MHNews: Is there a broader agenda that NAMI serves throughout New York?

Silverberg: Our agenda is often summed up as support, education and advocacy. Our 56 affiliates located throughout New York State are the grassroots backbone of our mission. Affiliate members provide mutual support, educate each other and reach out to educate the public and to impact mental health care in each individual locality. Our headquarters organization NAMI-NYS in Albany is the main advocacy arm, interfacing with officialdom and drawing strength from its many grassroots affiliates. Together it is our objective, with other advocacy groups, to work for better outcomes for consumers, more recoveries, more research to find cures and a far better mental health system.

A few issues have risen to the top of our agenda in recent years. These have included housing, insurance parity for mental health and the criminal justice system. Insurance policies that discriminate against mental health are one of many manifestations of sheer discrimination against mental health and the mentally ill in a number of contexts. These holdovers of medieval thought processes are both inequitable and uneconomical, and we continue to work to end such discrimination in all its forms. The thousands of individuals with mental illnesses who are currently caught up in our criminal justice system are another product of a health care system that short-changes the mentally ill, resulting in the often publicized fact that Rikers Island and the Los Angeles County Jail are now the largest mental institutions in the country. The dimension of the problem and the importance we attach to it at NAMI-NYS are shown by the fact that for three years we have devoted a full day of our three day Annual Educational Conference to criminal justice issues and have established a staff position led by Bob Corliss to deal solely with these issues. At the root of

this problem and so many others is the total inadequacy of the system of housing options currently provided for the mentally ill. The dumping of mentally ill individuals in often exploitive adult homes is another manifestation of the current housing crisis. We are currently looking for an adult home "fix" that will ameliorate the problem but what is needed is a general overhaul of our system of housing options for this vulnerable population.

MHNews: What key areas in the mental health world has NAMI had an impact.

Silverberg: Possibly our greatest impact is in increasing public understanding and combating stigma. As we swell our ranks, there is growing realization that mental illnesses are treatable no-fault disorders of the brain that can and do occur in every ethnic, racial, religious and other group, rich and poor, on every continent and that we are all in this together to beat these cruel and difficult illnesses.

We continue to work and hopefully to have an impact on each of the issues that affect our population, including housing, insurance parity, access to medications, the jail/prison population, police sensitivity training in responding to so-called "EDP" (emotionally disturbed persons) calls, and many others. It sometimes seems frustrating that our loved ones who courageously struggle against these difficult illnesses have so many other problems thrust upon them by societal ignorance, bias and indifference. Logic, science and justice are on our side so long as we persevere.

MHNews: What is your proudest achievement in your role with NAMI?

Silverberg: It is the organization as a whole and its members working together with each other and with other advocates that are able to accomplish improvements year by year. It has been my privilege to lead NAMI-NYC-METRO, our largest affiliate, as its president for five years and NAMI-NYS as president for three years. During this time I have worked to build an effective staff at each of these organizations, build our affiliates and increase the number of talented, interested and active members and future leaders. Our NAMI-NYS staff is now headed by an exceptionally talented and experienced

director, David Seay, who has rapidly earned the respect and affection of our affiliates as well as the leaders of government who are important to the shaping of our mental health system. We are similarly fortunate to have a dedicated and experienced Executive Director, Evelyn Roberts, who has been organizing and stimulating many new programs while overseeing over 20 support groups at NAMI-NYC Metro. We have many more effective advocates, are building strength at many affiliates, and are able to be responsive to more issues and more individual problems. Our efforts, I believe, are succeeding.

MHNews: What is your vision for the future, and are there any potential roadblocks that must be overcome in achieving that vision?

Silverberg: My answer is split into two parts, my vision for NAMI-NYS and my vision for our mental health system. Focusing first on my own organization, I would like to see it continue to grow in numbers, both family members and consumers, the large numbers that build a voice that is heard. And I would like to see those numbers become more broadly representative of all of our multicultural communities.

My vision for the mental health system begins is that our leaders and officials who have the power to shape the system will themselves develop a vision and not simply accept and tend the fragmented system that presently exists. I see only sparks of such vision from time to time at present and a lack of will to fix a system that has been allowed to deteriorate for at least four decades. The shortage of reasonable housing solutions has reached crisis proportions today, with thousands of the mentally ill in adult homes, nursing homes, shelters, the streets and jails and prisons. Thousands of hard pressed New York families have no relief in their role as caregivers for sick loved ones and are often frantic with concern as to what will happen to their loved ones when the family has aged out and is no longer here. My vision is for a society which will renew its social compact and perform its constitutional and moral obligation to provide quality coordinated housing and care and a way to really live for our loved ones stricken without fault with difficult psychiatric disabilities.

# NAMI-NYC Metro: A hometown source



**Evelyn Roberts, Ph.D.**  
Executive Director

**N**AMI-NYC Metro is, first and foremost, a community of people living with mental illness and their families, friends, caregivers, and advocates. It is a community dedicated to breaking down the barriers that stand between serious mental illness and meaningful recovery.

Our community is growing. In the past year, face-to-face outreach increased by 111%, Helpline calls increased by 38%, and the number of people served overall increased by 67%.

We are encouraged by our growth and increased visibility in the community. But we know that there are many more people that need our help. And we are aware that much more needs to be done to bring our issues to the public and make meaningful progress toward ending discrimination against those who live with mental illness. We are continuing to develop ever more creative and effective ways of accomplishing our goals.

It is only as a community that we will make meaningful progress. We hope you will join us as we move forward together.



Hundreds of NAMI members and supporters from around the country, including nearly 50 from NAMI-NYC Metro, Queens, Harlem and East Flatbush came together in Washington D.C. on June 6, 2002 to rally for mental health insurance parity.



At our September 2002 general meeting, our volunteer support group leaders discussed the numerous benefits of participating in one of NAMI-NYC Metro's support groups for consumers, family members and friends.

**T**he National Alliance for the Mentally Ill of New York City (NAMI-NYC Metro) is steadily building a strong community of mental health consumers and their family members and friends in New York City.

NAMI-NYC Metro tackles big issues like mental health insurance parity and adult home reform, while recognizing that sometimes it's the little things that help people get through the day, like having a kind, helpful voice on the other end of the telephone line or spending time with others who share similar life circumstances. We believe that by increasing public understanding of the real-life problems confronting people with mental illnesses, we have a better chance of improving the

lives of consumers and their families, that education breaks down stigma; and providing consumers and their families relevant information about mental illness is the best way to help people help themselves.

### **NAMI- NYC Metro: Providing Education And Support**

A grassroots, nonprofit, self-help organization, we achieve our goals of providing support and education in a number of different ways. Our peer and family member operated Helpline, available Monday-Thursday, noon-7 p.m. and Friday, noon-6 p.m., is on the front lines of crisis intervention, helping callers navigate the complex, and often frustrating, mental health system.

Our newsletter, website and cable television program are a source for the latest public policy, treatment and service information. NAMI-NYC Metro's Kenneth Johnson Memorial Research Library is home to a comprehensive selection of mental health literature and videos, as well as book and poetry clubs. And NAMI-NYC Metro's monthly general meetings—free, and open to all—bring members together to learn more about mental health issues. Upcoming topics include young adults and mental illness (Tuesday, January 14, 6:00 p.m.) and housing for people with mental illness (Tuesday, February 4, 6:00 p.m.)

NAMI reaches out to schools, hospitals and community organizations. Recently, we've increased our

outreach to Latino communities, creating a Spanish version of our NAMI brochure and adding a support group for Spanish-speaking consumers. Support groups for families with younger children and teens with a mentally ill family member are part of our enhanced outreach to younger families. We've also developed a program to bring young adult peer mentors into child and adolescent inpatient psychiatric settings to conduct support groups.

Family psychoeducation—educating consumers and family members about mental illness in order to facilitate recovery and improve the quality of life of the entire family—guides NAMI-NYC Metro's approach to its

*continued on next page*

# for support, education and advocacy !

*continued from previous page*

support groups and Family-to-Family and Peer-to-Peer courses. Our 20 plus support groups provide a welcoming environment for consumers, family members and friends to connect and get practical advice. NAMI's 9-week Peer-to-Peer course helps participants develop a clearer understanding of their illness. Trained mental health consumers guide other consumers through issues such as medication, coping strategies, relationships, and advocacy. Similarly, NAMI's Family-to-Family course is a 12-week program for family members of individuals with severe mental illness.

## Advocacy

NAMI-NYC Metro is engaged in an ongoing battle to improve the quality of treatments and range of services for consumers. Working with other mental health organizations, we advocate for family psychoeducation, mental health insurance parity, adult home reform, new housing initiatives, prison diversion for criminal offenders with mental illness, reforms in Medicaid's discriminatory policies, and pay increases for community mental health professionals.

Knowing that an educated voting bloc is necessary to hold politicians accountable to the promises they make, we do our best to keep our members and our elected officials informed. For example, following the 2002 primary election, we sent a survey to all city and state candidates detailing the political issues that have a direct effect on consumers' lives. The survey results were then used to help our members make



Patricia Warburg Cliff, Kenneth Johnson Memorial Library founder, and Xavier Amador, PhD, author of *I'm Not Sick, I Don't Need Help*, at the annual "Ken" book awards breakfast. Each year this event honors authors, whose work has significantly contributed to breaking down stigma, raising awareness and promoting understanding about mental illness.

informed choices on Election Day.

As many in the mental health community already know, when mental illness strikes, a lack of comprehensive mental health benefits can have devastating effects. To give this issue more weight in the wider marketplace of ideas, NAMI-NYC Metro has launched a two-year project to make the case for parity with the public, with legislators, large employers and other groups in New York City. If you, your client, or your family member has had difficulty paying for mental health treatment because an insurance company would not cover mental health expenses at the same rate as other health expenses, please tell us about it. Send your story to the Parity Project at the NAMI office, "ATTN: Parity Project" or via e-mail with "Parity Project" in the subject line to: [execdir@naminyc.org](mailto:execdir@naminyc.org). *Note: we will not use your story without discussing it with you first.*

## Join the NAMI-NYC Metro Community

NAMI-NYC Metro exists, first and foremost, because of the dedication and energy of our volunteers and members. As we move ahead to fight for parity—parity in housing, education, employment, community services, criminal justice, health insurance, and many other areas—it is essential for us to join together, create a stronger voting bloc and a more vocal community of people willing to work to end discriminatory treatment toward individuals with mental illness.

For information about any of NAMI-NYC Metro's programs or meetings, or to volunteer or become a member, call 212.684.3264 or visit us at [www.naminycmetro.org](http://www.naminycmetro.org)

### NAMI-NYC Metro is about EDUCATION, ADVOCACY and SUPPORT

#### Find out what works for you, your family or your clients

NAMI-NYC Metro offers more than 20 free courses and groups including "Family to Family" and "Peer to Peer" classes and support groups for consumers, and their family members and friends.

#### Learn more about services, treatment and advocacy

- Extensive research library
- Website ([www.naminycmetro.org](http://www.naminycmetro.org))
- Bi-monthly newsletter
- Cable television show
- Advocacy e-mail listserve
- Monthly mailings

#### Attend free monthly meetings

- Young Adults with Mental Illness, Tuesday, January 14, 6 pm
- Housing for People with Mental Illness, Tuesday, February 4, 6 pm

#### Volunteer

We're currently recruiting Spanish-speaking volunteers to work on our Helpline. Other useful skills: reception, web design, events, database management, fundraising, organizational and computer.

#### Become a NAMI-NYC Metro member

Join a community of people working together for better care and equal treatment for people living with mental illness.

To learn more about our programs, call the **Helpline at 212.684.3264**

NAMI-NYC Metro volunteers provide support and service referrals for housing, entitlements, medication, vocational programs, and legal and estate planning.  
Hours: Monday-Thursday: 12-7 pm, Friday: 12-6 pm.

National Alliance for the Mentally Ill of New York City  
432 Park Avenue South, Suite 710, New York, NY 10016

# NAMI-FAMILYA of Rockland County

## Rockland's Voice on Mental Illness

By **Rena Finkelstein,**  
Co-President



**Rena Finkelstein**

In 1981, when the family movement was still in its infancy, a small group of courageous parents of young adults with mental illness joined together to form the Family Support Group. The families shared a sense of isolation, confusion, anguish and anxiety. Like many others dealing with psychiatric disorders in those days, they were often misunderstood by friends and relatives, unable to speak honestly about their feelings to anyone. They felt mistreated by mental health professionals. At best considered inter-

lopers, and at worst the cause of their loved ones illnesses, they were frequently locked out of the therapeutic process. They also saw a tremendous service vacuum and, individually, were impotent to impact on and effect change in the mental health system. Under the leadership of Florence Gould Gross, they provided one another with support, an opportunity for family members to talk openly about their problems, to advocate for more and better services. They took the first important steps to bridge the gap between families and professionals.

Now known as NAMI-FAMILYA, we have grown steadily over the years, but our mission remains the same. I have been privileged to oversee FAMILYA's expansion during the past 16 years and have witnessed many enhancements in the scope of our activities, in our numbers and influence. We now reach out to some 1000 families, consumers, and mental health professionals with our newsletter, educational programs, and helpline. We are represented on every level of local Department of Mental Health and Unified Services planning. Our Board members serve on the Rockland Psychiatric Center Family Advisory Committee and Boards of many of the non-profit agencies that provide mental health services.

Both our advocacy efforts and educational projects are extensive, reaching out beyond our

membership to the community at large. About twelve years ago, when we first proposed making presentations about mental illness to high school students, we had to sell the idea to local school administrators. Our current high school education team, consisting of Mel Zalkin and Gerry Trautz, is now enthusiastically welcomed into the classrooms. We participate with professionals in the Mental Health Coalition and consumers in presentations to nursing, psychology, and sociology classes in local colleges and in public forums, "Breaking the Silence About Mental Illness." We spearheaded the formation of a County Task Force that is seeking ways to bridge the gap between mental illness/co-occurring disorders and the criminal justice system. The Task Force has conducted several highly successful conferences and educational projects, and recently published a guidebook for criminal justice professionals. We battle stigma and misunderstanding about mental illness through dissemination of information and brochures at libraries and fairs.

Some of our proudest accomplishments lie in our role in helping to develop and secure funding for two programs that directly serve the needs of consumers and families. The Compeer program provides friendship and companionship to individuals with mental illness by recruiting, training and supporting volun-

teers, and matching them in a one-on-one relationship. The Consumer Family Outreach program offers advocacy, support, coping skills, and linkages to services for families and consumers who have refused or dropped out of mental health services. Conceived and developed to meet gaps in services identified by NAMI-FAMILYA members, these programs are operated by the Mental Health Association of Rockland County

Happily, we now look upon mental health professionals as collaborators and not as adversaries. We have partnered with them on many projects, demonstrating that we can be most effective as a team. It has been my privilege, also, to work with an exceptional group of talented and dedicated family members and bright and motivated consumers.

There is still much to be done. Efforts to effect improvements in services for people with mental illness are severely hampered by fiscal restraints, both locally and statewide. In the next decade we must look to ways to put our organization on a firm financial footing and to hire some paid staff to assist our devoted volunteers. In the very near future we hope to be moving our operations into a centrally located and accessible office. NAMI-FAMILYA still is and, hopefully, will remain essentially a family organization, with families helping other families. Therein lies our strength and what makes us unique.

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***See page 52 for Details***

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of Rockland County



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# NAMI of Westchester

## Families Helping To Improve Lives

By Sarah Newitter, President  
NAMI of Westchester



Sarah Newitter

**N**AMI of Westchester began in the spring of 1980 when a few concerned families got together to determine how they could help improve the lives of their family members. Among the founders were George and Emma Shaw. George and Emma are still active participants in both NAMI Westchester and NAMI/New York State. Those of you who attended the NAMI/New York State Educational Conference in October will recall that George and Emma helped plan that very successful conference. It is the dedicated commitment of volunteers like George and Emma that make NAMI Westchester the organization it is today. We are now one of New York States's larger affiliates, with a mailing list of over 500 families, consumers and professionals. Our numbers may have changed, but our commitment to improving the lives of

people with mental illness and their families remains the same!

NAMI-Westchester provides important support and education for families as well as for the Westchester community. We manage a membership, provide information and referral, respond to telephone calls and correspondence, run self-help groups, write newsletters and advocate for systems change at the local, state and national level. Our monthly educational meetings, open to the public, inform about the health and social service systems, medication management, rehabilitation programs, research, and housing for the mentally ill. Very often NAMI is the first place people turn to when they are confronted by mental illness in their families. We connect people to resources in the community as well as offering support and understanding. We respond to hundreds of calls from families and consumers every year. Dedicated volunteers carry out most of this work.

Successful fundraising and grants from Westchester County have enabled us to hire two part-time employees. With the support of Steven Friedman, the former Commissioner of Mental Health, we were awarded a \$10,000 grant to hire a part-time administrative assistant, who is responsible for among other things, maintaining our membership, responding to telephone calls, and assisting with the newsletter and other correspondence.

NAMI's own fundraising efforts and an additional one time grant from the Westchester Department of Community Mental Health enabled us to hire a part-time Educational Outreach Director, who promotes NAMI's anti-stigma message through the implementation of "Breaking the

Silence" lesson plans in the Westchester schools. Jean Schneider, MSW, our Educational Outreach Director, has initiated an extensive campaign to reach all the principals, health educators and parent teacher associations to inform them of the availability of the Breaking the Silence Lesson Plans. The goal is to make sure every school in Westchester has a set of lesson plans and understands the importance of educating their students about mental illness. Ms. Schneiders's efforts have resulted in over 70 schools receiving these lesson plans. The responses of teachers using the materials have been very positive.

For the past 12 years NAMI-Westchester has been providing educational seminars for families through a grant from the Department of Community Mental Health. The program we now use is "Family-to-Family," which is sponsored by National NAMI and offered in a majority of states. Through the program, families learn about the illnesses of the brain and their treatments, coping skills, information about various community resources, and how to advocate for a loved one. Ann Loretan, Director of the Family-to-Family program, coordinates the free twelve-week sessions, which are held in the spring and the fall. Trained family members serve as teachers in this peer-based program

In Westchester, as in communities all over the country, NAMI self-help support groups meet regularly and enable families to share their experiences, to learn more about brain diseases, and to receive emotional support and practical advice about housing, employment and other community services. Our network of self-help support groups continues to be the backbone of our organiza-

tion. In fact, most NAMI members begin their experience with our organization through their connection with the support group. Our volunteer support group facilitators provide year-round support to people in crisis, as well as an opportunity to share experiences and information about community resources and treatment options. Their dedication and compassion is truly unlimited.

NAMI-Westchester maintains good relations with the Westchester mental health community, but it took many years of hard work educating people about the important role of the family in the recovery process. We see ourselves as effective partners with mental health professionals and look forward to working together in the future. We are fortunate in Westchester to have highly experienced and dedicated service providers and health care professionals. Our Department of Community Mental Health has been a continued source of support for our organization, and we welcome the opportunity to work with Dr. Schaffer, our new Commissioner of Mental Health.

Our continued existence and success as a family and consumer grass roots advocacy organization continues to depend on the dedication and commitment of our members. Although we have made progress in improving the lives of those who suffer from mental illness, much remains to be done. Stigma and discrimination are still barriers to full integration into our communities. Suitable housing is in short supply, and employment opportunities need to be developed. Helping people to lead full and productive lives remains a big challenge.



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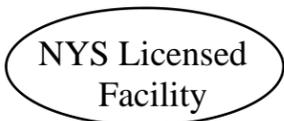
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# NAMI Corner

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**By J. David Seay, J.D.**  
**Executive Director**  
**NAMI-NYS**  
**New York's Voice on Mental Illness**



**J. David Seay, J.D.**

**H**ousing, housing and housing. These are NAMI-New York State's top three priorities in this year's advocacy campaign to improve the lives of persons with serious mental illness and their families. Newspaper headlines screaming "scandalous conditions" for persons with mental illness in "adult homes" and even worse scandals involving civil rights violations in previously

secret "lock down" units of private nursing homes, all point in one direction: to the lack of sufficient numbers of housing with support services for persons with serious mental illness. In fact, the adult home and nursing home scandals are just the tip of the iceberg in New York.

At one time, New York State cared for 93,000 seriously mentally ill in the state psychiatric system. Today there are only about 4,000 psychiatric center beds. Where did these people go? Some policy makers seem to believe that they have disappeared. That is close; they are "the disappeared" New Yorkers. By some estimates, more than 10,000 persons with serious mental illness are incarcerated in New York's jails and prisons, often for petty crimes directly related to their illnesses. It is sad to report that the Rikers Island jail is New York's largest mental institution, by default. Another 15,000 mentally disabled adults are in adult homes, many of which resemble the old state institutions from which they were discharged, only with less staff and worse conditions. At least a thousand, maybe more, are illegally locked in nursing homes against their wills and without due process or recourse. Many thousands more are homeless on the streets or suffering in city and private homeless shelters, and no one knows the number who are living with aging parents terrified of where their adult children will live when they can no longer care for them.

NAMI-New York State has been working both on its own and with coalitions of supported housing providers and

others to press the State to do more. Our logic is iron-clad: it is the right thing to do and it will save the State money in the long term. We have been calling for just two things to remedy this potentially explosive set of problems. First, we want to see a "down payment" now, in the form of a "fix" to the adult homes and nursing home problems and a commitment to a specified number of new housing units to be built over a multi-year period. At the same time, we must be mindful that inadequate payment rates risk the loss of existing supported and supportive housing stock for the seriously mentally ill. And second, we demand a commitment to an over-arching, thorough and non-partisan planning process composed of three parts: a statewide needs assessment of New Yorkers needing mental health housing and services of all types, an evaluation of existing capacity in the state psychiatric system with an eye towards finding new efficiencies in a system fraught with inefficiency, and a long-term plan with specific numbers of psychiatric center beds to be retained and housing units to be built, as well as other community mental health services. We call for this planning process to be overseen and directed by a special work group consisting of both government and private entities, including adequate representation of consumers and families of the seriously mentally ill.

NAMI-New York State just completed its 2002 Educational Conference and 20<sup>th</sup> Anniversary Celebration at the

Crowne Plaza Hotel in White Plains, New York, which was held October 25-27. More than 300 people attended these events which featured over 40 speakers, a dozen information-packed workshops and a fascinating keynote address by Dr. Frederick Goodwin of George Washington University and host of National Public Radio's popular "The Infinite Mind" program. We were also pleased to present several important awards, including the 2002 NAMI-NYS Excellence in the Media Award to Ira H. Minot, Founder and Publisher of this fine newspaper, *Mental Health News*. Awards also went to John and Alicia Nash for the Family Courage Award, Margaret Robinson received the 2002 Muriel Shepherd Award for local advocacy, Fred Levine was presented an award for his work in public policy and advocacy, and Dr. Martin Willick was honored for his work in enhancing the understanding of families and consumers on issues relating to research into mental illness.

We are already looking ahead and planning the NAMI-New York State 2003 Legislative Breakfast and Conference, which will be held on Tuesday, February 11<sup>th</sup>, 2003, at the Legislative Office Building in Albany. The morning program will feature prominent speakers from the Senate and Assembly as well as the Executive branch and the NAMI-NYS Government Affairs Committee. Meetings with individual legislators will be scheduled for the afternoon. Mark your calendar now and make plans to attend.

### About NAMI-New York State

The National Alliance for the Mentally Ill of New York State (NAMI-NYS) is 20 years old this year. Founded in a conference room in the Legislative Office Building in Albany on October 2, 1982 by Muriel Shepherd and other leaders from across the state representing family groups that had been formed to help people and families suffering from mental illness, NAMI-NYS was born with a fierce determination to make positive change. Much progress has been made in these past 20 years, yet much more needs to be done to find a cure for mental illness, to lessen the suffering until it is found, and to decrease stigma and discrimination against persons with serious mental illness and their families. The mission of NAMI-NYS includes providing support, education and advocacy.

A true grass-roots organization, NAMI-NYS now has 56 affiliate organizations around the state with 5,000 families as members. It has grown from a small band of volunteers to a large and powerful force of volunteers supported by a professional staff of 8 and a

budget of just under a million dollars a year. Programs and services provided by NAMI-NYS include:

Educational programs, including a three-day annual educational conference and a day-long legislative conference and lobbying day, "Breaking the Silence" school curriculum (in collaboration with a major affiliate), statewide radio and newspaper ad campaign to raise awareness on mental illness (in development), voter and candidate education pamphlets, as well as numerous other ad hoc educational presentations, booths and seminars for affiliates and members.

Support programs such as the NAMI Family-to-Family and Peer-to-Peer Training programs, a statewide Criminal Justice Program and a Habitat for Humanity project in the Capital District.

Information services, including the newsletters NAMI-NYS News and LeadersMailing, both of which are published quarterly, a website at [www.naminys.org](http://www.naminys.org), a statewide toll-free Helpline at (800) 950-FACT, dozens of informational pamphlets and brochures made available to affiliate, members and the public, a video lend-

ing library with over 100 titles on topics running the gamut of mental illnesses, diagnoses and treatments, and a statewide survey (in development) of the psychiatric system workforce's perceptions on the adequacy and quality of care.

Advocacy on behalf of persons with serious mental illness and their families on a range of issues including housing, mental health parity legislation, maintaining adequate service levels and other budgetary issues, jobs and job training, mental illness research, assertive community treatment (ACT) teams, adult homes reform, long-term planning, presumptive Medicaid eligibility and issues relating to the criminal justice system. Advocacy is done by NAMI-NYS both independently and working together with coalitions for positive change, including the Fair Insurance Today coalition on mental health parity, Mental Health Partnership for long-term planning, Mental Health Action Network on state budgetary issues, New York Campaign for Mental Health Housing Reform on housing needs and the New York Coalition for Adult Home Reform.

NAMI-New York State Board of Directors

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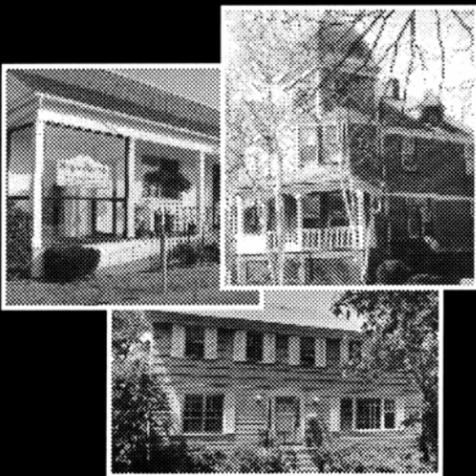
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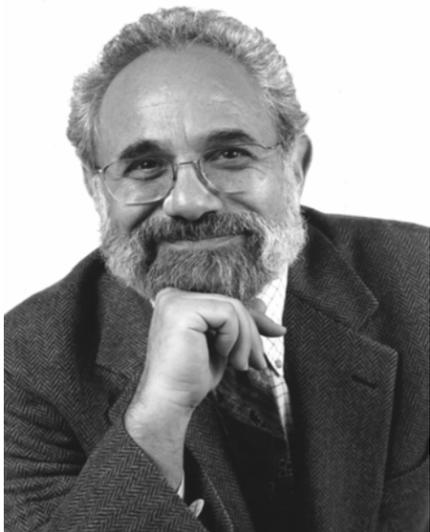
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# Point of View

## Stop Neglecting Families

By Michael B. Friedman, CSW



Michael B. Friedman

This issue of Mental Health News pays tribute to the National Alliance for the Mentally Ill (NAMI) and thus to the people who provide care and support to family members with psychiatric disabilities. It is a well-deserved tribute, a statement of recognition and gratitude which, unfortunately, is not paralleled in public mental health policy. In this society we take the care that families provide for granted, and neither New York State nor the federal government does much to help families to manage the burden they voluntarily took on when institution-based mental health policy was replaced with community mental health policy.

It is a commonplace that in the early phases of deinstitutionalization many people with serious mental illness were abandoned in the community with inadequate housing, treatment, and supports. But it is rarely acknowledged that deinstitutionalization also resulted in a great shift from institutional care to family care. As many as 2/3 of the people who left State hospitals returned to live with their families, who simply would not allow them to live in the squalid and dangerous housing that was

available for people on public assistance.

It was a major de facto change in social policy, from governmental responsibility for people with serious and long-term mental illnesses to family responsibility. It was a shift in social policy which, because it was not acknowledged, abandoned families, as well as their family members with mental illnesses, without the support, or even the gratitude, that they deserve for the care that they provide.

It is important to recognize that many families provide the full range of community supports that should be provided by a comprehensive mental health system.

For example, a great many families provide housing for family members with mental illnesses. According to the best estimates available, a third or more of people with serious, long-term mental illnesses live with their parents. That means that more people with mental illnesses live with their families than in housing certified or funded by OMH or in State hospitals or in nursing homes or in adult homes. Apparently families are the largest housing provider for people with mental illnesses.

Families also provide intensive case management. Not only do they serve as the link among multiple and changing service providers, not only do they negotiate systems which frequently don't work smoothly, they are also on call 24 hours a day, 7 days a week. Often they are the mobile crisis team by default for their family member.

Families also provide financial assistance, paying for sundry pleasures that no one living on income maintenance can afford, and families even pay for treatment and case management services when the public services are not available or good enough.

Family members—as NAMI illustrates—are also great mental health advocates. In its early days, NAMI and the family mem-

bers it represented focused heavily on protecting the institutional services on which our society had depended for more than a century. But increasingly families have realized that recovery is a real possibility and that their family members can live in the community independently or with greater reliance on peers than on families. Families, therefore, have become great advocates for a mental health system built on expectations of recovery. They are also vocal spokespeople for overcoming stigma and discrimination and for recognition of the basic human rights of people with mental illnesses—rights to housing, to work, to mental health insurance, to access to the mainstream, and to be treated with dignity.

Given all that families do, it is appalling that they are so neglected by the mental health system, which has not responded meaningfully to the needs of families or provided them with the support they deserve as major providers of care.

What should government do to help? Over the past fifteen years, I have spent a good deal of time in discussion with family members and perhaps as importantly have learned a great deal from having myself been responsible for a family member with a disabling mental illness. Several themes have emerged:

1) The mental health system is not helpful enough when there is a crisis that requires an immediate response. Too often it is only the police or an ambulance that can arrive quickly enough, setting in motion a process which frequently is emotionally painful and sometimes destructive. Alternative crisis intervention services are essential.

2) Professionals are still too often disdainful of families and primary consumers and do not treat them as partners in care. Training using a mix of families, consumers, and professionals as trainers could be helpful.

3) There are not enough psychoeducational opportunities for families, especially for families experiencing mental illness for the first time. This is particularly discouraging because psychoeducation is one of the few interventions other than medication for which there is research evidence of effectiveness.

4) Mutual support is highly valued by families. Government support for the development of family resource centers would be invaluable, particularly for centers which would emphasize outreach to families who are not now members of NAMI, including cultural minorities and “first break” families.

5) Parents worry about what will happen to their family members with mental illnesses after the parents die or become disabled. More support for future care planning to help families and consumers to prepare for the inevitable would be very useful.

6) Finally, providing support to family members with disabilities is expensive. One study estimated that family members provide more than \$200 billion a year worth of home care to family members with disabilities (physical as well as mental). Modifications of tax and income maintenance policy, to provide tax credits for families and to provide for full SSI benefits for people with psychiatric disabilities who live with their families could ease the financial burden. And it would show the gratitude of a society for the burden families have taken on since the massive shift of mental health policy took place in the middle of the 20th century.

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

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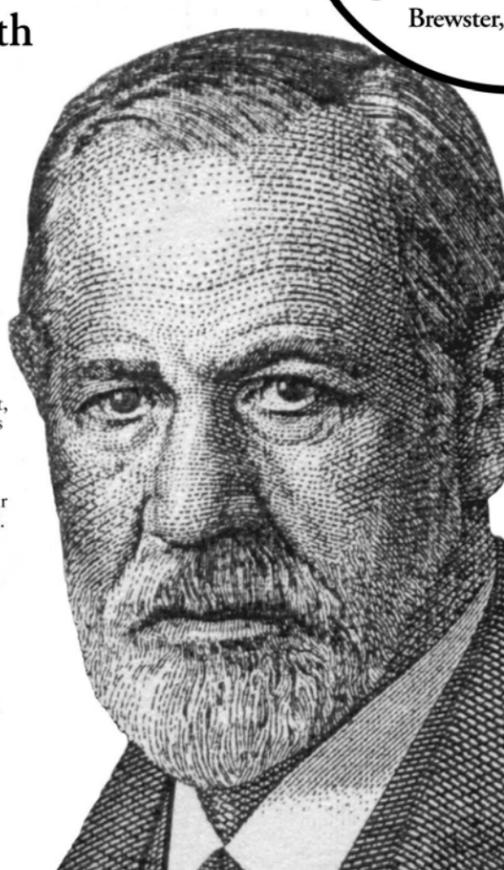
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# MHA of Westchester Website: A Vast Resource

## Staff Writer Mental Health News

If you need information on services for children traumatized by domestic violence, or need help in finding a therapist, or want to know about post-traumatic stress disorder, or want to keep a crisis hotline phone number handy, you can find it all and more on at [www.mhawestchester.org](http://www.mhawestchester.org).

The Mental Health Association (MHA) web site, launched in May 2002, offers a complete range of information addressing mental health and mental illness issues, listings of mental health services and support located throughout Westchester and Putnam Counties and a database of educational activities and training opportunities, many of which are offered free or at nominal charges. The sight was instrumental in making available the myriad of services that families could access in the aftermath of September 11<sup>th</sup>.

MHA is highly regarded throughout Westchester County for its clinical and trauma treatment services and for its Reduced Fee Plan that guarantees access to quality mental health treatment regardless of an individual's financial situation. MHA also offers individualized treatment and support to people in need in both home and com-

munity settings and has as a priority treatment for adults suffering from the most serious mental illnesses and children suffering with the most serious emotional disturbances.

As a leader in Westchester's coordinated community response to domestic violence, MHA provides comprehensive services to all family members affected by domestic violence including treatment and support to battered women and their children, on-site advocacy and assistance for victims at Family Courts, a psycho-educational program for men who batter and a 24-hour hotlines: **914-347-4558** for the Family Abuse Hotline and **914-347-6400** for the Crisis /Suicide Hotline.

As the front-line resource for mental health in Westchester, MHA provides a substantial community education program that works to improve the public's understanding of mental health and mental illnesses and to achieve community acceptance of people recovering from mental illnesses.

For additional information on clinical services in southern and central Westchester, please contact Carla Quail C.S.W at 914-345-5900, ext 244. In northern Westchester, contact Wade Anderson, Psy.D. at 914-666-4646, ext. 111.



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# The Mental Health Association in Orange County

## By Nadia Allen Executive Director

Mental Health Association in Orange County, Inc., founded in 1959 seeks to promote the positive mental health and emotional well being of Orange County residents, working towards reducing the stigma of mental illness, developmental disabilities, and providing support to victims of sexual assault and other crimes.

In partnership with service recipients, families, volunteers, and the community, MHA strives to fulfill its mission through direct services, public education, and responsiveness in times of community emergency.

MHA in Orange County is unique in that it plays a multifaceted role in the community. Last year MHA assisted over 26,600 residents by providing free mental health services with 23 programs. Some of the unique programs include:

**Orange County HELPLINE**, which provides services 7 days a week, 24 hours a day addressing a variety of personal, emotional and social issues. Calls range from personal or informational.

**Invisible Children's Project**, which provides family case management and in-home clinical consulting supports for families where a parent has a mental illness. Subsidized housing is available to families who are homeless and in need of family case management support services.

**Hudson House** is a club based on the psycho-social model, which offers vocational service, supported education and an opportunity for social interaction to persons with a psychiatric disability. Subsidized housing with case management services is available as well.

**S.A.N.E.** (Sexual Assault Nurse Examiner) A collaboration with Orange Regional Medical Center the Horton Campus, and The Or-

ange County District Attorney's Office, which assists rape survivors with the treatment and reporting process. Each month there are approximately six rapes reported to Orange County hospitals.

**RAPE CRISIS** 24-Hour service provides assistance to rape and incest survivors, offering accompaniment and advocacy. Also offers prevention and education programs to the community.

**HOME-TO-STAY** MHA's newest innovative program, which is a joint project amongst MHA, Rehabilitation Support Services and National Alliance for the Mentally Ill in Orange County, provides supported housing with intensive support services for individuals with psychiatric disabilities and who have not been successful while living at traditional residential programs.

These are just a few of the innovative, successful programs that MHA has created. We continue to seek new and innovative

approaches to mental health needs.

In the wake of September 11<sup>th</sup>, everyone's mental health was shaken. Within 24 hours of the tragic event, MHA—together with the county and other agencies—responded to the needs of Orange County residents. MHA in OC has expanded its information and referral services to include **Project Liberty**, which coordinates outreach and crisis counseling community based programs. In addition MHA in OC has established a year round online confidential mental health screening service. Screenings include Depression/ Manic depression; Alcohol; Eating Disorders and Anxiety/Post Traumatic Stress Disorder. To take the screening, or to learn more about MHA programs visit MHA's website at [www.mhaorangeny.com](http://www.mhaorangeny.com)

The MHA family shares a belief that every person has dignity and is to be treated with respect, compassion and acceptance.

# New Women's Program Meets Community Need

**By Helen Greer  
NewYork-Presbyterian Hospital  
The Westchester Division**

As more attention has focused on women's health care in the past two decades, it has become evident that certain mental health issues are seen exclusively or predominantly in women. There has also been increased awareness of the benefit that some women with psychiatric conditions would derive from a gender-specific environment. These may be women who are experiencing any type of mental illness during pregnancy, the post-partum period, or menopause. Also included are women who are victims of domestic violence, rape, or other forms of trauma. Additionally, just as many women traditionally turn to each other for social support and assistance, some may, when health care is needed, prefer to receive this care from women as well.

In response to these developments, NewYork - Presbyterian Hospital's Westchester Division has opened a new Women's Program, providing short-term inpatient psychiatric care for women over 18 years of age. Specialized treatment is offered for those suffering from mood or anxiety disorders and other forms of serious mental illness, which may be complicated in some instances by addiction or medical problems.

Kathleen McCarty, MD, Unit Chief of the Women's Program, has focused her psychiatric career on the treatment of trauma survivors, victims of domestic violence, and women diagnosed with serious mental illness. The program's multidisciplinary treatment team includes professionals in medicine, nursing, social work, art therapy and health care administration, chosen specifically for their interest and expertise in the area of women's mental health. In addition to program staff, gynecologists and appropriate medical special-

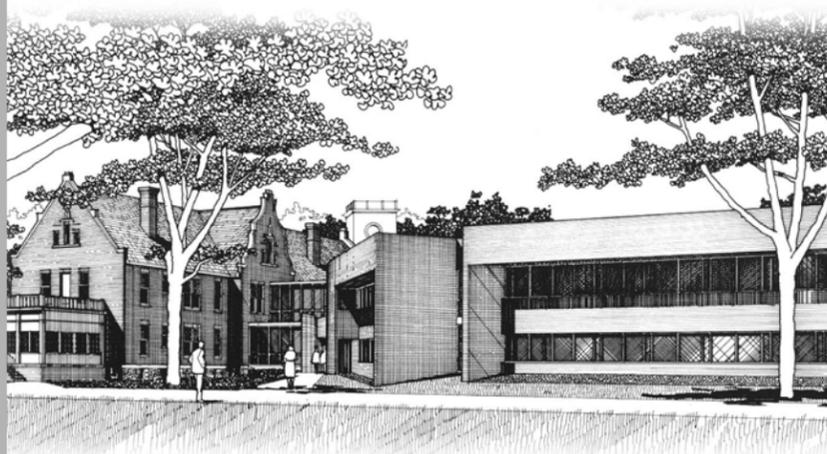
ists are also available to consult with patients as needed, as are pastoral care counselors and addiction recovery specialists.

Before the 1970s, male and female patients were treated in separate wings of the hospital, and the Women's Program continues this long history of providing specialized care for women. The new program's staff have extensive experience with and interest in issues of women's behavioral health. Isabel Rachlin, MSW, Senior Social Worker on the unit, has worked with women, couples and families in both in- and outpatient settings. Lisette Rodriguez, MS, RN, Patient Care Manager, has broad experience with women suffering from eating disorders and in the area of patient satisfaction with health services. According to both, many patients in the Women's Program have expressed a greater comfort level with same-gender groups. The patients find that certain issues are difficult to discuss in front of men and report that it is easier to be open about themselves if only women are present. "In any group—in the hospital, the corporate world, the community, or the classroom—the ways in which women communicate and understand each other may change in the presence of men," confirms Ms. Rachlin.

Upon admission, all patients receive an individualized diagnostic assessment that considers biological, psychological and spiritual aspects of health. Treatment includes individual psychotherapy, marital/family therapy, psychopharmacology, psychoeducation and group therapy. Discharge planning, a critical part of treatment, begins at the time of admission, and involves the patient, family members, referring clinician and community resources.

For further information about the Women's Program, or to make a referral, call 1-888-694-5700.

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# the NARSAD report

## The National Alliance for Research on Schizophrenia and Depression

By Constance Lieber, President  
NARSAD



Constance Lieber

I am delighted to have the opportunity to add my voice to those who write an ongoing column for *Mental Health News*.

As president of the National Alliance for Research on Schizophrenia and Depression (NARSAD), I will be reporting on developments of vital interest to those interested in the progress of brain and behavior research. NARSAD is the leading donor supported organization of raising and distributing funds for brain and behavior research worldwide. Since 1987, NARSAD has awarded \$128.1 million in research grants to 1,546 scientists in 191 leading universities, institutes and teaching hospitals around the world.

NARSAD has just completed its very unique celebration of progress in achieving better treatments and eventual cures for the severe mental illnesses. We had our 14th annual prize awards, and honors celebration and research symposium in New York on October 11th and 12th.

NARSAD's prizes, initiated in 1987 were intended to focus attention on outstanding lifetime achievements in the research effort to overcome mental illness. These awards, NARSAD's founders realized,

would help to inspire younger scientists toward building their careers in this dynamic field and bring broader recognition to its very special accomplishments. The first prize developed by NARSAD was the Lieber Prize for Schizophrenia Research. In terms of financial reward, it was the largest prize given for psychiatric research - \$50,000. Since its inception, it has been funded by the Essel Foundation. The selection of winners has created a sub-committee of NARSAD's 75 scientist Scientific Council, the leaders in all fields of brain and behavior research, headed by Herbert Pardes, M.D., president of New York Presbyterian Hospitals, former director of the National Institute of Mental Health and former executive vice-president and dean for Health Sciences of Columbia University. The extraordinary effectiveness of the selection committee has been demonstrated by the fact that two Lieber Prize winners subsequently received Nobel Prizes for their research. They are Dr. Paul Greengard of Rockefeller University and Dr. Arvid Carlsson of Gothenburg University in Sweden.

The NARSAD prizes proved such an important stimulation that in 1994 NARSAD inaugurated a prize for Affective Disorders, notably Depression and Bipolar Disorder. This prize, now known as the Nola Maddox Falcone Prize, has been awarded to 19 of the most outstanding contributors in the field of Affective Disorder research.

Recognizing remarkable progress in the field of child and adolescent psychiatry research, NARSAD inaugurated the Ruane Prize for that field in 2000.

The 2002 winners of the prizes were the Lieber Prize Award for outstanding achievement in Schizophrenia research, Francine M. Benes, M.D., Ph.D. Dr. Benes is both a cellular neural anatomo-

mist and a psychiatrist who has devoted her career to investigating how the brain may be miswired in Schizophrenia and other neuropsychiatric disorders. The Lieber Award committee recognized that these studies have helped to spawn a new era of neuropathology focused on specific circuits and neuroscience-based hypotheses of structural deficits in the brains of patients with Schizophrenia and bipolar Depression.

The Nola Maddox Falcone prize award winners for outstanding achievement in Affective Disorders Research were Ronald Duman, Ph.D. and Paul Grof, M.D., Ph.D. Dr. Duman was recognized for his distinguished contributions in defining the neurobiological mechanisms involved in the effects of stress and antidepressant medications. His findings were described by the prize committee as "Revolutionary in reviewing novel mechanisms of antidepressant action at the level of gene transcription and regulation". Dr. Grof shared the prize for his "pioneering studies revealing the unpredictable recurrent course of bipolar illness and the unique and complete response to lithium carbonate in a subgroup of patients. The committee said "his life's work has thus made critical contributions to the care and treatment of patients with this life-threatening illness."

The Ruane Prize was given to Judith L. Rapoport, M.D. because of her major scientific contributions to child psychiatry. The committee observed that "She pioneered pharmacological intervention in children with attention deficit disorder, with obsessive-compulsive disorder and most recently in children with Schizophrenia," adding that "Few individuals have been as important as Dr. Rapoport in the study of biological factors in childhood mental disorders."

The prizes are at the peak of an extensive and broad research support effort by NARSAD. The base is the provision of research grants to young scientists with innovative research projects and limited prospects for financial support. Each must be on the staff of a university or medical center which can provide full resources for the research. This year alone NARSAD is funding 434 Young Investigators, each with a \$60,000 two-year grant. The next level of support is the Independent Investigators at the Associate Professor level, each of these 141 scientists in 2002 received a \$100,000 two-year grant, aimed at building fresh insights and powerful investigations. The most selective of NARSAD grants is for the Distinguished Investigators, people of acknowledged leadership accomplishment with very innovative, even daring new ideas in the search for breakthroughs in brain and behavior studies. This year NARSAD is funding 23 of these Distinguished Investigators at \$100,000 for a one-year grant.

I will close with a quote from Steven E. Hyman, M.D. provost of Harvard University and recent director of the National Institute of Mental Health, "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. I think what they have done traditionally, which is to fund young investigators—the source of our innovation and our new ideas—in a really generous way over the past years, is exactly what this country has needed if we are going to have a cadre of effective mental health researchers to meet this enormous public health need."

# **NARSAD**

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# Zen Answers To Mental Health Questions

By Brenda Shoshanna, Ph.D.



Dr. Brenda Shoshanna

**Z**en takes a different approach to the problems which plague many of us. If we take a few moments to consider and try this alternative way of dealing with suffering, we may discover something of great value, readily available for all to enjoy and benefit from.

**Question:** I fear doing many things that I used to do because I never know when depression will hit me. So, I stay inside a lot and away from others, in case the depression comes. What else can I do?

**Answer:** Open the door and walk out of the house. Resume your normal activities. The more you fear, resist or hide from the depression the more power you give it over you. If you allow your fear of depression to be in charge of planning your day, your days will grow more and more restricted. By taking action, you are saying to the depression that it is not in charge. You are. If you do happen to feel uneasy as the day progresses, focus upon what you are doing and not upon your uneasy feelings. View your uneasy feelings as a thunderstorm that approaches and then departs. For some, just the simple act of resuming activities gives them a sense of strength and well being. They are not then viewing themselves as a sick person, unable to go forward in life. The way

we view ourselves and the actions we take based upon that has a great effect upon our feelings and lives.

**Question:** I have developed a distrust of people and feel that others are not on my side. I do not feel supported or cared for. How can I find supportive people I can trust?

**Answer:** The issue is not really about finding supportive people, but being able to see others realistically. Your experience of fear and suspiciousness and of feeling unsupported arises within yourself. Others are triggers for it. When we only perceive certain aspects of a person or situation it is easy to focus upon the negative and for it overwhelm the total picture. There are times when others can be supportive and other times when they cannot. When they cannot behave in the way you wish, it is better not to take this personally, as though directed at you, but to realize that all being go through difficult times and changes. If a person is involved with their own issues, they are often not available to be there for you. The best antidote to this is to learn how to depend upon yourself, to truly care for and support yourself.

Through the practice of zazen we learn how to let go of the leaning, depending mind and see where our true support comes from. As we sit, become centered and connect with the deepest part of ourselves, not only do we learn to support ourselves fully but become a source of nourishment for others. When you are focused upon caring for and nourishing others, it is impossible to feel a lack of trust or a sense of being unsupported. The whole universe is here to support you. It brings support in all kinds of ways.

**Question:** My husband keeps threatening to leave me if I don't shape up and do as he wants. He often points to my history of mental illness as a way to keep me in line. Recently I have begun to behave badly whenever he is around. No matter what he says, I can no longer listen. Am I just becoming sick again, as he says?

**Answer:** No one wants to be dominated or threatened by another due to their past history.

When one has suffered mental illness, one of the residual problems can be a lack of trust in oneself, and a lack of feeling that one has the right to follow one's own heart. This itself can cause further depression.

As an individual embarks upon Zen practice he hears a famous saying, "Do not put a head upon your head. What's wrong with the one you have?" This means that we must learn to listen to, honor and trust the head upon our own shoulders. No one else has the right to make choices and decisions for us. When they do, it is natural to want to rebel, to reclaim your own experience and live a life based upon who you are.

As we practice Zen we learn to stay in the present, not dwelling upon what happened before or what to expect tomorrow. Your husband's constantly pointing to your past history is a way of weakening you. It cannot affect you if you realize that the past is over and this is now. You are a different person now. There is no need at all to dwell upon what happened then.

As we practice Zen fear of what others think fades away as we realize that all the wisdom, strength and courage we need exists within ourselves. We do not judge the past, but simply move forward, step by step, with our own feet planted on the ground.

**Question:** I had a severe breakdown not long ago, was diagnosed with depression and am getting treatment, but am not able to work. I had a successful career before I became ill, and now feel like I am letting myself and everyone else down because I have not worked for the past year. These feelings only seem to add to my already difficult situation -- what should I do?

**Answer:** When we add self judgment and blame to an already difficult situation, we only exacerbate our suffering, as you wisely say. Although you may not think of it this way, you are still making a contribution to others. Before you gave to them through your work and now you are allowing them to give to you, to give love, understanding and support. Allowing someone to support you is giving them a gift.

They are now being given an opportunity to develop and express their own love for you.

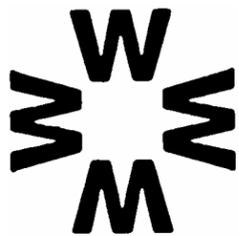
Beyond that, the feeling of not working can cause a sense of shame and uselessness. Although you cannot, right now, assume your former responsibilities, it would be very helpful for you to do some kind of work that you can manage, (as much as you can), that makes a contribution to others. There are all kinds of activities which could fulfill this criteria. There are many volunteer jobs as well as paid jobs where help can be offered to those in need. Some examples might be, mentoring someone in need, visiting the sick, doing wood work or other craft you might be involved with, that you can give to those who would enjoy it, working for the homeless. The possibilities are endless.

Even a few hours a week of doing this will build your sense of personal value. Giving to others in need will also show you that you are not alone in your suffering, and that indeed, despite your situation, you still have a great deal to offer. The more we give, the more we heal. Perhaps you cannot give what you used to give right now, but there are many ways of making a contribution. It is entirely possible that if you do this, new doors and activities which are meaningful can be opened for you.

In Zen this is called developing Parental Mind. Parental Mind is the mind that cares for others, that finds ways to be of service in keeping with one's abilities and where one is right now. There is a saying in Zen which says, "To care for things makes the whole world come alive." To care for others in any way you are able will also restore your sense of self.

*Dr. Brenda Shoshanna, psychologist, long time Zen practitioner and workshop leader is the author of Zen Miracles (Finding Peace In An Insane World), Wiley, 2002. In practice in Manhattan, she soon will be opening an office in Westchester where she will offer therapy, consultation and workshops on Zen and Psychology.. [Topspeaker@Yahoo.com](mailto:Topspeaker@Yahoo.com), [www.Brendashoshanna.com](http://www.Brendashoshanna.com).*

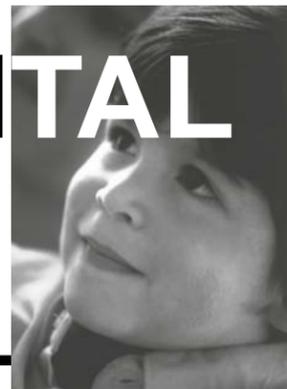
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## Dialectical Behavior Therapy: Balancing Acceptance and Change Compassionately

By Patricia Trainor, Ph.D.



**Patricia Trainor**

Sitting alone in the waiting room, Ruth is shredding the tissue she holds in her lap. She's thinking about the many therapists she's worked with since her late teens. Most have encouraged her to make some changes, but she is convinced none of them ever really understood how much she hates her life. Even when she's tried to change she just couldn't seem to persist long enough for some good to come out of any particular treatment.

Ever since she can remember Ruth has suffered from intense, painful emotions including depression, anxiety, anger, and self-hatred. When these emotions get the better of her she finds herself behaving impulsively in ways that are self-

destructive. Often she gets so upset she can't even think straight. And it seems that relationships with family, friends, and employers never seem to work out well. Sometimes Ruth feels so trapped in her misery that she is convinced she just can't take it anymore and wants to end her life. She's been in and out of hospitals more times than she can count. Today she is meeting a new therapist, hoping for a fresh start but not confident that this therapy will be any more successful than others she has tried.

Ruth has Borderline Personality Disorder (BPD), a very debilitating disorder that is difficult to treat and predominately affects women. Dr. Marsha Linehan, a psychologist at Seattle's University of Washington, is an expert in BPD. She explains that BPD develops when certain biological and social factors interact. This is the biosocial theory of BPD. We know that some children are born with highly sensitive emotions. These children need more help than most in order to learn how to regulate their emotions. When such a child is placed in an environment that chronically fails to recognize the difficulty she experiences with her emotions and does not teach her strategies for managing those emotions effectively, BPD behavior such as Ruth's results.

This explanation of BPD is critically important on a number of levels. Because the disorder is difficult to treat and change comes slowly, it is easy to “blame the victim” for lack of cooperation or not really wanting to get bet-

ter. Linehan's biosocial theory reminds therapists and clients that a compassionate approach is required because of the biological predisposition to the disorder and the lack of previous opportunities to learn how to manage emotions and behavior effectively. The person's behavior is understandable given the facts of her temperament and her life experience. The theory directs the treatment by identifying specific skills that will enable the client to regulate her emotions. Finally, the theory offers the client, and all those with whom she interacts, a non-judgmental explanation that alleviates blame previously focused on her alone.

Although Ruth is not optimistic about her new treatment, she is in luck today. This therapist is trained in Dialectical Behavior Therapy (DBT), a treatment developed by Linehan for chronically self-destructive women diagnosed with BPD. It includes the best aspects of several standard therapeutic approaches but is unique in that it also incorporates eastern philosophy and meditation. Linehan insists that if a person is so dissatisfied with her life that she no longer wants to live it, ending her life is not the solution. Instead, she must create a life worth living.

“Dialectical” refers to a philosophical point of view that is concerned with balancing opposites. DBT achieves a balance between accepting that the client is doing the best that she can given the circumstances of her life experience and at the same time asking for change in her behavior in order to create a life

worth living. A balance is struck between validation of responses to life as understandable and finding effective solutions to problems.

Clients are sometimes overwhelmed by many difficulties occurring simultaneously and it can be hard to know where to focus attention first. DBT offers guidance in solving this dilemma. The logical place to start, but not always the most obvious, is to assess whether or not the client agrees that change is necessary and is willing to commit to doing what is necessary in order to make change happen. If these conditions are not yet in place, the therapist can assist the client to make connections between what she wants in life and how to best achieve those goals.

Safety always tops the priority list when a client is engaged in DBT treatment. Once safe, clients focus on decreasing behaviors that interfere with receiving treatment or that seriously diminish her quality of life. Later in treatment other goals are explored. For example, if severe trauma has been experienced, emphasis may be placed on facing those memories with less suffering. Then the focus may shift to increasing self-respect while experiencing ordinary amounts of happiness and unhappiness. Finally, attention is directed toward the ability to experience sustained joy.

Throughout the more advanced stages of treatment it is essential to be alert to safety issues. Whenever necessary, work

*see DBT continued on page 28*

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## **DBT continued from page 27**

on other issues is put on hold, and problem behaviors replaced with skillful strategies to regain safety. Because change happens slowly, burnout is a danger for both the client and the therapist. The treatment provides support for both.

DBT is unique in that it assures that therapists remain motivated in the treatment. Therapists meet weekly to assist one another to adhere to the treatment model, maintain a balance between acceptance and the need to change, and remain fresh and focused. Clients receive ongoing support as well. Typically, a client receiving this therapy will receive individual DBT psychotherapy, phone coaching, and also participate in a DBT skills training group.

Individual therapy helps clients use new strategies to cope with life dilemmas. During sessions, problem behaviors are examined in detail in order to understand what triggers these behaviors and then generate ideas for responding differently in the future. But the work doesn't stop with the therapy session. Clients are encouraged to phone for coaching between sessions, before a problem behavior occurs, in order to get help in selecting skills to manage the crisis

effectively.

The function of skills training is to learn and then practice strategies that will lead to more effective behaviors. Some skills help the client to better focus attention and take hold of her mind. Other skills assist her to manage emotions more effectively and improve relationships with others while maintaining self-respect. And there are skills that will strengthen her ability to get through a crisis without making things worse.

One of the most frequently asked questions about DBT is "What exactly is skills training?" Perhaps the easiest way to respond is to describe the concept of Wise Mind, one of the first skills taught in DBT. Everyone has three states of mind. Picture two overlapping circles. The circle on the left represents Reasonable Mind, the place inside of us where knowledge about facts and logic reside. The circle on the right represents Emotion Mind, the place where we experience feelings. The area where the two circles overlap in the center is known as Wise Mind, the state of mind where both feelings and facts are considered as well as that elusive factor we call instinct.

Shoe shopping provides an opportunity to understand Wise Mind as it is experienced in eve-

ryday life. Most of us have at least one pair of shoes in our closet that was purchased in Emotion Mind. We loved these shoes at first sight and had to have them even though the fit wasn't so comfortable and they didn't really match any outfit we owned. These are the shoes that got worn once and then languished, forgotten, in the back of the closet forever because they just hurt too much.

On the other hand, most of us have bought at least one pair of shoes when in Reasonable Mind. Maybe those were the shoes that had to match a particular outfit for a special occasion. We didn't love them but they were the right color and fit well enough. Those shoes are also in the back of the closet, packed in the original box, because they are just not fun to wear.

The best way to shop for footwear is to be centered in Wise Mind. Successful shoes make us feel happy and comfortable. We know these shoes are the right shoes for us and feel confident about our decision. They work because our emotional reactions and logical decision-making are both considered.

Achieving the balance of Wise Mind is not always easy to accomplish, but it is one of the most important skills in life, allowing us to make decisions that

get us where we want to go. DBT is a fresh, exciting approach to helping people with BPD create the kind of life they want to live. Research shows that DBT works to help people restore safety in their lives. By balancing acceptance with the need for change in a compassionate way, the lives of many individuals are improving.

*Dr. Patricia Trainor is a psychologist in private practice in Mount Kisco, assisting adolescents, adults, and older adults to achieve balance when serious emotional and behavioral dysregulation disrupts everyday functioning. She specializes in Dialectical Behavioral Therapy (DBT), a cognitive-behavioral model, offering strategies and skills targeted at increasing commitment to treatment while decreasing suicidal and quality of life interfering behaviors. Clients learn to focus attention, manage emotions effectively, tolerate distress more gracefully, and improve interpersonal relationships. She holds a Ph.D. in psychology from New York University, and was trained in Dialectical Behavior Therapy by Dr. Marsha Linehan's training group. She has successfully coordinated a DBT treatment program for women with severe behavioral dysregulation on a long-term, inpatient psychiatric unit.*

*Dr Trainor can be reached at 914-666-2827*

# The Role of Art in Treating the Silent Screams

By **Bobbie Kaufman, MPS, ATR-BC**

The role of art therapy in treating the survivor of sexual abuse cannot be underestimated. From providing a vehicle for expression and catharsis for pent-up and unspeakable feelings, to strengthening ego and fostering insight, to providing information to assist in developing a credible diagnosis—artistic creations provide an invaluable tool in treating the survivor. Understanding how art therapists use drawings as a diagnostic tool is complex. Art is a universal medium used for expression of feelings. In this article, you will see a tiny glimpse of the art therapist's work.

Drawings are the language of metaphor. They represent a synthesis of the artist's inner reality. When an art therapist looks at a drawing to foster his/her understanding of an individual, they are looking at a compilation of factors. The total gestalt, or feeling of the drawing (i.e. does the picture depict a sense of loneliness, isolation, joy, sadness, etc), the size of the drawing in relation to the total size of the paper, the placement of the picture on the

page (does it touch the bottom of the page, float in the air?), the line quality (whether the lines are faint, fuzzy, clear, dark, broken or smooth), the presence and location of shading. The inclusion, exclusion and exaggeration of details, the use of color, and the use of transparencies are some of the features on which to focus.

One's artistic ability does not affect these factors. It may effect how pleasing the artwork is to view, but a person who is having difficulties with a particular issue will unconsciously reflect this difficulty through their drawing regardless of his or her artistic ability. The artwork may not appear to be art, per se, but to the art therapist, it is an otherwise untold world of knowledge.

When we (art therapists) analyze a creation using the factors listed above, our evaluative information is based on research that is very well documented, and widely studied. We are careful never to use one drawing to develop a definitive diagnosis. We read a drawing and use the information as a flag to help identify possible strengths, liabilities, weaknesses and problems. This point bears re-emphasis. The

interpretations of drawings are guides and flags to developing a diagnosis, and must be taken into consideration in conjunction with other psychological, psychosocial, psychiatric and neurologic evaluations, as well as behavioral indicators.

When reading a drawing, it is essential to understand the developmental norms of children's drawings. For example, in looking at the drawing of a person, we would not expect a three-year old to include a neck or hands in their drawing. But if a thirteen year old (adolescent) or a twenty year old (adult) left out a neck or hands, that would be a flag. We would wonder why this individual is leaving off hands and a neck—vital body parts.

Since each particular body part has a metaphorical significance, we look at how each body part is graphically treated. The head represents the seat of thoughts, fantasy life, the center of intellectual power and the center for control of bodily impulses. The neck reflects the regulation between the thoughts in the head and the feelings housed in the chest. We might therefore question whether the artist is uncon-

sciously cutting off their feelings. And if so, why? Since hands portray the way one interacts with the environment, we might surmise that the child who omitted hands from the drawing is having trouble socially. We would want to check this out behaviorally. Is this in fact so and if so, how and why?

Of all the types of drawings created by children, the human figure is the favorite subject (Griffith, 1935) and seems to embody children's feelings about themselves. By observing facial expressions, small children soon learn what they can anticipate. It is not surprising that young children concentrate on the head and face and little else in their drawings. Adolescents or adults who have been sexually abused may also focus on the head in the drawing of a person. This suggests a method for coping with abuse that involves an overemphasis on thought and a possible denial of feelings and bodily urges. The absence of legs and feet depict feelings of not being grounded, a lack of mobility, and should be present in a human

see *The Role of Art* on page 30

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***Samuel C. Klagsbrun, M.D.  
Executive Medical Director***

## ***The Role of Art from page 29***

figure drawing (developmentally) after age 5. Their absence, therefore, is significant.

Just as there are specific details that we expect in the drawing of a person, such as a head, facial features, a torso, limbs, hands and feet, there are details that are also expected in other projective drawings. When we ask a client to draw a picture of a house we are looking for the presence of walls, doors, windows, a roof and chimney. Each of these items has metaphorical significance. We also want to see if the house has a path leading up to it. Symbolically, the house serves as a self-portrait, reflecting the artist's body image, maturity, adjustment, accessibility to others, contact with reality, and emotional stability (Buck, 1981; Hammer 1980.) A twelve-year-old child who was sexually abused drew a house that had no path, and no handle on the door. This suggested her inaccessibility. The house had windows, but only on the upper levels. This feature is often seen in drawings of individuals growing up with family secrets, such as alcoholism. Without ground-level windows, the child can't see out, but more importantly, no one can see in. This child drew her house in such a way that the viewer could see into the bedrooms of the house. The walls were transparent. This was a concern because after age seven we expect a child developmentally to understand what reality is and what it is not. The walls of the house were drawn with very faint, tentative broken lines that suggested her weakened ego. The information was compiled and shared with other team members whose independent evaluations confirmed the art therapist's hypothesis—that there had been abuse.

Another projective drawing that is diagnostically helpful is that of the tree. This drawing is less likely to change over time and most closely reflects the individual's inner world—an externalization of that which is within. In the tree drawing we look for the presence of roots, a trunk and a crown, branch structure and leaves. Each detail about the tree carries a distinct meaning not the least of which is the type of tree which is drawn. A Christmas tree flags dependency needs; dead trees are drawn by extremely depressed individuals with profound feelings of inferiority and potentially suicidal behavior. When twelve-year-old

Joan drew a tree that had broken branches and a flayed root structure, we were alarmed. The branches represent her social interaction. Her depictions suggest the loss of her ability to cope with environmental pressures. Broken branches spoke of her inability to effectively interact. The flayed roots were coupled with a hole in the trunk that was wide enough to affect the integrity of the tree. The trunk of a tree is representative of ego strength. In addition, the hole had a full-sized animal peeking out. There was also a ground swell pushing up against the roots. The compilation of these factors suggested a child who was raped and we also suspected and feared that she was pregnant. Upon conferring with the treatment team, it became clear that this was exactly the case. Moreover, the large hole, which represents a psychic injury, reflects that the rape was affecting Joan's ego strength. The art therapist was able to work with Joan to help her express her fears, anger and helplessness by using paint, clay and collage. With time, Joan felt more empowered and was able to interact with her peers.

Art creations of all types, such as drawings, paintings, sculptures and constructions can and are used to assist in diagnosis. I often ask children to draw a picture of your family doing something (The Kinetic Family Drawing) through which we can assess the interactions and dynamics of the family members. Other specific drawings such as 'draw your biggest fear' and 'draw yourself crossing a river' are very helpful in gaining a fuller picture of the individual's strengths and liabilities. As the individual proceeds in his or her healing, the process of diagnosis is ongoing. Patients will often make spontaneous drawings and paintings as part of their ongoing treatment. All of these visual expressions play an invaluable role reflecting and fostering the survivor's process of change and healing.

*Bobbie Kaufman, MPS, ATR-BC is in private practice in Riverhead, Long Island, specializing in the treatment of sexual abuse victims. She is the co-author (with Agnes Wohl) of "Casualties of Childhood: A Developmental Perspective on Sexual Abuse Using Projective Drawings." Brunner/Mazel, Inc. 1992, and "Silent Screams, Hidden Cries." Brunner/Mazel, Inc. 1985.*



The Mental Health News

# New York City Section

## Mental Health News - New York City Section A Milestone in Education and Newspaper's Vision For Future

### Staff Writer Mental Health News

Back in the spring of last year a group of leaders from New York City's mental health community agreed to meet with Mental Health News to learn of the newspapers interest in better serving the mental health education needs of the five boroughs of Manhattan, The Bronx, Queens, Brooklyn and Staten Island.

The outcome of that meeting resulted in the formation of a new and growing Metro-NYC Leadership Committee (see below). This committee provided the impetus and participation necessary to enable Mental Health News to launch this wonderful

new regional section of the newspaper.

Mental Health News founder and publisher Ira H. Minot, a survivor of mental illness, began the newspaper in the fall of 1999 with the vision of creating a *roadmap to recovery comprised of vital information* for those whose lives have been touched by mental illness. In only three short years, his vision has created a publication with over 100,000 readers.

According to Minot: "Thanks to the efforts of our growing leadership committee, Mental Health News will now be able to reach many thousands of individuals and families throughout the city, with the paper's message of hope and caring for those who battle mental illness every day. In addition,

I believe we will be providing vital, early intervention education and resources to those who are experiencing emotional difficulties for the first time in their lives. For them, picking up a copy of the newspaper will have a profound impact on their recovery efforts, reduce their feeling of shame and stigma about having a problem and will save the life of someone whose hopeless despair about problems may have them at the brink of suicide."

Mary Hanrahan, Director of Treatment Services at New York Presbyterian Hospital, stated: "This is a historic moment...We now have an essential mental health information and resource guide in New York City for consumers and families."

The premier of the New York City Section comes on the heels of the newspaper receiving its new status as a charitable organization eligible for major funding from governmental, corporate and private sources. Minot responded: "We desperately need a regular stream of major funding to build the infrastructure necessary to carry on this vital work and fulfill our future vision of reaching communities throughout New York State and beyond. The NYC Section premier marks a big step for us as a hallmark in the eyes of major funders, as well as a model for our friends in Long Island, New Jersey, Connecticut and Upstate NY regions to want to have their own section in each issue of the newspaper."

#### Mental Health News Metro-New York Leadership Committee

Peter Campanelli, President & Chief Executive Officer  
Institute For Community Living

Amy Chalfy, Mental Health Director - Bronx District  
JASA

Kenneth J. Dudek, Executive Director  
Fountain House

Mary Guardino, Founder & Executive Director  
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New York State Office of Mental Health

Margaret E. Moran, C.S.W., VP of Administrative Services  
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Evelyn J. Nieves, Ph.D., Executive Director  
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Phillip Saperia, Executive Director  
Coalition of Voluntary Mental Health Agencies

Alan B. Siskind, Ph.D., Executive Vice President & CEO  
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Giselle Stolper, Executive Director  
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Jonas Waizer, Ph.D., Chief Operating Officer  
F.E.G.S. Behavioral & Health Related Services

Joyce Wale, Assistant Vice President - Behavioral Health  
New York City Health & Hospitals Corporation

Peter Yee, Assistant Executive Director  
Hamilton - Madison House

*committee in formation*

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## New York City



## NewsDesk

## Brooklyn Mental Health Court Sparks Opinions

**Mental Health Court... Solution or Saccharin?**

**By Heather Barr  
Staff Attorney, Urban Justice  
Center, Mental Health Project**

October 1, 2002 marked the opening day of New York City's first "mental health court," a court designed to deal specifically with criminal defendants with serious mental illness, by sentencing these defendants to treatment rather than jail or prison. The court, located in Brooklyn Supreme Court, is the creation of New York City's Center for Court Innovation. Funded by the New York State Office of Mental Health (OMH), the New York State Office of Court Administration (OCA), and numerous private funders, the court actually began accepting clients several months ago.

I was not involved in the design or implementation of the Brooklyn Mental Health Court, but I have watched its creation with great interest. As an advocate working to fight the "criminalization" of mental illness, I have found that my thinking about mental health courts has evolved over time. Five years ago, when I began thinking about mental health courts, very few existed (only the first one, in Ft. Lauderdale, FL, was well-established). At that time, mental health courts seemed to me like a great idea – the stated purpose of these courts is generally to "divert" people with mental illness out of the criminal justice system and into mental health services, a goal perfectly in line with my belief that the criminal justice system in the U.S. incarcerates far too many people (2 million to be exact – the highest rate of incarceration in the world), including a vastly disproportionate number of people with serious psychiatric disabilities.

Over time, however, as I learned more, I became skeptical about mental health courts for two reasons: 1) many of them seem to be more about coercion than diversion; and 2) they do nothing to repair our broken mental health system.

A study of the first four men-

tal health courts in the U.S. released by the Department of Justice in 2000 found that one thing these courts have in common is their restriction of eligibility to defendants with non-violent misdemeanor charges and without histories of violence. Of course, the fact that people with mental illness are typically no more violent than everyone else can not be repeated often enough, but it seems like a shame that even specialized "compassionate" courts were ready to throw away the key on the rare occasions when a person with a mental illness does commit a violent offense (which may be something as minor as pushing someone, threatening to hit someone, or struggling while being arrested). It also raises the question of whether what these courts are doing can really be called "diversion." People who have committed non-violent misdemeanors are usually not sent to jail. Mandating that people go to mental health services rather than sentencing them to jail is only "diversion" if the person really would otherwise have gone to jail. If mental health courts are mandating to treatment people who would not have otherwise gone to jail, then the courts are practicing coercion, not diversion. When courts practice coercion, we should call it what it is and not try to pass it off as "diversion."

Second, and even more importantly, no mental health court can fix a bad mental health system, and New York City's mental health system stinks. With a 2% vacancy rate in our supportive/supported housing system, waiting lists for essential services such as case management, a great need for more peer support and self-help services, huge obstacles facing people wishing to apply for Medicaid and public assistance, virtually no access to services for people without insurance, thousands of homeless people with mental illness living in our shelters and on our streets, a new adult home scandal every week, and growing evidence from authorities such as the U.S. Surgeon General that people of color are underserved

**see Saccharin on page 44**

**Brooklyn Mental Health Court Offers Options**

**By James L. Stone  
Commissioner, New York State  
Office of Mental Health**

The Brooklyn Mental Health Court, New York State's first court dedicated to the handling of non-violent cases of defendants with serious mental illness, officially opened its doors on October 1, 2002. A joint project of the New York State Office of Mental Health, the New York State Unified Court System and the Center for Court Innovation, the Brooklyn Mental Health Court is a voluntary program that gives defendants the opportunity to choose treatment for their mental illness. The goal of the new court is to identify defendants whose mental illness is likely to have contributed to their involvement with the criminal justice system and who would ordinarily be sentenced to jail or prison, and link them to appropriate treatment as an alternative to incarceration.

The Mental Health Court is an idea whose time has come. Existing problem solving courts in New York, such as the Drug Treatment Alternative to Prison (DTAP) and Treatment Alternative to Prison for Dually Diagnosed Defendants (TADD), have proven that it is possible to provide certain defendants with needed treatment while ensuring the safety of the community. As Chief Judge Judith S. Kaye has stated, when mental illness is a factor in lawlessness and that fact is ignored, the result can be an unproductive recycling of the individual through the criminal justice system.

Several other states are using mental health courts, but New York's court differs from most in that, because the goal is to divert individuals from incarceration and instead engage them in treatment, it focuses on defendants who are charged with non-violent felonies or misdemeanors that would likely result in a jail sentence. Participation in the Mental Health Court is based on the defendant's plea of guilty to the criminal charges. The new court features judicial monitor-

ing and enhanced accountability, and has increased coordination and communication between the criminal justice and mental healthy systems.

The Brooklyn Mental Health Court operates out of a dedicated courtroom, and uses a team of mental health clinicians who perform assessments and develop individualized treatment plans which address each defendant's mental health needs. The team then links individuals to treatment and services, and Brooklyn's single point of entry for housing and case management has identified individuals referred from the Mental Health Court as a priority population for placement.

Throughout the course of treatment, a defendant is required to make regular and frequent court appearances to report on their progress. This not only keeps the judge engaged with the defendant for the life of the case, it also reinforces for the defendant the seriousness of the process.

Other government and non-profit partners involved in planning the Mental Health Court include the Kings County District Attorney's Office, the Legal Aid Society, the Brooklyn Defenders Service, the New York City Department of Mental Health and numerous representatives of the mental health treatment community.

The Brooklyn Mental Health Court fits in well the Office of Mental Health's multi-year quality agenda, which is well underway across the State. Single points of entry for all case management and housing services are being established, ensuring that throughout the mental health system, individuals with the greatest need have priority access to services. Concurrently, New York's community-based rehabilitative, support and housing services have seen unprecedented expansion: in fiscal year 2001-2002, Governor Pataki and the legislature funded the largest single year increase in the mental health budget, allocating \$125 million for service expansion. Case management and assertive community treatment

**see Options on page 44**

# New York City NewsDesk

## The New York Work Exchange Releases Guide to NYC's Mental Health Employment Programs

**Staff Writer  
Mental Health News**

The New York Work Exchange, a program of The Coalition of Voluntary Mental Health Agencies, Inc., has released the First Edition of *The WORKbook*, a comprehensive guide to mental health employment programs in New York City.

"Increasingly consumers are pursuing employment and careers. This book was written explicitly for such consumers to help them in the decision-making process," says Alan Menikoff, Deputy Director of the New York Work Exchange.

*The WORKbook* is a unique publication designed to help individuals achieve their employment goals and realize their aspirations. Employment is both a right and a responsibility of citi-

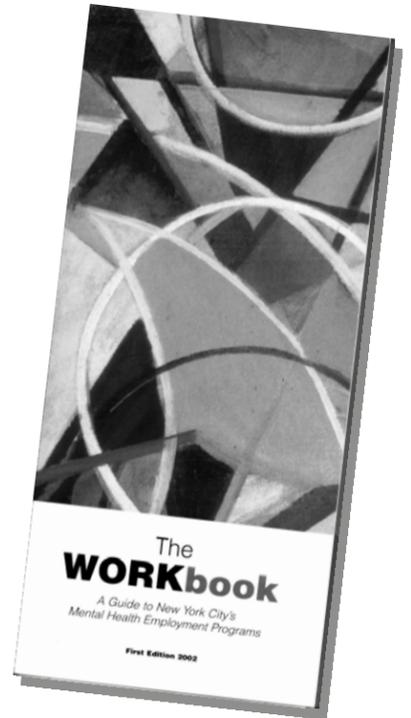
zenship. We know that most people want to work, need to work, can work and can benefit from work. Consumers speak strongly about the central role of work in recovery. The New York Work Exchange believes that *The WORKbook* will be an invaluable resource for all consumers confronted with the challenges of identifying the most effective employment program to aid them in their recovery. It will also provide a comprehensive view of New York City mental health employment programs to providers, policy makers, and public officials.

*The WORKbook* uses a categorization of programs that allows consumers to easily select the program that meets their needs. These approaches include: working among consumers; individual employment with supports; clubhouses; sheltered workshops; psychosocial clubs; and prevoca-

tional programs. It includes 116 programs across the five boroughs. Each listing includes the approach, services provided, types of jobs available, contact information, and directions.

To make arrangements to pick up your copy of *The WORKbook*, call Deborah Short at The New York Work Exchange, (212) 742-1122x235. An online version of *The WORKbook* will be available shortly on the New York Work Exchange's website [www.nyworkexchange.org](http://www.nyworkexchange.org).

The Coalition's The New York Work Exchange is an innovative program funded by the New York State Office of Mental Health, created to help mental health providers break down the barriers between people with mental illness and the job market, and to facilitate consumers' access to the dignity of paid, productive employment.



## A Caring Approach To Wall Street's Mental Health

**Staff Writer  
Mental Health News**

Investors and the hourly news bureaus constantly take the pulse of the market's performance, but how about the mental health of Wall Street Stockbrokers.

Dr. Alden M. Cass, a clinical psychologist has spent the past three years researching the indicators which reveal some compelling findings about brokers emotional states. His sample of male brokers indicated that 23% were diagnosable with clinical levels of major depression—with moderate to high levels of emotional exhaustion, anxiety, depersonalization (emotional detachment from their clients), and burnout.

Cass's confidential study findings also reveal that drugs and alcohol were commonly used to combat stress—did little to relieve these problems in the long run, yet few reported willingness to approach Employee Assistance Programs (EAP's) for help.

To respond to these realities, Catalyst Strategies Group was

developed to address mental health issues endemic to the Wall Street scene—assisting companies in identifying and correcting potential employee problems within the financial services industry before they occur.

Employees and their employers are rarely aware of the strong relationship that exists between symptoms of depression, anxiety, burnout, and substance abuse and a decrease in productivity and the increase in costs to a company. CSG takes the "corporate temperature" of each company through the use of a comprehensive job demands analysis, and assesses, intervenes, and prevents these hidden problems from affecting not just each individual employee, but the company as a whole. CSG uses an elaborate coding system, allowing employees to fill out assessments and receive written feedback that remains completely confidential—eliminating an employee's concern about being labeled by his or her employer and each employee can then be proactive in utilizing the companies

underused Employee Assistance Program.

Dr. Cass specializes in working directly with senior executives, including high-profile CEO's, helping them to achieve their corporate and personal goals. He has presented his research on stockbrokers and their mental health in both national and international conventions (A.P.A., and ICPP-Stockholm). Additionally, he spearheaded a Community Service Workshop, "Rebuilding From Within," that combined psychologists, psychiatrists, and financial analysts into one venue. The purpose of this workshop was to help those individuals working within the financial sector of Wall Street in dealing with the trauma and stress that was elicited by the World Trade Center tragedy. This event was co-sponsored by St. Lukes-Roosevelt Hospital and the Security Industry Association.

Dr. Cass has appeared extensively in the media and has been seen on CNN's "Lou Dobbs Mon eyline," CNBC London, the Financial Times, On Wall Street

Magazine, Business Week magazine.

For more information visit [www.catalyststrategiesgroup.com](http://www.catalyststrategiesgroup.com) or you can reach Dr. Cass directly at 914-774-1319 for more details.



**Dr. Alden M. Cass**

# JBFCS Upholds a Tradition of Quality Care to Meet Changing Community Needs

**Staff Writer  
Mental Health News**

The world as we knew it changed irrevocably on September 11<sup>th</sup>, 2001. Living with constant uncertainty has created levels of stress and anxiety never before imagined. Subsequent demands on the mental health system have been enormous.

While no one could have been fully prepared for the catastrophic attacks of 9/11, the Jewish Board of Family and Children's Services' network of counseling centers were unfortunately used to responding to extreme crises facing families, individuals and the community at large. Every day, its 12 community counseling centers witness firsthand the ravages of stress and conflict. These centers -- called Madeleine Borg Community Services -- meet the complex needs of New York's families and children every day at locations in the five boroughs.

"Staff were on the front lines on September 11<sup>th</sup>, 2001 as they are every day and as they have been for more than five decades, explains Alan B. Siskind, Ph.D., JBFCS Executive Vice President and CEO."

What its staff of highly trained staff of social workers, psychologists, and psychiatrists can attest to is that high quality, confidential counseling can make a positive difference in peoples lives. Whether a client is facing the challenges of everyday life -- divorce, parenting, teen conflicts -- or unexpected life crises, these 12 centers are poised to respond and to help individuals and families work through their difficulties and restore their ability to cope and even to thrive.

## Reflecting Each Local Community

JBFCS counseling centers provide services without regard to age, religious or ethnic background, disability, gender, sexual orientation, or ability to pay. Those serving large immigrant populations have an understanding of different cultures with staff fluent in many languages including Russian, Spanish, Chinese, Korean, Farsi, Yiddish, and Hebrew. Each center uniquely reflects and is an integral part of the community where it is located. Centers maintain close contact with local institutions and special programs may be located at community centers or other neighborhood locations. Staff are also available to con-

duct workshops or speak before local groups.

Our centers are in turn supported by the training, educational, and administrative resources and experience of JBFCS and its network of 185 community based programs, residential facilities, and day treatment centers which each year help more than 65,000 New Yorkers. JBFCS is accredited by the Joint Commission on Accreditation of Healthcare Organizations. Each counseling center is licensed by the New York State Office of Mental Health and the New York City Department of Health and Mental Hygiene. In addition, JBFCS is proud to be a beneficiary agency of UJA-Federation and A United Way Agency.

## Comprehensive, Individually Tailored Services

Clients referred to our centers receive comprehensive individually tailored services from highly trained and caring professionals. We offer individual, family, couples, and group counseling in a supportive environment where confidentiality is protected. Every client is assigned an individual therapist and specific appointments for service are set as conveniently as possible and all centers are open several evenings a week.

Multidisciplinary teams of certified social workers, psychologist, and psychiatrists develop individualized treatment plans. These mental health client assessments can include crisis intervention and medication evaluation and management services if needed. Special programs also are available for a range of areas including learning issues, early childhood, and adolescent related concerns.

## Fees and Referrals

Fees are based on a sliding scale, according to income, resources, and particular family circumstances. An appropriate fee for each client or family is discussed during the initial interview. Medicaid, Medicare, Child Health Plus or payment by managed care providers and most private insurance plans are accepted, although clients are responsible for deductibles and co-payments.

Individuals and families may apply for services by calling the Counseling Centers directly (see box). Every effort is made to see an individual as quickly as possible or to refer them to other appropriate services. Referrals are

also accepted from managed care organizations, schools, clergy, hospitals, day-treatment programs, senior citizens centers, physicians and other professionals and agencies.

Anne Zweiman, C.S.W., herself a veteran of the MBCS Division, is the proud director of this remarkable network of services. In spite of tremendous fiscal constraints and pressures to limit services, she remains confident

that JBFCS Community Counseling Centers can and must provide the high level of support for which they have always been known and on which New Yorkers have come to count. Her philosophy is clear, "Our centers are about teamwork—teaming with the client and family members, with one another and with the communities to build—and rebuild—the structures of peoples lives."



Meeting of Community Counseling Center Directors and related staff (seated left to right) Paula Held Sharf, Patricia Nitzberg, Anne Zweiman, Division Director, Pam Lotenberg, and Joan Adams (standing, left to right) Todd Schenke, Mark Kleinman, Patricia Payne, Jeanne Murphy, Karen Czwilinski, Sandar Cohen, Inna Litrovnik, Arnold Markowitz, Robin Brinn, Helene Stone, and Carol Curtis.

## JBFCS

### Community Counseling Centers

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The Harry Blumenfeld Counseling Center  
750 Astor Avenue – Bronx, NY 10467  
(718) 882-5000 – fax: (718) 798-7633

#### Riverdale Office

The J.W. Beatman Counseling Center  
4049 Henry Hudson Parkway – Riverdale, NY 10471  
(718) 549-6900 – fax: (718) 601-4587

#### Bay Ridge Office

94-35 Ridge Blvd. -- Brooklyn, NY 11209  
(718) 238-6444 - fax (718) 238-5165

#### Boro Park Office

1273 53<sup>rd</sup> Street – Brooklyn, NY 11219  
(718) 435-5700- fax: (718) 854-5495

#### Break-Free

2020 Coney Island Avenue – Brooklyn, NY 11223  
(718) 676-4210 – fax: (718) 676-4216

#### Mid-Brooklyn Office

2020 Coney Island Avenue – Brooklyn, NY 11223  
(718) 676-4210 – fax: (718) 676-4216

### Southern Brooklyn Office

The Doris L. Rosenberg Counseling Center  
333 Avenue X – Brooklyn, NY 11223  
(718) 339-5300 – fax: (718) 339-9082

### Starrett City Office

1201 Pennsylvania Avenue, Suite 1B  
Brooklyn, NY 11239  
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### Manhattan North Office

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### Manhattan West Office

The Alan and Kathryn Greenberg Counseling Center  
120 West 57<sup>th</sup> Street – New York, NY 10019  
(212) 397-4250 – fax: (212) 632-4495

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UJA-FEDERATION OF NEW YORK



## Connections: Helping People Heal Themselves Post- Sept. 11<sup>th</sup>

**By Ellen Stoller  
Assistant Vice President,  
Community Services, Training  
and Consumer Affairs, FECS**

“Sorry we’re late,” said Esther and Margaret, at the last group meeting, “we went to the gift show at the Javits Center. Esther’s daughter got us passes.” On a day where the temperatures topped 96 degrees, these two over-65 year old women, who met in a 9/11 support group, were out and about. Esther and Margaret, both lower Manhattanites, who watched from their apartments as the World Trade Center disintegrated, had become more socially isolated after Sept 11th. Both had stopped taking pleasure in daily activities and events that had previously kept them occupied. Both felt their families didn’t understand their preoccupation with the events of Sept 11th. “They all tell me to ‘get over it already’; they don’t understand.” Said Esther in December, in March and still in May and August. Margaret and others in the group support her, validate her feelings and agree. They have had the same experience.

Since Oct. 10th, 2001 I have been the facilitator, leader, or perhaps just the witness, to a fascinating phenomenon. It is not anything new, not anything I can wholly take credit for, but nevertheless the result of work and forethought and continued effort on my part, and on the part of my colleagues. It is the helping of people to help themselves.

On Oct. 10th, the first session of what has become a long playing support group began for residents of Lower Manhattan, who felt upset, affected, or otherwise thrown off balance by the tragedy of Sept 11th 2001. The group has grown and shrunk and grown and shrunk, yet has met every single Wednesday afternoon for ten months now.

Over time it has become clear that although Sept. 11th is what has brought people out to support groups, many of the people who stay, or were still calling to join, as the anniversary of 9/11 approached, are adults who are not strangers to tragedy, disaster, and life turmoil. After all, how can you grow up without experiencing loss, tragedy and emotionally trying times? But just by virtue of

temperament, type and personality, people need different kinds of support to get through life.

Periodically, people in my group seem to blame themselves for being so weak that they need this group. Yet I think of them as an amazingly strong and insightful group of people who have many things in common, besides Sept. 11th that are helping them heal and help each other.

Trauma is not brand new to any of them. We have, in no particular order, children of Holocaust survivors, children of alcoholics, people who were sexually abused, people who were emotionally abused, people who suffered early losses, people who have been divorced, people who are Viet Nam vets. Their ages range from 30’s to 70’s.

None of them announced to me that they have started to call each other for support when they are having a hard week. Maybe they thought I might be jealous. It just slipped out. Margaret called me on a day that she was very depressed and I suggested various ways she could get through. “I think I’ll call Adam, he took a walk with me once before, that helped me.” Adam did go for another walk with her that day, and they talked on the phone another day. They no longer feel isolated, and they don’t need a formal group meeting to make contact when they need it.

If this were a long-term therapy group, these outside relationships would change the dynamic of the group. But this is not group therapy. We have started to talk about what makes a group a support group as opposed to a group therapy. I have ended up explaining it as this: all support groups are therapeutic but not all supportive groups are group therapy.

What will happen when the funding for this group no longer exists? When someone determines that the money for supporting victims of 9/11 is gone, or not to be used in this way anymore? What will happen is what is naturally occurring...my support group will support each other. They will talk on the phone, meet for coffee, go to a movie. They will become friends. Friends brought together by tragic events. Friends, who if they met in any other way, would not have seen the things they have in common. Friends whose connection is Sept. 11th.



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A United Way Agency of New York City/Long Island



**The  
Coalition**  
of Voluntary  
Mental Health  
Agencies, Inc.

# The Coalition Report

By Phillip A. Saperia  
Executive Director



Phillip A. Saperia

The Coalition of Voluntary Mental Health Agencies is the umbrella advocacy organization for the New York City's mental health community, representing more than 100 not for profit, community-based providers of mental health services. Our member agencies provide every manner of service from clubhouses to clinics to residences and offer them to more than 300,000 consumers. The Coalition advocates, educates, and provides technical assistance and many other kinds of services on behalf of the mental health sector.

This year, the advocacy challenges are particularly acute because of the confluence of impending budget shortfalls and the end of a decade in which contracts, rates and fees in the mental health sector were hardly adjusted. One of symptoms of these low reimbursement rates has been staggeringly high turnover and appallingly low salaries. As reported by The Coalition, turnover in 2000 averaged a shocking 37% to 54% depending on the type of staff. The recently passed COLA and Medicaid hike were needed infusions of funding, but they do not address gaps left by a decade of stagnant contracts.

With turnover so high, agencies are engaged in a constant struggle to maintain the quality of care. The therapeutic relationship between consumers and mental health workers—so important for rehabilitation and recovery—is increasingly difficult to maintain when workers are lured away to higher paying jobs outside the mental health sector. As a result, stabilizing the workforce through the institution of a structural COLA and MA increase remains our chief goal.

In order to monitor more comprehensively salaries and turnover in the men-

tal health sector, The Coalition applied and was selected to work with a team of graduate students from New York University's Wagner School of Public Service. These students will work on a follow-up to the highly regarded Salary and Turnover Survey for 2000. This endeavor should provide greater detail on the low salaries that characterize the mental health sector. We are hopeful that the findings will help us make the case for an institutionalized COLA and Medicaid rate increase.

Among the most serious issues facing the mental health sector is in the realm of housing. In particular, New York City is facing a serious problem in the form of vanishing federal homeless assistance support. The McKinney-Vento Act, which funds permanent and temporary housing for homeless individuals with disabilities, brings approximately \$60 million in federal funds to New York City on an annual basis. For the next application cycle, if most programs are renewed for two years, as is customary, they will cost \$86 million, resulting in a shortfall of \$26 million.

In committee, the House of Representatives and the Senate recently approved spending bills, each of which provide a \$193 million carve-out for HUD's existing Shelter Plus Care (S+C) programs. Of this amount, New York City will receive slightly more than \$6 million. Unfortunately, the majority of New York's permanent housing is in Supportive Housing Programs (SHP) to the tune of \$20 million.

In most cases, these funds provide the support services, which stabilize fragile people in permanent and transitional housing. Without these services, city- and state-funded residential programs could be left with little more than a front desk clerk to look after the physical and emotional well being of the residents. In order to maintain the stock of existing HUD-McKinney housing, The Coalition is continuing its advocacy efforts by working with legislators.

The struggle for residential services is not just about holding the line for what currently exists. The very same low contract rates plaguing the mental health system also impact mental health housing. In addition, there is an acute need for greater capacity for residents of nursing homes and adult homes. A recent preliminary report called for the creation of 5200 units for this population; advocates are calling for another 9000 just for the homeless. Whether these will be funded—let alone at the increased rates that they require—remains to be seen.

Among the many activities of The Coalition is a project called the New York Work Exchange, an OMH-funded program created to address the lack of participation of individuals with psychiatric disabilities in the competitive labor market.

The New York Work Exchange achieves its goals through education, training, research, technical assistance and the sponsorship of special projects.

The education activities, which include a series of seminars and workshops, cover a wide range of employment-related topics. In the next few months, for example, the New York Work Exchange will offer seminars entitled, "Understanding Benefits and Entitlements for Individuals with Psychiatric Disabilities" and "Integrating Employment Support Services and Clinical Services."

The New York Work Exchange was recently asked by the New York State Office of Mental Health to develop a portfolio of educational curricula in the arena of employment services. The final report will recommend alterations in all levels of the delivery system - agency, program, and personnel - throughout New York State, by emphasizing and supporting the use of evidence-based practices in these systems. The working committee—the State-Wide Educational Advisory Board

(SWEAB)—is made up of prominent individuals from universities, think tanks, city and state agencies, and private consultants.

The WORKbook, a consumer-oriented listing of employment programs in NYC, (highlighted on page 39 in this edition of *Mental Health News*) is one of the major projects of the New York Work Exchange.

The New York Work Exchange has also commissioned a number of studies, one of which examines the role of Employee Assistance Programs in helping employees with psychiatric disabilities and one that investigates the role of unions and how they may be useful to mental health consumers in pursuing employment.

An active partner in the planning and implementing of job fairs for persons with psychiatric disabilities, the New York Work Exchange held its first job fair in the Spring 2001 in partnership with the Urban Justice Center and Community Access Inc. Subsequent job fairs are scheduled for later this year.

**The  
Coalition**  
of Voluntary  
Mental Health  
Agencies, Inc.

For more than 30 years, The Coalition of Voluntary Mental Health Agencies has been the umbrella advocacy organization for more than 100 not for profit, community-based providers of mental health services in New York City. Our member agencies provide every manner of service—from clubhouses to clinics to residences—to more than 300,000 consumers annually.

Coalition members receive top-rate services including vital technological assistance on such topics as managed care and HIPAA, access to high level government administrators and elected officials, and up-to-date information on mental health issues facing New York City and State.

**For more information, call (212) 742-1600**

Phillip A. Saperia  
Executive Director

Alan B. Siskind  
President

# Culturally Competent Evidenced-Based Treatment

**By Benjamin R. Sher, MA, CSW  
Director of Training  
and Staff Development  
Institute for Community Living**

In August of 2001, the New York State Office of Mental Health (NYS/OMH) conducted a series of four focus groups with local government leaders, service providers, advocates and recipients of service. The goal of these focus groups was to introduce the concept of evidence-based practice for persons with mental illness that are served in the public and not-for-profit sector of New York State. Evidence-based practices are interventions for which there is consistent scientific evidence showing that they improve consumer outcomes. Dubbed the OMH "Winds of Change" campaign, eight service categories that have been grounded in research were identified as priority for implementation in New York.

They are:

- Assertive Community Treatment (ACT) and Intensive Case Management (ICM)
- Supported Employment
- Wellness Self-Management
- Family Psychoeducation
- Integrated Treatment for Co-Occurring Substance Abuse and Mental Health Disorders
- Psychotropic Medication Management (using treatment guidelines for optimal prescribing practices)
- Self-Help and Peer Support Services, and;
- Post-Traumatic Stress Disorder (PTSD) Treatment.

The grounding philosophy for this initiative has been the serious gap that exists between the treatment and interventions that have been proven by research to be effective and the treatments and interventions that are provided in routine mental health care practice. This service gap has been addressed in a seminal book, Crossing the Quality Chasm: A New Health System, written in 2000 by the National Academy of Sciences' Institute of Medicine. Among other assertions, Crossing the Quality Chasm emphasized that all consumers, regardless of the health care service that they are accessing, should receive care based on the best available scientific knowledge. Therefore, the State Office of Mental Health has answered this challenge by designing their "Winds of Change" Program.

At the same time that the medical and mental health community have been advocating for evidenced-based treatment, Mental Health: A Report of the Surgeon General, released in 1999, reported that though there are effective, research-based treatment available for most mental health disorders, Americans on the whole do not share equally in the best that science has to offer. Often, barriers to care are based on racial, ethnic, and cultural concerns. In fact, the Surgeon General's report determined that disparities in mental health services exact a greater toll on overall health and productivity for racial and ethnic minorities. With this issue in mind, it is important to examine exactly how culture is involved in evidenced-based care for persons with mental illness. Because evidence-based treatment has not been grounded on a diverse ethnic and racial base, it is imperative that the mental health community ex-

amines current trends and concerns in care for persons of color. One of these concerns is people of color's response to psychotropic medication.

## Psychotropic Medication and Culture

Of the four federally recognized underserved minority groups, research has proven that two groups, African Americans and Asian Americans/Pacific Islanders, have been found to react differently than whites to psychotropic medication. As discussed in the Supplement to the Surgeon General's Mental Health Report - Mental Health: Culture, Race, and Ethnicity (2001), it was determined that a greater percentage of African Americans than whites metabolize some antidepressant and some anti-psychotic medications more slowly and therefore may be more sensitive to these medications than whites. This higher sensitivity is shown in a faster and higher rate of response to medication, and more severe side effects. When this finding is paired with the research that suggests that African Americans are often overmedicated with anti-psychotic medication, this points to the need for a campaign promoting provider awareness with respect to the intersection of ethnicity and clinical interventions.

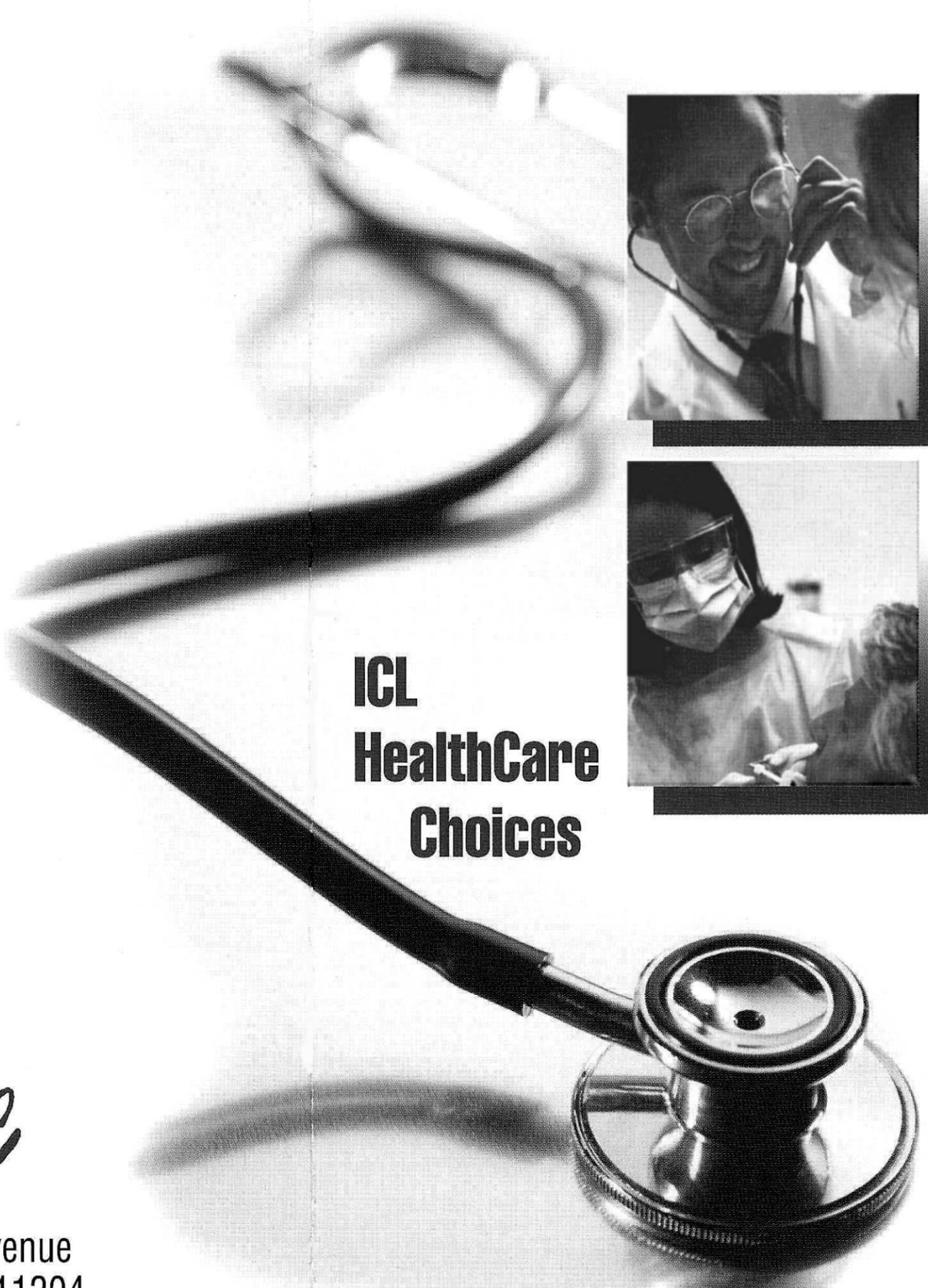
Similarly, Asian Americans and Pacific Islanders respond differently to psychotropic medications. As with African Americans, preliminary evidence has shown that Asian Americans and Pacific Islanders improve on neuroleptics, tricyclic antidepressants, lithium and benzodiazepine medication at lower dosage levels. Therefore, care must be taken to not over-medicate persons from this minority group when prescribing these medications.

Psychotropic medication, when administered properly and in scheduled dosing guidelines, has been proven to be an effective and efficacious form of treatment for persons with mental illness. Therefore, medication should be used as a response to treatment needs for consumers. This being said, culture, race, and ethnicity must be considered when medication are prescribed. As discussed above, there is evidence that certain minority groups metabolize medication differently. Therefore, as evidence-based treatment moves forward for persons with mental illness, it is important that we fully understand how psychotropic medication is dosed and utilized. In order to accomplish this, the pharmaceutical companies and research community must develop treatment formularies for medication that include separate sections for minority groups that have different sensitivities to medication.

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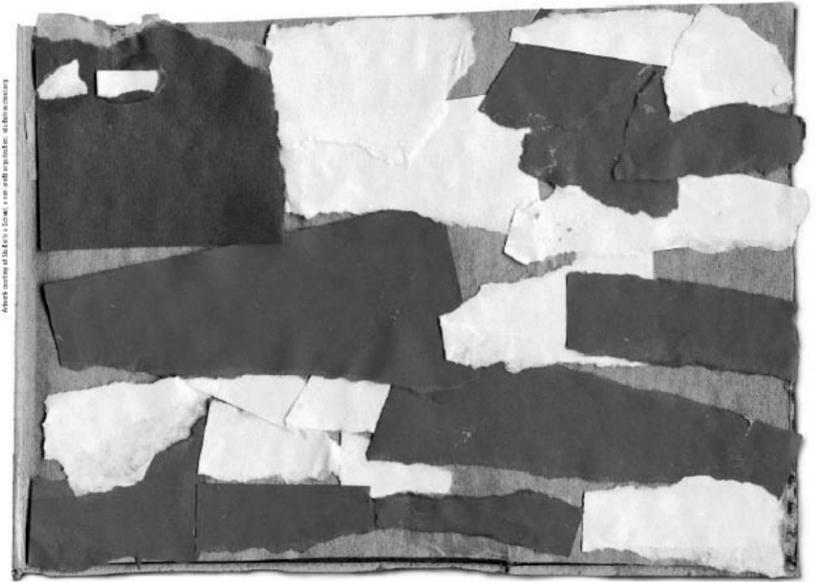
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# mha mental health association of new york city

## MHA of NYC - 24 Hour LifeNet Hotline Provides Vital Mental Health Link to Victims of 9/11

By Giselle Stolper  
Executive Director



Giselle Stolper

The Mental Health Association of New York City's LifeNet, a 24 hour mental health hotline service, was selected to implement the new mental health benefit program by the September 11<sup>th</sup> Fund and The American Red Cross. The benefit program helps people most directly affected by 9/11 pay for extended mental health and substance abuse treatment.

LifeNet is assisting individuals and members of their immediate families in finding licensed providers and clinics and is helping determine eligibility for the benefit program. Calling LifeNet (1-800-543-3638) from anywhere at any time of any day enables all eligible persons to easily enroll in the program. The September 11<sup>th</sup> Fund and the American Red Cross ensure that all subsequent treatment is paid for through American Case Management, their third party payer.

We at MHA know that the cost of treatment can deter people from getting care. The new benefit program eliminates that concern and makes a real difference to thousands of individuals and their families.

MHA is committed to expanding access to mental health care, and we are delighted to work with the September 11<sup>th</sup> Fund and the American Red Cross in implementing this program.

In the wake of September 11, LifeNet has been New York City's main source of information for crisis counseling and other related mental health services. Over the last year, LifeNet has assisted close to 80,000 callers, nearly half of whom report being affected by the terrorist attacks of September 11, 2001. LifeNet is also the designated hotline for the federally funded Project Liberty program, and made 10,000 referrals to free crisis counseling services for persons emotionally impaired by 9/11. Since launching the 9/11 benefit program LifeNet has conditionally enrolled over 3,500 primary victims of the disaster who are seeking free mental health treatment.

Several groups and their families are eligible for mental health assistance from the American Red Cross or the September 11<sup>th</sup> fund. These include family members of persons lost in the attack, seriously injured individuals, and rescue and recovery workers. Also covered by the benefit program are displaced workers from designated areas near the WTC, displaced residents, persons evacuated from the WTC and surrounding buildings, and schoolchildren south of Canal Street on September 11. Immediate family members of persons falling in these categories are also eligible for the benefit.

The mental health benefit program initiated by the September 11<sup>th</sup> Fund and The American Red Cross is for people struggling with the emotional effects of 9/11 with or without health insurance. Common emotional problems in the wake of the disaster have included posttraumatic stress disorder, complicated bereavement, depression, severe anxiety,

and substance abuse. Funding is available for a variety of mental health and substance abuse services including outpatient treatment, medications, and—in some limited cases—inpatient care.

LifeNet has been talking to thousands of New Yorkers over the last year, and we know that the September 11<sup>th</sup> Fund and the American Red Cross are making a most important contribution to the recovery effort. We are honored to work with them to assist persons in need by efficiently screening those who inquire about eligibility for the program, and then expedite the enrollment process. For individuals not covered, LifeNet

can help them receive affordable, community based services elsewhere.

MHA's LifeNet has over 6,000 resources in its database and our staff of multilingual mental health professionals is available 24 hours a day 7 days a week to help callers find out what type of services best suit their needs.

MHA is proud to contribute its services to these efforts, with the hope that all victims of this horrible tragedy entering this program receive the mental health care they may need to assist them in their road back to hope and recovery.

**The Mental Health Association of  
New York City, Inc.**

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and Substance Abuse Problems.*

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At the end of yours.**

---

**Quando cree que no  
hay esperanza, llámenos**

---

當你在電話線的另一端徬徨無助的時候，  
我們會在這邊為你誠意排憂解難

# Partial Hospitalization Program at the Payne Whitney Clinic of New York-Presbyterian Hospital Continues to Serve the Community

**Staff Writer  
Mental Health News**

**D**ebra Faecher, CSW, is a Senior Social Worker and the Coordinator of the Partial Hospitalization Program at the Payne Whitney Clinic. The Partial Hospitalization Program is located at 525 East 68th Street in New York City and occupies a separate wing in the hospital's Ambulatory Division. Ms. Faecher is also Educational Coordinator for the Masters Level Social Work Training Program at New York-Presbyterian Hospital/Payne Whitney Clinic. We recently had the opportunity to interview her about the Partial Hospitalization Program.

**Q:** When did the Partial Hospitalization Program begin at Payne Whitney? Did it come from a perceived need for a particular level of care for patients?

**A:** The program began in 1999. As inpatient hospital stays shortened, the need for an acute level of care to continue to treat people with active psychiatric symptomatology in an ambulatory setting became clear. The program also serves as a diversion from inpatient psychiatric hospitalization. Our goal is to provide rapid stabilization of symptoms in a brief period of time, with an average length of stay of eight days. We devote ourselves to helping patients reach higher functional capabilities. In this intensive treatment setting, patients acquire tools to further manage symptoms, stress and emotions and ultimately return to their daily roles in the community.

**Q:** How does partial hospitalization fit into the range of programs offered at the Payne Whitney Clinic?

**A:** This program is part of a larger continuum of care at the Payne Whitney Clinic. Often someone will go from the inpatient level of care into our program. They may later be referred to our Outpatient Clinic or our Continuing Day Treatment Program. This allows us to provide a wide range of services to patients depending on their clinical needs. It further demonstrates our commitment to the highest quality of care and helps establish a commitment to treatment from our

patients.

**Q:** What can a patient expect upon admission to the Partial Hospitalization Program?

**A:** Upon entering the program, the patient is evaluated by our multidisciplinary treatment team, which includes a psychiatrist, a social worker and many trainees including Masters Level of Social Work interns and third-year psychiatric residents. In this evaluation the team develops an individualized treatment plan with the patient to establish short-term treatment goals. Each patient is assigned a social worker, who provides individual psychotherapy, while the consulting psychiatrist meets with the patient to provide further diagnostic clarification and intensive pharmacological interventions. In individual sessions, people's progress toward their goals is continually evaluated. Patients then begin to attend groups that further help them reach their treatment goals. The treatment team meets regularly to discuss patients' progress and to strategize about what needs to be addressed before people will be ready for discharge to a less intensive level of psychiatric care. We also stress the importance of involving family members and outpatient providers in the patient's treatment plan.

**Q:** Can you describe a typical day in the Partial Hospitalization Program?

**A:** The program meets Monday through Friday from 10 am to 2:30 pm. Patients attend four groups a day, run by various behavioral health experts. Groups deal with a broad range of topics, including family issues, coping skills, relapse prevention, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, stress management, goal setting and goal review, role recovery, illness management, and self awareness, among others. Since patients' short-term goals have been established at the outset, patients can work within their groups to achieve these goals. One popular group is called "Ask the Doctor," where patients can ask the psychiatrist questions related to their comprehensive care.

People in the program also help one another in the group

setting. One patient may have found a way to solve a problem someone else is dealing with and be able to offer practical advice. For example, if someone has trouble remembering to take their medication, another patient may say, "You know what really helps me is I keep the pills by my bed. I set the alarm, and then I know when to take them."

**Q:** Can you give an example of a type of problem that would be best addressed in the Partial Hospitalization Program?

**A:** We treat patients with a variety of different diagnoses, including affective, psychotic, personality, anxiety and secondary addiction disorders. Typically patients are coming out of an inpatient unit and still have acute symptoms. They are going from the protected environment of the hospital to their homes, where they're confronted with the stressors of everyday life—such as paying bills, returning phone messages, and establishing a date to return to work. Given the multitude of stressors in their early recovery, they may experience an exacerbation of symptoms. We work with them to manage these stressors and avoid a potential relapse.

For example, let's take someone with bipolar disorder who continues to have symptoms of hypomania. To begin with, the structure provided in our program, along with adjustments in the patient's medication, help to stabilize symptoms. Furthermore, we help people in a very concrete way to take one step at a time, advising about such matters as calling friends, cleaning the apartment, or talking to a family member about their illness. We help them to manage their time so that as they take care of logistical issues, they are also making sure they are taking their medication, getting enough sleep and exercise, and not engaging in high-risk behaviors that may further exacerbate symptoms of mania.

We strongly urge family involvement and educate family about how best to help in the patient's recovery process. We provide education to family members about their loved one's particular illness, and we conduct family interventions during the patient's stay in the program. We also discuss with the family the need to

create a low-stress environment for the patient, which includes no yelling or arguing in the home and no substance abuse. We advise families on their role in the recovery process which may include helping patients with medication compliance, making phone calls to access further psychiatric care, and providing emotional and/or financial support.

**Q:** How do you plan for the patient's discharge from the program?

**A:** Our team is constantly assessing what patients' needs will be once they are discharged from the program. Our aim is to try to improve their functioning while they are in the program so that they will be better prepared. For example, we may recommend that a patient try a particular treatment such as a Twelve-step program or a mood disorders support group while they are in the program, so they can bring us feedback about how it worked out or didn't work out. As they begin to resume significant roles, we are better able to evaluate their level of functioning and ultimately their readiness for discharge. Once patients are ready for discharge, we make appropriate recommendations, which may include follow-up treatment within our system or with providers in the community. An example of an aftercare plan for someone whose acute symptoms have resolved may be to attend psychotherapy once a week and medication management once a month. Someone whose acute symptoms have resolved, but who needs longer-term structure to gain further acquisition of skills, may be referred to our Continuing Day Treatment Program or Intensive Psychiatric Rehabilitation Program.

Patients often refer to their groups as "classes," where they feel they have been taught a full range of skills to manage different systems and face stressors, such as returning to work or telling people about their hospitalization. Upon discharge from our program, patients feel better prepared to engage in longer term treatment issues and have greater confidence in their continued success.

*For further information about the Partial Hospitalization Program or to make a referral, call Ms. Faecher at 212-746-3741.*

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212-305-6001

**The Allen Pavilion**  
5141 Broadway  
New York, NY 10034  
212-305-6001

**Affiliate**

**New York State Psychiatric Institute**  
1051 Riverside Drive  
New York, NY 10032  
212-543-5000

**Weill Cornell Psychiatry**

**The Payne Whitney Clinic**  
525 East 68th Street  
New York, NY 10021  
888-694-5700

**The Westchester Division**  
21 Bloomingdale Road  
White Plains, NY 10605  
888-694-5700

## DOHMH Campaign Promotes Adolescent Mental Health

**Staff Writer  
Mental Health News**

The New York City Department of Health and Mental Hygiene (DOHMH) launched a new public education campaign to help parents and caregivers recognize the signs of emotional problems in adolescents and seek help when needed. The campaign, "If Only the Signs Were This Easy to Read," is currently appearing on subways and telephone kiosks throughout the City in both English and Spanish, and urges parents and other adults who have

concerns about a child's behavior to call LifeNet, the City's counseling and referral line at 1-800-LIFENET (1-800-543-3638) for information.

The campaign depicts adolescents who are physically wearing their signs of emotional distress - a girl wears a necklace that says "Depressed;" a boy wears an athletic jacket with "Feeling Worthless" written across the back - demonstrating some common feelings of emotionally distressed adolescents that are not so easily recognized. DOHMH has also developed a brochure that lists warning signs suggestive of emo-

tional problems in adolescents, such as marked change in school performance, recurring nightmares, and persistent negative mood.

DOHMH Commissioner Thomas R. Frieden, M.D., M.P.H. said, "Our new campaign reflects the reality that it is sometimes difficult to identify kids who are experiencing emotional distress. Moreover, young people often keep such feelings to themselves. It is particularly important to remember that our children may also still be dealing with the aftereffects of the World Trade Center disaster, and we want parents

and caregivers to be better able to recognize the warning signs of emotional distress in adolescents, and how to get help."

DOHMH developed the campaign through a collaborative effort with several community groups. The Mental Health Association of New York City operates the City-funded LifeNet hotline, which is available in English, Spanish (1-877-AYUDESE), and Asian (1-877-990-8585) languages. Other languages are also available through a translator.

For more information, call 1-800-LIFENET. For copies of the campaign, call (212) 788-5290.

### Saccharin from page 32

by the mental health system, we may need a wrecking ball more than a specialty court. OMH, the agency that funds or doesn't fund many of our mental health services including the most crucial of all - housing - has funded the Brooklyn Mental Health Court. OMH's commissioner was on hand at the opening ceremony to talk about his pride in the court, but OMH has yet to spend one penny on creating new services in the community to meet the needs of the defendants being released from the Brooklyn Mental Health Court. People with mental illness who end up in the criminal justice system usually end up there because they are homeless, penniless, and have no access to services; what people in this position need most is a place to live. Commissioner Stone has not provided one bed of housing for the Brooklyn Mental Health Court, and until he does, it is tempting

to think that OMH views this project as a wise PR move and nothing more.

Mental health courts remain, in the words of a hero of mine, Henry Steadman of the GAINS Center for People with Co-Occurring Disorders in the Justice System, "an entity with a very brief history, an unclear conceptual model, and unproven effectiveness." The people involved in starting the Brooklyn Mental Health Court have worked very hard to make the project a success, and seem very well-intentioned. To their credit, they have also designed the court to serve people charged with felony offenses, rather than misdemeanors, a decision that hopefully makes it more likely that they really are "diverting" people. But they are still waiting for Commissioner Stone to give them a single bed of housing for the people they are trying to help. If OMH really cares about New Yorkers with mental illness that have

been "criminalized," then we'll next see Commissioner Stone at the press conference where Governor Pataki announces the creation of hundreds of new units of housing for people with mental illness who are being diverted from the criminal justice system to decent lives. Let's all hold our breath.

1. David Satcher, *Mental Health, Culture, Race, and Ethnicity: a supplement to Mental Health: A Report of the Surgeon General*. Aug. 2001.
2. Henry J. Steadman, Susan Davidson & Collie Brown, *Mental Health Courts: Their Promise and Unanswered Questions*. 52 *Psychiatric Services* 457-458 (2001).

### Options from page 32

were expanded by 10,000 slots, and there has also been a significant increase in children's services. Two thousand additional units of supported housing were

also funded; in fact, the number of residential units for persons with mental illness has increased by 50 percent since 1995.

Recovery from mental illness is possible and does occur, but it involves the integrated delivery of a variety of services tailored to meet a person's individual needs. In a system as large and complex as New York's public mental health system, it is essential that we continuously work to improve the quality of our clinical, support and rehabilitative services. The Brooklyn Mental Health Court is a meaningful, multi-agency effort to address the complex issues posed by criminal defendants with mental illness. I continue to work closely with local governments, advocates, providers, recipients and their families and all stakeholder groups to manage and refine a public mental health system which produces high quality outcomes for all New Yorkers with a mental illness.

## Meeting the Needs of Older Adults: An Integrated Service Model

By Amy Chalffy  
Bronx District Director  
JASA

Aging well involves taking pleasure in family, friends, and meaningful activity. It can be a time of genuine renewal and fulfillment. It can also be a time of daunting challenges, requiring greater resiliency of spirit and energy than at any other period of life. A societal ageism that questions an older person's capacity for change, as well as a generational self-consciousness about seeking treatment, are additional burdens. Even those individuals who have coped well

during previous life crises may find that they struggle. Those who have suffered from persistent mental illness are significantly vulnerable when losses related to physical health, social supports, and financial security occur.

Older adults rarely present with a mental health issue only. Ill-health (whether chronic or sudden onset), isolation from family and friends, and financial needs are usually prominent in the presenting situation. Stabilizing a client's mental health functioning may require extensive case management and, in cases where individuals are difficult to engage, resolving a social

service need often facilitates mental health service delivery. The JASA Geriatric Mental Health Outreach Service clinics in the Bronx and Manhattan were developed to provide an integrated and cohesive response to meeting mental health and multiple case management needs.

Under the supervision of the Clinic medical director, the primary therapist, a social worker psychotherapist, leads the treatment team and also directly addresses case management issues, whether it is to access entitlements or arrange for homecare. All clinical and case management services are available in-home.

An enriched and interdisciplinary team approach includes mental health workers who provide chore and personal care duties.

JASA, the Jewish Association for Services for the Aged, was established in 1968 to meet the needs of aging NYC residents and its mission is to sustain and promote successful community living for elders for as long as possible. JASA staff operate on the understanding that being elderly and emotionally frail are not obstacles to successful treatment and improved daily living.

# In The New York City Leadership Spotlight

Staff Writer  
Mental Health News



Joseph Lazar

Joe Lazar has been the Director of the New York City Field Office for the New York State Office of Mental Health since October of 1995. In this role he is responsible for the coordination, certification and oversight of all mental health services within the City of New York, including oversight of the New York City Department of Health and Mental Hygiene. His office also reviews and approves all "Prior Application Reviews" (PAR's) in New York City, for program and fiscal integrity. Mental Health programs in New York City exceed \$4 Billion annually.

In 1989 he was appointed Assistant Regional Director for Fiscal Services with the New York City Regional Office of the New York State Office of Mental Health.

Before joining the State in 1984, Lazar was the Director of Fiscal Affairs for the New York

City Department of Buildings, responsible for budget, licensing, revenue collection, and all administrative services for the Department.

Mr. Lazar holds a Master's Degree in Urban Studies from Long Island University.

He has been overseeing the State's Mental Health efforts in New York City, coordinating the efforts of the Federal, State and City governments in the aftermath of the World Trade Center Disaster, and in the days and months leading up to the implementation of "Project Liberty." This required coordinating the efforts of the U.S. Public Health Service, the US Substance Abuse and Mental Health Services Agency (SAMHSA), the Federal Emergency Management Agency (FEMA), the State Emergency Management Office (SEMO), the NYC Emergency Management Office (OEM), the American Red Cross, the NYS Office of Mental Health, the NYC Department of Health and Mental Hygiene, the NYS Department of Education, The NYC Board of Education and several hundred voluntary organizations.

#### The Role of the NYC Field Office In A Complex System of Care

The NYS Office of Mental Health (OMH) interacts directly with and supports the New York City Department of Health and Mental Hygiene (NYCDHMH) in the development and implementation of a comprehensive community based system of care, helping to assure that adults, children and adolescents with the highest need of care receive quality services on a priority basis. Many of these activities are per-

formed by OMH's New York City Field Office. The Services provided to and in collaboration with NYCDHMH include:

- Developing local plans for the provision of mental health services, incorporating the views of stakeholders, e.g. consumers, families of consumers and not-for-profit agencies;
- OMH manages over 28,000 housing units for the mentally ill statewide, with over 18,000 units in NYC.
- Coordinating the implementation of new program initiatives and reconfiguration of existing services to assure availability of services based on need and desire of recipients, including the coordination of quality/evidence based efforts in NYC - coordination and implementation of OMH's strategic priorities (ABC's), as well as initiatives in the areas of functional family therapy, integrated treatment for dual diagnosed disorders, family psychoeducation and supported work - implementation of and expansion of OMH's Assertive Care Team initiative (ACT) - implementation of Kendra's Law with the development and implementation of AOT;

- Development of several demonstration projects in New York City which, once proven successful, will ultimately will be rolled out statewide. Those projects include the Brooklyn Mental Health Court, Single Point of Entry for Housing in Brooklyn (which is currently being expanded city-wide), Single Point of Accountability for Adult Case Management in Brooklyn, Single Point of Accountability for Children's Case Management in the Bronx, and the development and imple-

mentation of a behavioral network demonstration project on Staten Island;

- Monitoring and overseeing all OMH certified and funded programs throughout the City, providing timely review and follow up of complaints and incidents;
- Developing spending plans, budget strategies and arrangements to help assure timely flow of funding, particularly for new initiatives;
- Coordinating family support and peer support activities, promoting effective linkages with other mental health and service organizations;
- Facilitating incorporation of evidence-based practices in all mental health programs; and
- Facilitating expertise in the treatment of special populations, e.g. individuals with co-occurring mental health and substance abuse diagnoses and persons involved in the mental health and criminal justice systems.

*"Mental Health News salutes Joe Lazar for his coordination and oversight of the mental health needs of consumers and families in New York City.*

*When asked to serve on the leadership committee for our New York Section of Mental Health News, Joe was willing and eager to help out.*

*We are deeply honored to have his participation. It enables Mental Health News to have an important connection to the NYS Office of Mental Health's New York City Region as we strive to serve and assist in providing for the vital mental health education needs within the City of New York."*

*Ira H. Minot  
Founder & Publisher MHNews*



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JASA is committed to improving the quality of life of all older New Yorkers and supports individuals in their homes and communities with 81 programs located in NYC and Long Island

**For Further Information Call (212) 273-JASA**

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# Saint Vincent Catholic Medical Center Addressing Long-term Mental Health Needs Since September 11th

By Donald Thoms, M.S., Director  
World Trade Center Disaster Services

More than a year after the World Trade Center disaster, our region continues to feel the repercussions of the emotional devastation caused by that tragedy. Like other major behavioral health providers in New York City, the Behavioral Health Services division of Saint Vincent Catholic Medical Centers (SVCMC) has moved beyond short-term crisis counseling and support to address the longer-term mental health needs of those affected by 9/11, as well as the training and research needs of the clinicians who have been on the front lines of the disaster.

SVCMC is an active part of the New York Consortium for Trauma Treatment, which is providing a state-of-the-art training program on the assessment and treatment of traumatic stress disorders. With the support of the New York Times 9/11 Fund, the consortium developed a curriculum and invited internationally recognized experts to provide this urgently needed specialized training. This work, in conjunction with the research efforts underway, has added important new insights into the treatment of

traumatic stress disorders.

Research studies already have shown that the impact of 9/11 on the city's children will last far into the future. With the support of several foundations, SVCMC is implementing a long-term intervention program to assist schools in Manhattan in meeting the mental health needs of students, faculty and parents. As part of a federal child traumatic stress initiative, SVCMC and Safe Horizon, a victim services agency, have been awarded a \$1 million grant by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (SAMHSA) to establish a child trauma care center. The center will provide a unique and comprehensive continuum of services and treatment for child trauma victims and their families. The center will participate in national research and evaluation activities to identify the most effective treatments.

SVCMC's child and adolescent WTC program staff at St. Vincent's Hospital Manhattan are working closely with the New York City Board of Education to provide services to teachers, school children and their families at many of the schools closest to Ground Zero. These services continue to expand as the city's chil-

dren continue to feel the traumatic effects of the disaster.

Through SVCMC's involvement with the Project Liberty Program, we have provided 9/11-related counseling and support services for thousands of individuals, businesses and community organizations both in lower Manhattan and in Staten Island. We have received additional funding through Project Liberty to add additional staff and to open a new office at the corner of Church and Murray Streets in downtown Manhattan. We are actively involved in outreach to those communities to ensure that their ongoing mental health needs are addressed. Since the day after the tragedy St. Vincent's Manhattan has offered an integrative stress management program to the community at no charge, which includes acupuncture, massage therapy and other modalities.

Since 9/11, SVCMC has worked closely with the uniformed services that were so greatly affected by the tragedy and its aftermath. SVCMC clinicians have provided crisis counseling services to FDNY officers while they were at Ground Zero, at the Manhattan Counseling Service Unit and at the Staten Island and Fort Totten Fire De-

partment Family Assistance Units. We continue to provide services at their firehouses and at the counseling units, and we have reached out to the firefighters' families. Similar counseling and support services are being provided to members of the Port Authority Police Department, the NYC Correction Department's Emergency Services Unit personnel, to the members of the Transport Workers Union (Local 100) and to Ground Zero construction workers.

Several weeks after 9/11, Spencer Eth, M.D., Medical Director for SVCMC Behavioral Health Services, testified at a congressional hearing: "It is important to recognize that many of the people who are seeking our help now would never have needed mental health services were it not for this disaster. The magnitude of the public's need for traditional therapies, outreach to schools, businesses and communities, and innovative and alternative treatment is unprecedented" As we have at each stage of this disaster, Saint Vincent Catholic Medical Centers is committed to collaborating with the behavioral health community to continue the recovery of our neighbors, our region and our nation.

## Mental Health News Needs Your Help To Reach Out

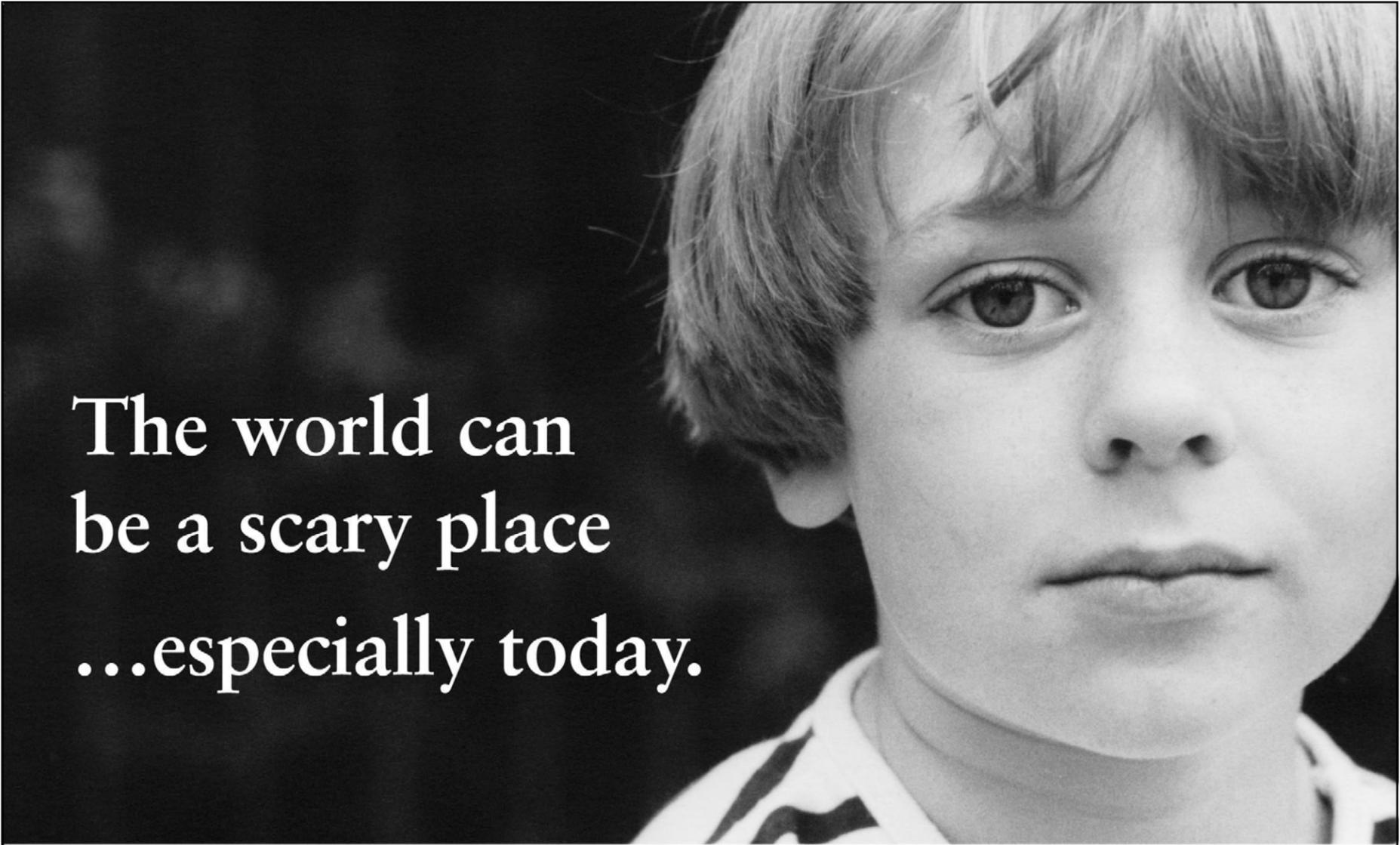
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# The MHA Connection



**Mental Health Association  
in New York State, Inc.**

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Albany, NY 12210  
Phone: (518) 434-0439 Fax: (518) 427-8676  
Website: [www.mhanys.org](http://www.mhanys.org)

By Joseph A. Glazer  
President & CEO, MHANYS



**Joseph A. Glazer**

“Governor Carey is determined to improve the quality of life for our mentally ill and mentally retarded populations. This entails improving both services rendered to inpatients of state psychiatric centers and to the mentally ill who are most appropriately served in community-based settings. The ultimate goal of state policy is the creation of a balanced system of treatment that maximizes both public and non-public resources”

Robert J. Morgado, Secretary  
to Governor Hugh L. Carey  
June 15, 1978

*The Unfinished Promise of Willowbrook: Twenty-Five years of Unnecessary Despair for*

*New Yorkers Living with Mental Illnesses*, was released in late October by the Mental Health Association in New York State, Inc. (MHANYS). Joined at a press conference by Danny Donohue, President of the Civil Service Employees Association (CSEA), the report focuses on the promise to revamp both the mental health and mental retardation/developmental disabilities systems in the wake of the Willowbrook exposes.

“New York’s failure to create an effective, balanced system of community based care for people with mental illness remains at the heart of the all the recently highlighted issues,” Joseph Glazer, President/CEO of MHANYS said. “Whether we’re talking about the horrendous conditions in adult homes, inappropriate housing of individuals with mental illnesses in nursing homes, inadequate housing for the homeless people with mental illness, or the lack of services for individuals coming out of jails and prisons, the fact remains that promise of a plan has gone unfulfilled for 25 years.”

“Scandal after scandal has been disclosed regarding the Office of Mental Health’s irresponsible mistreatment of individuals inside and outside the system, yet there is still no movement toward any comprehensive reform,” said CSEA President Danny Donohue.

The report, produced by MHANYS and endorsed by CSEA, is based on a memorandum written by Robert J. Morgado, Secretary to then-

Governor Hugh Carey, on June 15, 1978. While the memo was written to outline the implementation of the Willowbrook consent decree, Governor Carey and Morgado clearly intended to fix the mental health system as well. The Morgado memorandum specifically states, “Governor Carey is determined to improve the quality of life for our mentally ill and mentally retarded populations. This entails improving both services rendered to inpatients of state psychiatric centers and to the mentally ill who are most appropriately served in community-based settings. The ultimate goal of state policy is the creation of a balanced system of treatment that maximizes both public and non-public resources.”

According to CSEA, the Carey Administration committed the state to developing a better system of care for individuals with mental retardation and developmental disabilities and for individuals with mental illness. The approach has been followed in the Office of Mental Retardation and Developmental with the result that New York has a system of community care that is a national model. The Office of Mental health on the other hand has totally abandoned its commitment and responsibilities resulting in a system that is a national disgrace.

“Of the nearly 400,000 individuals provided mental health services in New York, 99% receive these services without the coordination and

forethought provided in a plan which, not only was promised 25 years ago, but is required by law,” Glazer said. “At least 60,000 New Yorkers with mental illnesses – the 15,000 in adult and nursing homes, the 15,000 in jails and prisons, and the nearly 30,000 homeless mentally ill housed each night in New York City shelters – have never been identified by the State Office of Mental Health in planning documents as populations needing mental health services.”

The report states that NYS officials will need to demonstrate stronger political will than has been shown in the past 25 years to make the changes necessary. The state must make a lifetime guarantee of housing for people with mental illnesses, must create a streamlined system of care, transition and individual supports, and must restore millions of dollars lost to the mental health system through the diverting of funds and ultimate expiration of the state’s Community Mental Health Reinvestment Act.

“Because of the failure to plan, the failure to lead, there are more people even worse off today than when the Carey Administration announced its intent to fix the system. We have slid backwards, and ten of thousands of our brothers, sisters, friends and other loved ones have slipped through the cracks, landing in places like adult homes,” Glazer said.

A copy of the report is available at [www.mhanys.org](http://www.mhanys.org).

***Mental Health News Can Bring Your Community  
Up To Speed In It’s Ability To Provide  
Mental Health Education - See Page 53 For Details***

# The NYSPA Report



By Dr. Barry Perlman, President of the New York State Psychiatric Association



**Barry Perlman, M.D.**

In the first NYSPA Report I described the mission of the New York State Psychiatric Association, an organization comprised of 4350 psychiatrists, dedicated to advocacy on behalf of persons with mental illness and our profession, to assure that psychiatry is practiced in a scientific and ethical manner, and to strive for access to psychiatric care on a fair and equitable basis. Thus NYSPA works within New York State for the objectives established for our profession by the American Psychiatric Association, the professional society which represents 30,000 psychiatric physicians nationwide.

Working to realize these goals inevitably leads NYSPA to confront issues of public policy and commercial practices that impact, often adversely, upon the availability and quality of mental health services.

Simultaneously, NYSPA has vigorously sought the passage of "Parity" health insurance coverage of mental illness and managed care reform. NYSPA views "Parity" as a matter of equity and as non-discrimination, civil rights legislation. While one may discuss issues related to behavioral managed care without becoming enmeshed in the "Parity" issue, one can not raise the issue of "Parity" without acknowledging that it is unlikely to become reality as other than a managed benefit. Therefore, what we seek is that mental

health coverage be "managed" no differently than other healthcare coverage.

Before turning our attention to the specifics of the struggle for "Parity," it is necessary to review the reality of behavioral managed care and efforts to contain its most egregious practices. Psychiatrists along with other physicians and a broad majority of American citizens have been terribly disappointed by Washington's failure to complete work on a "Patients Bill of Rights." Providers, patients, consumers, recipients' family members and others who have fought against their managed care companies in order to obtain proper care, at a time when hassles and obstacles are particularly unwelcome, know how critical it is that such legislation be passed. Unfortunately, the strong resistance of the HMO industry has thus far defeated all efforts at passage of a consumer friendly bill. Given the failure at the federal level, we have had to focus our efforts at the level of our state government, being aware that any such law would only protect the portion of our population not covered under federally ERISA exempted corporate health insurance plans.

Those requiring psychiatric or other mental health services have been among the most severely impacted by the changes wrought by managed care revolution due to the way mental healthcare is managed. An important segment of the managed care industry evolved which was devoted to behavioral managed care. As a "carve out" industry, these companies were engaged by general health HMO's to manage their mental health benefits. As such, when entering into risk contracts they received a small part of the HMO's capitation rate from which they have to provide all mental health care and extract their profit. From the get go managed care and behavioral managed care has had an adversarial relation with providers and patients. The inherent conflict of the BMCO's profiting from denials of access to adequate care outraged many who had to work within that new system.

It was in this environment that, in 1992, the NYSPA, discussed its concerns with Senator Nicholas Spano (R-Yonkers), then Chair of the NYS Senate's Mental Hygiene Committee, who then introduced legislation to address these matters. That early bill was directed at righting perceived problems with how BMCO's functioned. It

would have prohibited payment incentives based on savings, prohibited gag orders, created a mechanism for independent dispute resolution, required disclosure by plans of clinical criteria, among its other requirements. That bill passed the Senate. In 1994, NYSPA joined with the Medical Society of the State of New York (MSSNY) and an array of other provider and consumer groups as the Campaign for Quality and Choice in Managed Healthcare. That coalition played a pivotal role in the passage of NYS legislation addressing citizens' concerns with managed care. Many of the concerns addressed in the original Spano sponsored bill were incorporated into the "Healthcare Consumers Protection Act of 1996." Subsequently, the "External Review Law" was enacted as Chapter 586 of the Laws of 1998; it dealt with an important omission of the prior legislation.

These laws, which represented significant steps towards protecting patients in managed care plans in New York State, have now been on the books long enough for their strengths and limitations to have become apparent. For example, while access to external appeal of HMO decisions was established, due to bill language and legal opinion, the laws offer providers no opportunity to appeal or challenge decisions on behalf of consumers where any part of their care has been "concurrently" managed, as is most care today; as a result, these laws afford only limited opportunity for institutional providers such as hospitals or individual practitioners to advocate on behalf of their patients. This problem deserves correction. A second problem relates to payment for emergency services. While an "emergency" admission may not be denied, there is no definition of the period of responsibility of the HMO. Of particular concern to those providing emergency psychiatric services is the acceptance of a 2 hour period before the BMCO's psychiatrist must be available to discuss the clinical case with the treating psychiatrist. This rule was made part of the model contract for HMO's which provide managed Medicaid services in NYS and places a significant, untoward burden upon those seeking as well as on the care Emergency Departments and the psychiatrists who staff them. Finally, it should be noted that as a result of the 1996 Law, the NYS Department of Health issued its first annual New York State Managed Care

Plan Performance report in 1997. This annual report represents a valuable consumer guide to learning about the quality and performance of many of the states HMO's. Unfortunately, the report offers no guidance to those wishing to learn about the quality of the BMCO's. By working cooperatively with the DOH, NYSPA is hoping to effect changes such that the format of information gathering and analysis will permit the annual report to provide salient information about the carve out BMCO's in the future and thus offer useable information to those for whom mental health care is an important matter.

The historic fight to achieve "Parity" for mental health insurance coverage had its first federal success in the adoption of the Domenici - Wellstone mental illness parity amendment to the VA - HUD appropriations bill which was signed into law by President Clinton on September 26, 1997. President Clinton subsequently extended Parity for mental illness and substance abuse treatment to federal employee participants in the FEHB by an Executive Order. Earlier this year, President Bush too called for the passage of "Parity" legislation. At the state level it has been disappointing that New York State has yet to enact Parity legislation, especially given the fact that 34 states have enacted such legislation through 2002. Both federal and state legislation are necessary in order to assure all citizens a "Parity" mental health benefit. NYSPA has enthusiastically supported the broad "Parity" bill which the Assembly has passed for the past several years. During the same period "Parity" legislation has been introduced in the Senate. While a "Parity" bill has gained considerable support, the Senate has yet to pass a bill based which the two houses could seek compromise.

The above overview makes it clear why the NYSPA has felt compelled to simultaneously advocate for "Parity" in mental health benefits as well as improving consumers' and providers' rights in relation to behavioral managed care. If "Parity," when passed, is to be truly meaningful and not be a chimera it must be managed no differently than any other health care benefit.

*Readers wishing to contact NYSPA may write to: New York State Psychiatric Association, 100 Quentin Roosevelt Blvd., Garden City, NY, 11530.*

# National Artists for Mental Health

365 Main Street, Catskill, NY 12414 • 518-943-2450 • www.namh.org



By Franklin Marquit, CEO & Founder



**Franklin Marquit**

## THE ROAD BACK

keynote address: "Healthy Alternatives Through the Healing Arts" conference held on 10/30/02

The other night as I worked at my office I stopped and reflected about this Halloween week 2002 will be our organization's 11<sup>th</sup> year anniversary. As I pondered, I thought about where I started on my journey to recovery. I often felt painfully alone. Friends and family really didn't seem to understand me nor did I realize the road I was traveling was going to be so frantically out of control and so potentially dangerous to me. Tormented by gut wrenching fears, and suffering from isolation, horrors, I encountered near death from suicide attempts and accidental alcohol/drug overdosing. I have been treated for bipolar, panic disorder, obsessive-compulsive personality disorder and acute chronic alcoholic and poly-drug abuse in remission. I was homeless and 20 years of my life was spent traveling on different side roads, fervently attempting to rip off these chains of hopelessness. It's like walking down the sidewalk and falling in a hole. You scramble out of the hole, walk down the same sidewalk and fall into the same hole again. You have to find a different path to walk down. I walked down a seemingly never-ending path of self-destruction until 1980. I was sick and tired of being sick and tired, so I created my own path. It was my own self-directed path, an exciting path on the road back to recovery.

What I mean by that—my own path—is that yes, my path represents 20 plus years in talk therapy, a period of time that doctors had me on 800mg of Thorazine and 1800 mg of Lithium. Later, I was on anti-depressants of all kinds along with spending 3 months in Binghamton State Psychiatric Hospital, detox centers and Day-Top Village Drug Rehabilitation. This was all part of the Recovery process, but one thing that I did not lose sight of was my determination to recover and I kept that hope alive with a laser-like focus and vision of becoming well again. Mental illness and alcohol/drug abuse was not going to beat me—just like each and every one of you today who is attending this conference. We are all looking for healthy alternative ways to move forward in our lives, to be well, to stay well.

So I began to learn and read about how healthy alternatives (holistic health practices

and expressive arts) could enhance and speed my recovery). Just a simple thing like learning how to take long deep breaths helped me when I got upset, angry and frustrated with things, people, or myself. Taking deep long breaths had a major impact on me emotionally and physically. It gave my body and thoughts time to calm down, and I became aware of what was going on within my inner and external environment, so that I could rethink and respond differently than I had previously, before my old-self-defeating ways could kick in. That was my first real insight on how to use one of many holistic health techniques. Don't get me wrong, I still need to take medications, although I take many vacations from them now.

I started to learn how to eat better and as you can see by the size of me, I eat very, very well. I learned to take long walks and enjoyed the outdoors especially where there is plenty of wildlife around. I decided to have pets and now have 4 dogs, birds, and aquarium fish along with plenty of houseplants to nurture and care for. My pets, which are dear to me, give me so much love and care, they have had a profound healing effect on me.

As another form of stress reduction, I used a method of treatment called biofeedback. They wire you up to monitors to read your skin temperatures, heart rate and brain waves. These monitors had numbers on them from 0 to 100. When they hooked me up I was usually 100 plus due to anxiety, so I had to learn how to physically and emotionally bring the level down to the lowest point I could. I got very good at calming myself down. This helped me learn how to control my inner thoughts in a more positive and relaxed fashion.

I then discovered how writing, journaling and poetry can positively effect your health.

Journaling and writing is one of the more useful self-help instruments we have for long term self-review and development. It contains personal experiences and records what a person sees, feels and thinks. Something above and beyond ordinary communication takes place when you record the movement of your life. You learn to be more articulate about your beliefs and experiences. When you clarify them, you change your perceptions and expand your horizons. The feedback from the journal is cumulative and can be a primary source of your own autobiography.

After about 9 years of recovery, I decided to try college again. I previously failed and flopped out a number of times. In fact, it took me 16 years to get a 2-year associates degree. I was determined to get a college education and was relentless about it. Two masters degrees later, I am now working on my doctorate degree.

College is tough for me because my attention deficit gets in the way. I open up those textbooks and start reading the chapter and I read 3 or 4 pages and realize that my mind has drifted, and I don't remember anything I just read. So I ended up reading the same pages over a number of times, trying to get my drifting mind to focus and through biofeedback and meditation I have gotten control over this. This process of learning how to refocus has helped me a great deal throughout my recovery. Now I want to segway into the idea of focus and vision, two things that have profoundly helped me.

To go back a little bit, in 1987 I became a peer advocate and volunteered at a local community residence as a compeer buddy work-

ing with folks as they came out of the state psychiatric center. I found volunteering a fruitful and rewarding venture, relearning how to get use to working with people, getting used to being supervised as a volunteer and learning how to communicate and control my anger. I always try to make sure I am going forward in my recovery process. One of my major experiences as an advocate was bringing a homeless person, who I met, at the community residence, into my home. This person had severe difficulties, but is now doing very well. This is when I learned how to be an advocate and in the process, I created a family group called AMI of Greene County. I needed support in the caring process and soon wanted to create a peer group. I also realized that this work had become my purpose in life. My calling was to help my fellow peers. Hence the idea and implementation of developing a peer group in my community of Catskill, NY.

A non-profit mental health organization was born out of a concept of an entrepreneurial spirit. I thought if I had a core group of peers who were creative, we could produce postcards and greeting cards. In this way, we could raise the funds necessary to become a more prosperous group with the ability to expand. I had no idea of what that meant or what the future held at that point. I put some of these thoughts down on a paper napkin while I was in a dinner having coffee one day. These initial thoughts and visions were the start of *National Artists for Mental Health*. As an advocate, I began to network and connect with other mental health advocates, people likeminded that had the resources that could help NAMH. Without funding I could not do much. Finally I received a \$5,000 dollar grant to open a drop-in center. I opened the doors of that drop-in center on Halloween 11 years ago (1991). I also held a larger vision which was to create and develop an organization that was controlled and governed by a mixture of peer artists and non-artists. This organization would be peer based to have the most impact, offering self directed choices on how a peer can recover and heal through the utilization of complementary alternatives and expressive arts. National Artists fosters and promotes painting, dancing, music, dream therapy and all the creative arts and healing arts.

Holding a personal vision of becoming 'whole' and well again was a major part of my recovery process. I held this vision close to my heart and it had the most powerful influences on me in providing the focus and energy to develop *National Artists for Mental Health*.

*Vision*, is the best manifestation of creative imagination and the primary motivation of human action. It's the ability to see beyond our present reality—to create, to invent what does not exist, to become what we have yet to become. It gives us capacity to live out of our imagination instead of our memory. My vision is to help my peers create a expressive arts and wellness organization. Having a vision and purpose for getting up in the morning and facing the world, I was able to transform myself. Finding a vision created passion, which in turn gave me a set of goals and objectives to follow, and enabled me to make positive life changes. Always going forward.

I found that I was able to break free of my old destructive patterns by having a personal wellness focus. No matter how small or big the chore, be it: making a bed, cleaning my

room, taking a shower or getting myself dressed and out of the house, this personal vision gave me strength. I could volunteer, spend time with friends, go to college and then go back to work. I also learned that that all parts of your life are connected and by taking baby steps one can accomplish and improve. My life had been fragmented in many ways, but by approaching life wholistically I have become a more well-rounded person.

That is what today's conference is all about—Healthy Alternatives. Learning ways to help you to grow and develop through a physical, mental and spiritual process. That is why I believe having a personal vision for yourself is so important. Through making personal choices and having meaningful goals and focus, I believe all of us can become well. The wellness process needs to be integrated into the fabric of everyday living.

We all have some ideas of what we would like our life, our future and dreams to look like. And that vision, that concept, can create consequences. More than any other factor, I believe focus and having vision for ourselves affects the choices we make and the way we spend our time which has a direct impact on living true to ourselves.

What I did learn to do over the years in my recovery was to rethink how I looked at problems. The alternative to focusing on my problems is to focus on what I want. By knowing what I wanted, I could then: design my day better, focus more on my goals, choose whom to be with, hold to my vision, see my outcomes, take action on one part of my life every day by first taking baby steps—sometimes giants steps, continually evaluate my progress, take a different approach to the problem if that's what was needed; stay as positive as possible, and be relentless and persistent in moving forward toward wellness each day.

My final thoughts are that to me, a personal vision represents the deepest and best within you. It comes out of a solid connection with your inner life. It is the fulfillment of your own unique gifts—because each one of us is unique. You are all very special. It is the expression of your unique capacity to contribute. It is based on principles of contribution and a purpose higher than self. It integrates all. It includes fulfillment in physical, social, mental and spiritual dimensions.

You can decide right here, right now, to begin if you haven't already to change your life by finding empowering ways to be healthy, and creative. You can choose to live in a positive way, either by taking baby steps as I did in the beginning of my recovery or giant steps if you are further along the path. Either way, you will reap the rewards of transforming your life.

Since using these techniques my self-esteem and my life have improved drastically. I believe I have only scratched the surface of my potential, and know that if I can go from where I was to where I am now, anything is possible—and that goes for each one of us. I share my story with you in hope that you will feel that change is possible for you too. I still have a background of self-destructive, emotional difficulties, insecurity and fears, but I am not letting that hold me back. I can't change the past, but I sure as hell can change today and tomorrow and so can you! I hope to see each one of you on the road to a healthy and happy life. Thank You and Have a Wonderful Day!

**A Primer from page 5****Back to the Drawing Board**

The absence of long-term, comprehensive planning is as critical a problem as the lack of resources for New York's mental health system. For example, long-term and intermediate care beds continue to close, but those that are left remain in very large and inefficient facilities with no plan on how to provide this kind of care in the future. The obliteration of long-term and intermediate care, the criminalization of the mentally ill, the adult homes and nursing home scandals and the impending collapse of fragile community services, particularly housing services, are the results of a piecemeal, short-term, expedient approach that has backfired time and again. It behooves the state to assess the needs of New Yorkers with serious mental illness and make a long-term comprehensive plan to preserve care and ensure the most efficient allocation of resources.

**An Essential Investment**

No overview of the plight of the state's mental health services is complete without mentioning research, an area that should eventually provide the ultimate service to residents with mental illness: curing them. With such breakthroughs as the mapping of the human genome, there are now several significant opportunities to find cures for mental illnesses, which, of course, would save the state many billions. New York State supports two institutions that do this work and also function as cutting edge medical treatment centers. Continued investment in research is the only way to ensure that an end will finally be reached.

In summary NAMI- New York State asks legislators to ensure the state will:

**Maintain mental health services**

Persons with mental illness don't "just go away." They need care sooner or later. It is much more cost effective to provide care sooner, with services that work, than for them to tour homeless shelters, social service programs, jails and prisons before their problem is addressed. Cutting mental health services only increases overall costs across the board.

**Fund programs to "decriminalize" mental illness**

Treating persons with mental disorders instead of jailing them is not only more humane, it is much more cost effective. That is why mental health courts, which provide for treatment as an alternative to incarceration, are growing in popularity throughout the country. Too often, persons with mental illness have been jailed and punished as an alternative to

care, because of a lack of understanding and/or community mental health services.

**Provide adequate funding to preserve community mental health services, particularly housing**

Many community housing organizations simply cannot cover their costs, so care is sacrificed. The crisis in community housing may well become the next horrific scandal to embarrass the state. Acting now, before what is in place collapses, would again not only be the right thing, but the fiscally prudent thing to do.

**Make a comprehensive plan for the future**

A major reason why the system has gotten into the mess it's in has been the lack of a long-range plan. Eliminating long-term and intermediate care will only put further strain on the entire human services system, and some people literally cannot live without such care. Preserving care throughout the system while making it more efficient must be the state's top priority.

**Specific Upcoming Legislation**

The following issues should be subject to legislation next year. We in NAMI-NYS urge legislators to give these issues particular attention, and to vote to accomplish the following:

**End discrimination in health insurance and health plans**

New York law still allows insurance companies, HMOs and other managed care plans to discriminate against persons with mental illness by covering these illnesses differently than the other so-called "physical" illnesses. The number of doctor visits can be severely limited, co-payments can be higher and treatments are subjected to very difficult-to-navigate "behavioral health care management" techniques which effectively discourage and limit access to care for millions of New Yorkers. And it is still perfectly legal in New York to continue to practice this antiquated and fiscally illogical form of discrimination.

A growing body of evidence, from both the public and private sectors - including large national companies that have examined their overall health claims experience - shows that it costs more to NOT treat mental illnesses than it costs to treat them. Recalling the old adage "penny wise and pound foolish," this evidence reflects the fact that persons in the work force, and their family members, whose mental illness goes untreated or under-treated experience significantly higher health insurance claims for other physical illnesses than do persons who either do not suffer from a mental illness or who receive adequate treatment for it. Those companies also experience

higher absenteeism and lower worker productivity when these conditions are not adequately treated.

As for the effect of mental health parity on the cost of insurance, several studies have shown that implementing mental health parity causes only a .8% to 1.4% increase in premium costs.

New York spends millions of dollars unnecessarily to treat the physical and mental illnesses of people whose insurance coverage discriminates against them, and millions for other services as well. When restricted mental health benefits run out, employees have decompensated and lost their jobs, sending their families into a downward spiral that has resulted in bankruptcy and disintegration. They and their dependants have moved from the tax rolls to the welfare rolls. Not allowing people to be able to recover means maintaining them in the economic underclass. There is no medical or scientific rationale for continuing this practice, and it makes no sense, financially, for the state to allow it.

Across the country 34 other states have adopted some form of "mental health parity" legislation, including a law in Texas signed by then-Governor George W. Bush, and business opposition to it has waned as the real financial data have come out. The time has come for New York to join them. The New York State Assembly has consistently passed such legislation for several years, but the Senate has failed to act. New York voters and legislators must make 2003 the year for mental health parity in New York.

**Take adequate steps to fix adult homes**

New York's adult homes are aptly described as 21st Century "snake pits." A New York Times series published last April detailed the suffering caused by shifting up to 15,000 persons out of the mental health system and warehousing them in adult homes. The stories of widespread, and often fatal, neglect, abuse and exploitation by unscrupulous adult home operators has prompted several investigations, studies and workgroups calling for a wide range of remedies.

Making up for the neglect of thousands of people will have costs. However, the current state of affairs hasn't been a boon to taxpayers, either. A recent study by the Commission on Quality of Care found that "many residents received multiple layers of services from different providers that were costly, fragmented, sometimes unnecessary and often appeared to be revenue-driven, rather than based on medical necessity."

By factoring in Medicaid and

room and board costs, the study found that the average annual total cost was about \$37,000 per adult home resident, more than a quarter of a billion dollars annually for the 7,000 residents living within the New York City area alone.

The tasks the state must accomplish to fix this mess include hiring an adequate number of legal services attorneys to keep the system honest; establishing mandatory minimum fines to provide an incentive for improvement; providing trained nurses to dispense powerful antipsychotic medications, instead of untrained adult home staff members; providing case managers to ensure appropriate care, and building appropriate mental health housing for those 5,000 or so residents who never should have been put into adult homes in the first place.

**Apply the law to "special" nursing home units**

New York State law is very clear regarding the limits, legal protections and procedures that must be adhered to when individuals are involuntarily committed. Dumping people into locked facilities where they are detained indefinitely without protections breaks the law in several ways. Those who established these units, in 1996, must have been aware of this fact, because apparently only a few people within the Executive Department knew that the units existed.

**Abolish the practice of confining persons with serious mental illness in "special housing units" in state prisons**

According to the state Department of Correctional Services, about half of the inmates confined in "SHUs" for disciplinary punishment are persons with a mental illness. SHUs impose 23-hour solitary confinement, often for many months. Experts have said repeatedly that such conditions of extreme deprivation cause prisoners to psychiatrically deteriorate. Placing seriously mentally ill inmates in SHUs only makes the sick sicker, and rises to the standard of cruel and unusual punishment. Support for legislation to abolish this practice is growing, and a recent lawsuit by inmate advocacy organizations should spur the legislature to seriously consider such a measure.

*Voters: Please make sure the candidates for the state legislature in your district are aware of these issues. Call, write and go to see them.*

For more information contact: NAMI-New York State, 260 Washington Avenue, Albany, N.Y. 12210 1-800-950-3228 and at [www.naminys.org](http://www.naminys.org)

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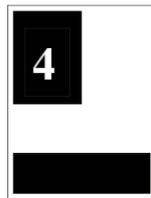
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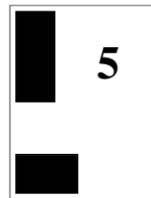
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# Nation's Leading Experts Discuss Role Of Drugs In Treating Mental Illness At Silver Hill's Fall Seminar

By Dr. Richard Frances  
President and Medical Director  
Silver Hill Hospital

The newest developments in psychopharmacology (the use of drugs as medication in treating mental illness or substance abuse) were discussed and evaluated by five nationally recognized mental health experts at Silver Hill Hospital's recent Fall Seminar. The presentations were based upon the latest evidence acquired in studies conducted throughout the United States. Areas of treatment included eating disorders, bipolar disorders, depression and psychoses, schizophrenia and substance abuse, and agitation and psychosis in dementia.

In the past few decades, tremendous progress has been made in the development of medications to treat mental illnesses. New drugs appear on the marketplace every year, and many of the newer drugs are more successful than their predecessors in alleviating the symptoms and suffering associated with mental illness. The success of various drugs is measured by several criteria including the effectiveness of the initial response, the side effects, and the frequency of relapses among those treated. Years of experience in research and development by pharmaceutical companies continues to yield more and more effective medications, yet the "perfect drug" for any illness has yet to be invented. As Dr. Robert Cancro, Chairman of the NYC Medical Center's Department of Psychiatry, said of the treatment of depression and psychoses, "There are no free lunches. Drugs with powerful positive effects will also have side effects. If there are no side effects, it's unlikely the drug will produce any significant good results."

Several of the experts noted that it's important that psychopharmacology be accompanied by psychosocial treatment and the study of the mental and emotional processes underlying human behavior and motivation in its relation to environmental influences.

## Eating Disorders

The use of psycho-dynamics was stressed by Dr. Eugene V. Beresin, a professor of psychiatry at Harvard Medical School and co-director of the school's Center for Mental Health and Media who spoke on eating disorders. He said, "Anorexia Nervosa and Bulimia are a way of life, and it is very difficult to get patients to take any sort of medication or change their diet. Treatment is a process. We must understand what the patient is giving up (by changing their behavior), and what will take its place. I believe the deeper problems involve the sociological aspects of our culture—the image of being thin and athletic. Most patients also suffer from low self-esteem, identity problems and poor

family relationships. Their own bodies are the one thing they feel they can control. These issues must be addressed before they will be receptive to any sort of medication. Those who get better with treatment have personal relationships that are nurturing.

## Bi-polar Disorders

"In treating Bi-polar disorders such as manic depression, we need to embrace fully integrated psychodynamics as well as psychopharmacology," said Dr. Russell G. Vasile, also a professor at Harvard Medical School and Director of the Affective Disorders Programs at Beth Israel Deaconess Medical Center. Substance abuse is a huge issue with many Bi-polar patients. The problem with many anti-depressants is that while they treat depression they induce cycles of manic highs. Lithium is one of the primary mood stabilizers but one of the side effects may be weight gain. There are several types of Bi-polar disorders, and they respond differently to various medications. Careful diagnosis is crucial in choosing the best treatment option.

## Depression

In discussing treatment of depression and psychoses, Dr. Cancro stated that for most patients, anti-depressant medications approved by the FDA are generally considered equally effective, with positive response rates ranging from 50 to 75 percent of those treated. He said, "Psychiatrists diagnose patients on the basis of behavior, observation, complaints, symptoms and pathophysiology—not pure physiology like the medical profession. Not all patients respond to acute therapy and achieve or maintain a complete response over time. We must focus on the many different types of patients undergoing therapy to get records of the effectiveness of different treatments, and to realize the difference between response and remission."

"Remission is basically what we do—helping people maintain a certain level of functioning. We don't have the tools to cure everyone, but we do have ability to help a lot of people. We have to see the glass as half full. Great progress from where we've been, but still a way to go.

The combination of two different anti depressants has been successful and is currently a popular strategy, but the evidence is not as complete as we would like. As a general rule, the least medication you can get away with in achieving a positive response, the better. A supportive structured environment is often more important than a pill," he concluded.

## Schizophrenia

Schizophrenia was the topic of Dr. Alan Green, Director of the Commonwealth Research Center, Massachusetts Mental Health Cen-

ter, a professor of psychiatry at Harvard Medical School, and the new chairman of the psychiatry department at Dartmouth Medical School. He said that with some of the newer medications, there's hope that early intervention can help. Schizophrenia is a developmental disorder of the brain which affects most people in adolescence or the early twenties. The early symptoms include anxiety, isolating self, a lack of interest in normal activities, and cognitive and communication problems. Fifty percent of people with schizophrenia have substance abuse issues and 90 percent smoke.

Schizophrenia affects a part of the brain circuit involving the reward system. Those with the disease have an abnormal reward system and tend to self medicate with alcohol or drugs. Substance abuse can trigger a latent schizophrenia or make a psychosis dramatically worse. New anti-psychotic drugs can block neuro-transmitters which lead to substance abuse. This results in improved efficacy of treatment, fewer side effects and fewer relapses. To achieve best results, the goal is to identify those with the underlying symptoms of schizophrenia before the first episode.

## Dementia: Agitation and Psychoses

Dr. Allen Frances, professor of psychiatry and Chairman Emeritus, Duke University School of Medicine, presented Expert Consensus Guidelines for the Treatment of Agitation and Psychosis in Dementia. Dementia is uncommon in individuals under 60 and much more frequent in those over 80. The most troubling aspects of dementia are not the loss of memory, but the agitation and psychosis. Dr. Frances has developed Consensus Guidelines which are a summary of what 100 experts around the country advise as treatment, based upon experience.

The most important part of any treatment is Differential Diagnosis—a very careful diagnosis which differentiates between a true dementia and the appearance of dementia due to other factors.

There are four stages of diagnosis. First, one must rule out medical reasons such as pain which may lead to agitation or an inability to communicate. An elderly person may have fallen and broken a bone or suffered trauma to the head without remembering the fall or realizing the damage. Delirium can also temporarily affect the brain. A second factor is medication. The average geriatric person takes 6 to 8 medications and they may interact negatively. Also the patient may get them mixed up or and not follow dosage. A third possibility is underlying psychiatric conditions which the patient had before, which are causing agitation but may not be actual dementia. Finally, a change of environment and structure, such

as moving into a new group setting in a retirement or nursing home may cause agitation that is not due to dementia.

Dr. Frances recommends "sitting at the bedside and doing a thorough cognitive evaluation and an assessment of the medication of the patient." He also believes that the environment is often more important than the medication, and the best treatment may be a psycho-social intervention to change the environment. He says, "The main reason people are put into nursing homes is their families can't cope with their agitation and psychoses. The remedy is to educate families and provide support groups. Try to figure out if there is a pattern of agitation at certain times of the day, then try to change the environment and remove the person from the situation or person stimulating the problem. A structured routine helps."

In clear cut cases of depression, he recommends one of the newer anti-depressant drugs. However he cautions against giving a dementia patient multiple drugs and urges physicians to taper off dosage gradually after a few months. Dosage recommendations for geriatric patients are ¼ the normal amount for an adult. The most common side effect is short term cognitive loss. "We can significantly reduce the morbidity (progression of the disease) of the elderly with dementia, but it requires a team approach of medication combined with psychosocial interventions," he concluded.

*Silver Hill Hospital is a nationally recognized psychiatric and substance abuse treatment center which provides a full range of services for adults and adolescents, from inpatient to partial hospital, halfway houses and outpatient programs. For further information, call (203) 966-3561, Extension 2509.*

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Jan 15 / Feb 12 / March 5  
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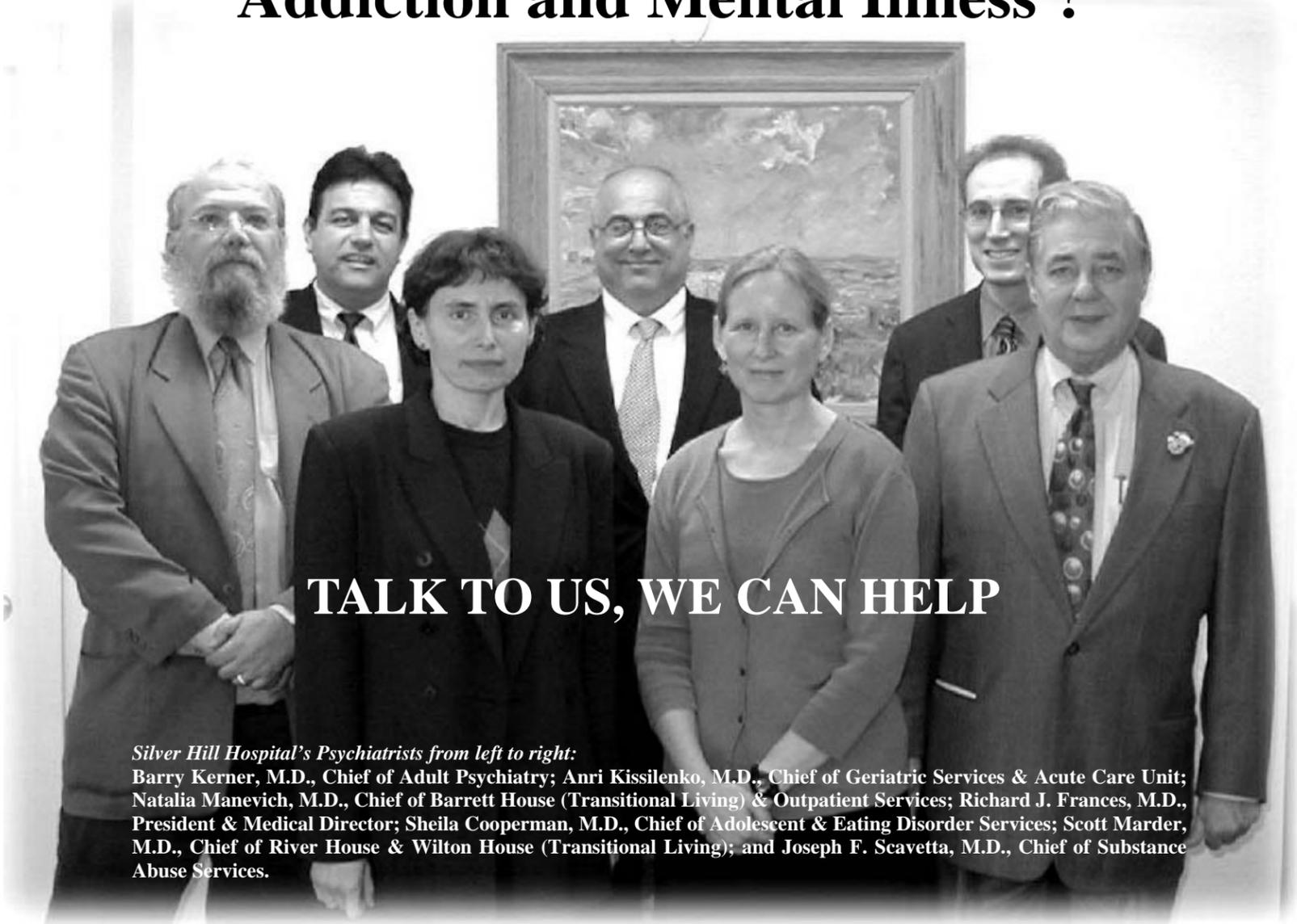
The Spring Event Seminar  
"Addiction Psychiatry  
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Thursday April 10, 2003  
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