The Veterans Mental Health Primary Care Training Initiative: Training a Healthcare Workforce to Meet the Mental Health Needs of Returning Veterans

Behavioral Health News to Honor Alan Siskind, Andrew Solomon and Phillip Saperia at Its First Annual Leadership Awards Reception on May 20th

By Richard Gallo and Rachel Fernbach, Esq.

The New York State Psychiatric Association (NYSAPA) is taking a lead role in working to meet the mental health needs of veterans returning from combat duty through its Veterans Mental Health Primary Care Training Initiative (VMH-PCTI). The VMH-PCTI, which provides educational programs on mental health issues affecting returning veterans, is supported by a $165,000 grant provided by the New York State Legislature and administered by the New York State Office of Mental Health. The grant is intended to provide training for primary care providers, including physicians, physician assistants and nurse practitioners. The training focuses on veteran-specific mental health disorders, including combat-related post-traumatic stress disorder (PTSD), depression, anxiety, substance use disorders and traumatic brain injury.

The primary goal of the grant is to advance the development of a primary healthcare workforce that is well-educated and well-equipped to recognize the unique mental health needs of veterans. Educating this segment of the healthcare workforce is essential as many veterans visit primary care providers when they return home from active duty, often seeing the same physician who treated them before deployment. Primary care providers who complete the training will gain clinical knowledge and skills as well as learn best practices for identifying, treating or referring psychiatric issues that may become apparent during routine primary care visits.

Training programs are planned as “grand rounds” presentations at teaching hospitals, webinars and separate events at other central locations around the state. The training curriculum includes general guidelines for the treatment of PTSD and traumatic brain injury, including psychotherapeutic and pharmacological.

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Staff Writer
Behavioral Health News

Behavioral Health News will host its first Annual Leadership Awards Reception on May 20th at NYU Kimmel Center’s Rosenthal Pavilion. Jorge R. Petit, MD, Board Chairman of Mental Health News Education, Inc. (MHNE), publisher of Behavioral Health News, made the announcement saying, “We are extremely excited to be holding our first Leadership Awards Reception and equally excited to be honoring three outstanding leaders of the behavioral health community. Alan B. Siskind, PhD, LCSW, Andrew Solomon, PhD, and Phillip A. Saperia, MAT. We hope all of our colleagues and supporters will come out to pay tribute to our three honorees and to help support behavioral health education.”

Dr. Siskind has had an extensive and distinguished career in social work and mental health as a clinical practitioner, administrator, teacher and author. He had been the Executive Vice President and CEO of the Jewish Board of Family and Children’s Services until September 2007. JBFCS is one of the nation’s premier voluntary mental health and family service agency, which serves over 65,000 clients annually in 185 programs in the five boroughs and in Westchester. Dr. Siskind is currently in independent practice with individuals, couples and families. Alan was the Founding Board Chairman of MHNE and will be receiving MHNE’s “Founders Award” at the May 20th event.

Dr. Andrew Solomon is a writer and lecturer on politics, culture and psychology, and a Professor of Clinical Psychology at Columbia University. His newest book, Far From the Tree: Parents, Children, and the Search for Identity won the National Book Critics Circle award for nonfiction; the Wellcome Prize; the Green Carnation prize; the J. Anthony Lukas Award; the Anisfield-Wolf Award; the Books for a Better Life Award; the Dayton Literary Peace Prize; and more than 30 other national honors. Dr. Solomon’s previous book, The Noonday Demon: An Atlas of Depression, won the 2001 National Book Award for Nonfiction, was a finalist for the 2002 Pulitzer Prize, and has been published in twenty-four languages. His prior books are The Irony Tower: Soviet Artists in a Time of Glasnost and the novel A Stone Boat. He writes regularly for the New York Times and The New Yorker and appears frequently on NPR. Andrew will be receiving MHNE’s “Humanitarian Award” at the May 20th event.

Phillip A. Saperia, MAT, began as Executive Director of the Coalition of Behavioral Health Agencies in 1994. In that position, he has overseen The Coalition’s program of education, advocacy and technical assistance to the diverse community-based behavioral health providers of New York City. Today, he serves on New York State’s Medicaid Redesign Workgroup on Behavioral Health as well as the Subcommittee on Children and Families. He is deeply involved in the impending transformation of the health and behavioral health sector that he serves, including policy, advocacy and organizational reengineering. Starting as a teacher, he has been in the fields of community and government relations for over 30 years. Phillip will be receiving MHNE’s “Advocacy Award” at the May 20th event.

Ira Minot, LMSW, Founder and Executive Director of MHNE stated, “I am very proud of our Board who are undertaking this first ever event for our organization. Our Leadership Awards Reception this May will celebrate our 15th year of providing vital behavioral health education to the community. I am very honored that we will have this opportunity to pay tribute to three outstanding leaders of our community, and hope everyone will come out in support of their lifetimes of achievement.”

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Behavioral Health News
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New York State Tailors Treatment Services
For Veterans with Alcohol and Substance Use Disorders

By Arlene González-Sánchez, MS, LMSW, Commissioner, New York State Office of Alcoholism and Substance Abuse Services (OASAS)

ew York State and the country face formidable challenges in meeting the behavioral health needs of veterans returning from active duty in Iraq, Afghanistan, and other countries. The New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS) and its treatment provider partners are taking a leadership role in meeting these challenges by overseeing and supporting state-of-the-art residential services for female and male veterans, specializing in veteran-tailored treatment, and making veteran-aware referrals available through NYS OASAS’ confidential toll-free HOPEline.

Understanding Veterans Behavioral Health Needs

Since the beginnings of Operation Enduring Freedom in 2001, Operation Iraqi Freedom in 2003, and Operation New Dawn in 2010, more than 2 million U.S. military active duty service men and women and reservists have been deployed overseas. More than half of them have been redeployed multiple times according to the United States Department of Defense. The New York State Division of Military and Naval Affairs estimates that 80,000 of these troops have already returned or are in the process of returning home to New York. In this time of ongoing overseas conflict, NYS OASAS recognizes that the demands of military service and trauma from combat exposure can make the return to civilian life a difficult one.

With each deployment and redeployment, service members can encounter increasing strains on their physical and mental health, which can result in increased and behavioral health problems, most notably post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). The stress of deployment, combat exposure, and exposure to other types of trauma can also lead to increased use of alcohol and/or prescription or illicit drugs by many veterans. These stresses also contribute to increasing rates of veteran suicides and homelessness.

Like our returning veterans, their family members struggle with the ramifications of extended and/or repeated deployments which can result in serious emotional and psychological tolls on the family unit. NYS OASAS commends the service of the state’s 1.1 million veterans from all generations who have sacrificed both at home and abroad for their country. The agency continues to work to provide best practices in behavioral health services, including specialized veterans services for returning soldiers and their families.

Alcohol and Substance Use Disorder Treatment Services for NYS Veterans

Residential & Outpatient Service Models: To address the issues often encountered by returning veterans or the veterans who returned some time ago, and to provide a welcoming, supportive environment, in 2008, NYS OASAS began the process of establishing three 25-bed residential programs exclusively for housing and helping veterans with alcohol addiction and/or substance use disorders. NYS OASAS has provided $26 million in funding that contributed to the building of three new, state-of-the-art residential facilities:

- Freedom Village Veterans Treatment Center, operated by Horizon Health, Inc., in Sanborn, N.Y., in Niagara County;
- the Women Veterans Program, operated by Samaritan Village in Ellenville, N.Y., in Ulster County;
- and the recently-opened Colonel C. David Merkel, M.D., Veterans Residence, operated by St. Joseph’s Addiction Treatment and Recovery Center, Inc., in Saranac Lake, N.Y., in Essex County.

The Women Veterans Program in Ellenville is one of only a few programs nationwide that is devoted solely to serving the needs of female veterans.

The Samaritan, Horizon Health and St. Joseph’s programs are “best practice” models that have been replicated by other NYS OASAS-certified-providers across the state. Several NYS OASAS-certified providers have established veteran-specific treatment programs which provide patient-centered care in supportive, trauma-informed environments, much like the care offered at these programs. These programs pride themselves in recognizing the values, core beliefs and unique culture of military service.

Today, including these three programs, there are 386 veterans treatment beds, operated by eight certified providers throughout the state. In addition, three providers are also supporting veterans-only outpatient programs. These residential and outpatient programs for veterans support a clinical culture grounded in concepts of trauma-informed care. They also take military pride and values into account when offering a patient-centered approach to care.

Many treatment providers across the state offer outpatient services geared toward veterans with substance use disorders that may have already left military service. For example, began a comprehensive outpatient treatment program for male and female veterans with alcohol or substance use disorders in November 2014. Veteran Specific Treatment: Because of the spirit of teamwork and camaraderie upon which the culture and traditions of the military are based, veterans often perform best when approaching challenges or tasks together even within a treatment setting. Veterans feel most comfortable, understood, and safe when they are with their “battle buddies” or “brothers in arms.” Many veterans say that no one quite understands the term “got your back” better than a fellow soldier, sailor, marine or airman who’s been through combat. Perhaps that is why NYS OASAS data indicates that veterans complete treatment at a higher rate than their civilian counterparts. For many of them, treatment is seen as a mission and completion of that mission is a familiar objective for military members. When possible, provider program staff members are veterans themselves, which helps build empathy and rapport.

In addition to alcohol and substance use disorder treatment, many NYS OASAS-certified providers offer additional specialized services including individualized case management, 12-step therapy, and trauma-informed care. Treatment providers throughout the state are also supporting veterans with dual-diagnosis or mental illness and alcohol or substance use disorder. Many NYS OASAS-certified programs offer additional services including individualized case management, 12-step therapy, brief intervention, and referral to treatment (SBIRT) program in the vicinity of Fort Drum, the largest military facility in New York State, and two programs in west-central parts of New York. SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. This SBIRT program was begun in 2012 to serve the behavioral health needs of active members of the military, veterans and their families.

Silent rates of psychological trauma that may have influenced their alcohol addiction or substance use disorder. These evidence-based practices have been shown to be effective in treating veterans.

In addition to these treatment modes, NYS OASAS established a screening, brief intervention, and referral to treatment (SBIRT) program in the vicinity of Fort Drum, the largest military facility in New York State, and two programs in west-central parts of New York. SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. This SBIRT program was begun in 2012 to serve the behavioral health needs of active members of the military, veterans and their families. Best Practice Trainings for Clinical Staff that Provide Treatment for Veterans: Trauma, including the types of trauma typically suffered by those serving in the military, is often deeply rooted for those who are diagnosed with an alcohol addiction or substance use disorder. Trauma can function as both a cause and continuing trigger for addictive behavior. To make sure that clinical staff in NYS OASAS-certified programs better understand and can more effectively serve traumatized patients, NYS OASAS developed a two-day training titled, “Trauma-Informed Care: An Awareness Perspective.” This 12-hour program, delivered to providers throughout the state beginning in 2012, seeks to provide participants with an understanding of the significant role traumatic life experiences can play in addiction. Clinicians attending this training learn to ask their patients, “what happened?” as opposed to “what’s wrong?” This helps individuals focus on what events may have triggered their behavior and understandings of the values, core beliefs and unique culture of military service.

According to SAMHSA, fewer than half of people with PTSD receive treatment. In addition, though many veterans are aware of the need to seek help, many do not. According to the United States Army, only 40 percent of veterans who screen positive for serious emotional problems seek help from a mental health professional (Mental Health Advisory Team IV, Operation Iraqi Freedom, 2007). In addition, only 30 percent of veterans with PTSD or depression seek help from the Veterans Affairs Health System (Invisible Wounds of War, 2008).

Though it is known that increasing numbers of veterans are returning with serious mental health and substance abuse issues, unfortunately, many service men and women do not seek help. According to the United States Army, only 40 percent of veterans who screen positive for serious emotional problems seek help from a mental health professional (Mental Health Advisory Team IV, Operation Iraqi Freedom, 2007). In addition, only 30 percent of veterans with PTSD or depression seek help from the Veterans Affairs Health System (Invisible Wounds of War, 2008).

The Army recognizes that stigma is a major barrier for veterans in need of mental health care (Mental Health Advisory Team IV, 2007). According to SAMHSA, service members frequently cite fear of personal embarrassment, disappointing comrades, losing the opportunity for career advancement, and dishonorable discharge as motivations to hide symptoms of mental illness, alcohol or substance use or abuse, from family, friends and colleagues (2007). NYS OASAS-certified providers for veterans with behavioral health and addiction problems, masters-level clinicians who staff the NYS OASAS HOPEline, have been trained to

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It is incredibly important to discuss how family members can prepare themselves for the physical and emotional changes they may have to make when their spouse, parent, or child returns home from combat. Many service members experience intense stress reactions as they adjust to a very different life at home. These stressors can result in symptoms of anxiety, depression, post-traumatic stress and substance abuse.

What should you watch for? There are common physical and mental/emotional reactions that your service member may experience in the first few months of being home such as: trouble sleeping, upset stomach, headaches, flashbacks/frequent unwanted memories, anger, guilt and being overly critical. Some common behaviors to look out for could also be, trouble concentrating, being on guard and lack of self-care. Again, these behaviors and reactions should subside after a few months as reintegration takes place, but if problems last longer, or if your service member is coping with stress by drinking, doing drugs, withdrawing, or having sudden emotional outbursts, it’s probably time to seek outside help. Going symptoms like these could be the beginning signs of post-traumatic stress disorder (PTSD). Your service member could also be experiencing other common mental health issues such as: depression, suicidal thoughts, violence and substance abuse. If you are seeing any of these behaviors in your loved one, take the first step by educating yourself.

The service member isn’t the only one making adjustments. It’s important that family members also consider their own adjustments as everyone involved will have changed, both physically and emotionally. Here’s how families can prepare.

What to Expect When Your Service Member Returns Home

Paige Prentice, MM, CASAC
Spouse/Partner

If the returning service member is your spouse or significant other, you’ll probably experience a “honeymoon phase” for a time after demobilization. Then reality will have to kick in. If you have children, they’ve grown and changed and developed new habits and behaviors. And whether you have children or are child-free, you and your spouse or partner will have to figure out how to balance responsibilities and expectations again. If your service member has been through traumatic experiences, these experiences will affect your everyday lives for some time.

Children

Children may take some time to warm up to this person who has suddenly re-entered their lives. They will react differently depending on age and temperament, but in general:

- Infants (younger than 12 months) may react to changes in their schedule, physical environment, or caretaker by showing apathy or refusing to eat.
- Toddlers may be clingy, throw temper tantrums, or not sleep well.
- Preschoolers may Backslide with potty training or thumb sucking, or experience sleep problems, clinginess, and separation anxiety.
- School age children may be irritable, aggressive, or whiny, or complain of stomachaches or headaches.
- Adolescents may rebel against new family roles and responsibilities after the deployed parent returns home.

Prepare children to be with your returning service member by giving them extra attention, care, and physical closeness when possible, encouraging them to talk about their feelings and maintaining routines as best as you can.

Parents/Siblings

If your returning service member’s parents live nearby, they will have to make many of the same readjustments as spouses or partners. They will also have to recognize that everybody has grown and changed, and adjust their boundaries as they get reacquainted with their loved one. If they, or the service member’s siblings, have been helping you and your family while your partner was away, those roles will have to be renegotiated also.

One of the best things you can do to prepare yourself and your family for a service member’s return is to talk to someone who has experienced it and/or get help through counseling. Family and couple sessions are often an integral part of the therapy process. Many family members seek additional help for themselves or their loved ones who are already in treatment. It’s vital to find a valuable and private outlet for veterans to manage their stress and maintain their ability and passion for the lifesaving work they do. Learning and practicing healthy self-care through a coaching style therapy helps to stimulate productivity, a renewed interest in personal growth, and reconnection with family, friends and loved ones.

The VA, the military and other veteran organizations can provide you with helpful information. You can also reach out to Community Mental Health Organizations such as Horizon Health Services and Horizon Village in Western New York, Samaritan Village in New York City and Ulster County, J-CAP in Queens, New York and/or St. Joseph’s Rehabilitation in Saranac Lake. Two other tremendous resources are NYS Office of Alcoholism and Substance Abuse Services (NYS OASAS) and Alcohol and Substance Abuse Providers of New York State (ASAPNYS).

On May 15, 2015, the Veteran Services Committee of ASAPNYS is presenting a one-day Veterans Summit (see display ad across from this article). If you wish to learn more about issues impacting our Veterans and their loved ones and the resources available to help them, contact Janet Braga at ASAPNYS to inquire about this event and/or register. Phone Janet at 518 426-3122 or email her at jbraga@asapnys.org.

Paige Prentice, MM, CASAC is Vice President of Operations, Horizon Health Services, Horizon Village, Inc., in Buffalo, New York. She is the Co-Chair of ASAPNYS’ Veterans Summit, Committee member of their Women, Children and Family Services, and a member of the ASAPNYS Board.
Register Today at asapnys.org!

WELCOMING HOME OUR VETERANS:
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Welcoming Home our Veterans Summit is presented by the Veterans Issues Committee of the New York Association of Alcoholism & Substance Abuse Providers and designed for substance use disorders services providers and other behavioral health organizations offering services to our Veterans. For more information call (518) 426-3122 ex 103 or visit www.asapnys.org.
The term “Homeless Veteran” should be an oxymoron. No Veteran of our armed services should return to a civilian life that doesn’t include a permanent home and the appropriate supports needed to successfully reintegrate back into society, but some do. According to the 2014 Annual Homeless Assessment Report (AHAR) to Congress, prepared by HUD, there were 49,933 homeless Veterans on any single night in the United States. This startling statistic is part of what prompted the Veterans Administration (VA), five years ago, to make a commitment to end Veteran Homelessness in 2015, which includes addressing not only the Veterans’ concrete housing needs, but also their behavioral and physical health needs that will enable them to stay in their own homes.

At ICL, “Homecoming” is a word that has special meaning to veterans returning home with families and friends after having been away for long periods of time. A veteran’s return home does not end just because he or she is now back on American soil. Indeed, for many, the long journey “home” only begins at that point. Reestablishing emotional connections and a personal role with family and community after significant time away from home may require ongoing support and assistance. ICL offers services to veterans of all eras to help on the journey home at the ICL Borden Avenue Veterans Residence (BAVR), funded by the New York City Department of Homeless Services (DHS). ICL BAVR is a short-term transitional housing program for homeless veterans located in Long Island City, NY. The BAVR accommodates 243 male and female veterans. Veterans at the BAVR receive case management services that include assistance accessing supportive housing and other appropriate permanent housing placement assistance. BAVR also has on-site medical and psychiatric services. ICL works closely with DHS and the US Department of Veterans Affairs to provide coordinated and comprehensive services to homeless veterans residing at BAVR to smooth and ensure their transition to independence.

For 243 male and female homeless Veterans in living at the BAVR, this temporary transitional residence is where they have a safe place to call home while working on permanent housing and where they can simultaneously access other support services to reconnect with family and other relationships. Few of our Vets are newly discharged. Many have struggled on their own for years before arriving at ICL Borden Avenue. The following is a story of one such Veteran, Mr. Michael Rodriguez.

Mr. Rodriguez is typical of the struggles and resilience we see on a continual basis in the vets at BAVR. He entered BAVR in August of 2014. He served in the Navy and was honorably discharged; however his transition back to civilian life was difficult. He had trouble reconnecting to family and finding a role for himself. Although he was back on American soil, he didn’t feel like he was truly home. Due to his income and eligibility challenges for housing options, he felt as if his situation was hopeless. He struggled with domestic and separation challenges from his spouse, medical issues, Post Traumatic Stress Disorder (PTSD), low self-esteem, depression, and a history of suicide attempts and substance abuse issues. His symptoms increased and his personal relationships deteriorated. He was unable to find work. Eventually, Mr. Rodriguez became homeless, which only added to his suffering. Since 1987, he experienced several periods of homelessness with little sense of connection to his family, and was overwhelmed by his symptoms and substance abuse.

PTSD is an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Traumatic events that may trigger PTSD include violent personal assaults, natural or human-caused disasters, accidents, or military combat. People with PTSD have persistent frightening thoughts and memories of their ordeal and feel emotionally numb, especially with people they were once close to. Its effects can affect a veteran’s psycho-social and socioeconomic aspects of life.

Early detection of PTSD, combined with well planned, researched and developed screenings, can assist in providing adequate services to Veterans. According to Jakupcak (2007), “Veterans who screened positive for PTSD reported significantly greater anger and hostility than those in the subthreshold-PTSD and non-PTSD groups. These findings suggest that providers should screen for anger and aggression among Iraq and Afghanistan War veterans who exhibit symptoms of PTSD and incorporate relevant anger treatments into early intervention strategies.” Williamson (2009) explains that, “we have yet to see the full extent of troops’ psychological and neurological injuries.” Service members are still deploying on long and repeated combat tours, which increase the risk of blast injuries and combat stress. Rates of marital stress, substance abuse, and suicide are all increasing. Untreated psychological injuries are also a risk factor for homelessness; almost 2,000 Iraq and Afghanistan veterans have already been seen in the Department of Veterans Affairs’ homeless outreach program.

When he arrived at the ICL Borden Avenue Veterans Residence, Mr. Rodriguez had significant trust issues. He consistently voiced the wish for someone to believe in him. Our staff is trained in Trauma Informed Care – a philosophical approach that assumes all our clients are “Wounded Warriors” who have experienced traumatic, painful events or PTSD. Trauma Informed Care is sensitive to an individual’s past experiences and how they may impact current choices and behaviors. Trauma-informed care asks not, “What is wrong with you?” but rather, “What happened to you?” Helping people view their behavior and symptoms as reasonable reactions to bad situations takes the blame away. It starts them on the path to seeing themselves as survivors who found the strength to get through bad times instead of thinking (or being told) that they are to blame for their illness.

Being approached as a person to be respected for what he has survived provided the breakthrough Mr. Rodriguez needed to open up and access help. Mr. Rodriguez felt heard and empathized with, instead of blamed and judged. As he began to feel cared for and valued, Mr. Rodriguez was able to access the services available to him. Mr. Rodriguez was able to see his symptoms as a reaction to what had happened to him, instead of thinking he was a bad person for having these problems. As he felt better about himself, he could envision a future that included a permanent home. After the shame and guilt were removed, Mr. Rodriguez has been able to achieve sobriety and accept treatment for his mental and physical health.

Mr. Rodriguez likes to share his story to give others hope. He remembers when he felt like no one believed in him or cared about him. He wants others to know that they can reach out for help and find caring, supportive staff who will listen to them. Mr. Rodriguez is currently getting treatment for his behavioral and physical health issues and on the path to obtaining permanent housing. It has been a long and difficult road, since he first became homeless in 1987. The stories of Mr. Rodriguez and others like him have and must change the way we address Veterans’ issues. We hope that by providing Rapid Re-Housing and immediate access to social services, the Veterans coming home from Afghanistan will get the help they need to readjust to life at home, at the first sign of difficulty, ending the need for the term “homeless veteran.”
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*Data compiled 2012-2013 from multiple sources including agency EHR, satisfaction evaluations and data reported to regulatory agencies.

ICL is an award-winning not-for-profit human service agency, dedicated to assisting individuals and families affected by or at risk of behavioral health disorders or developmental disabilities with integrated comprehensive care designed to improve their wellbeing, recovery and participation in community living. For nearly 30 years, ICL has been providing the building blocks for New Yorkers with disabilities and helps people with situational crises get better through innovative treatment and pioneering rehabilitation programs.
We mental health advocates all agree that America’s mental health system should be better. We do not all agree about how to make it better. That’s a problem. Our differences have contributed to a political standoff in Washington where efforts to bring about major changes in the nation’s mental health system have been stymied as much by disagreements among mental health advocates as by the inability of Democrats and Republicans to work together on a vast number of important issues. We are a house divided against itself.

As always, our differences are rooted in competing interests, ideologies, and egos. I’ll leave egos out of this discussion.

America spends about $300 billion per year on mental health and substance abuse services. That’s a lot of money. It supports powerful vested interests and drives tremendous competition. Hospitals, community providers, private practitioners, drug companies, universities, governments, insurance and managed care companies, and others each have a piece of the action. Each believes that what it provides is essential and that some of what others provide is not only not essential but wasteful. The call to take from them and “reinvest” in us is widespread among mental health advocates.

In addition, some people who care about mental health have a libertarian bent; some have a protective bent. Those who are more or less libertarian want to protect the rights of people said to be “mentally ill”; they are willing to accept some of the inevitable hazards of liberty for the sake of avoiding unjust incarceration and loss of personal privacy. Those who tilt towards protection worry that people with mental illness (and others) are “dying with their rights on.” We should, they believe, change the criteria for involuntary inpatient and outpatient commitment and should also change the rules of confidentiality so as to be able to share information more easily among providers and with families. Some also believe that America has gone too far in reducing inpatient utilization. More people, they insist, should be admitted to hospitals, and they should stay there longer.

There are also major disputes about the hegemony of psychiatry and its system of diagnosis. Some people who care about mental health believe that scientific psychiatry, with its heavy reliance on medication (to which America now commits 30% of behavioral health resources), should be the dominant force in the field of mental health. Some people believe that medicine is overserved, that the hope for a biomedical breakthrough is sadly unrealistic, and that the dominance of the mental health system by the profession of psychiatry is a mistake. They tend to see most of what is now labeled as mental illness as part of the human condition and to believe that it can better be addressed with humane, or even spiritual, interventions and with efforts to overcome societal problems such as violence and poverty.

I do not believe that we can overcome these deep ideological divisions, nor do I believe that we can find a singular common cause. But I do believe that we can work together to achieve some of what most of us agree about.

I have identified 15 areas of agreement. There are probably more. They include:

1. More and easier access to mental health services
2. Improved quality of services
3. More stable housing for people with serious, disabling mental disorders
4. More outreach to engage people with serious mental illness who reject or fail to go for mental health services
5. More “rehabilitation” services to promote recovery
6. Improved integration so as to overcome fragmentation within the mental health system, between mental health and substance abuse services, and between behavioral and physical health services.
7. More support for families caring for family members with psychiatric disabilities
8. Reduction of the mortality gap—i.e. the difference in life expectancy—between people with serious behavioral health conditions and the general population.
9. Reduction of the rate of suicide
10. Reform of the criminal justice system
11. Enhanced mental health services for specific populations such as children and youth, veterans, minorities, and older adults.
12. Enhanced prevention and early intervention
13. Reduction of stigma
14. Enhanced research
15. Adequate funding to support all of the above.

Fifteen areas of agreement! This is very hopeful, no?

Some advocates will certainly say that the list is overwhelming. They will argue that we need a lever not a laundry list. That is, we need to identify a point of intervention that will set many changes in motion and rapidly produce major change. Maybe, but wouldn’t you love to be? Our government seems to be betting that health care reform, driven by the Affordable Care Act, will do much to improve the system. Providing more people with health insurance and the inclusion of a requirement that health insurance cover mental and physical health services equally should result in more people having access to treatment for mental and substance use disorders. In addition, health care reform includes a variety of measures to improve integration of behavioral and physical health care and to prevent people in need from “falling through the cracks.” The expansion of managed care through complex organizational structures such as health homes and accountable care organizations is, of course, aimed at holding down costs; but it is also intended to engage people in serious need and assure they get the care they need. Improved coverage and improved integration taken together should result in better identification of behavioral health disorders, more treatment, and better physical and mental health outcomes, including longer life expectancy.

Can we achieve a consensus to pursue this health care reform agenda? Partially, yes. I think that we can all agree to work to defend The Affordable Care Act, as it faces a challenge in the Supreme Court and vituperative rhetoric and legislation from a Republican Congress. But I don’t think we can all agree on the reorganization of the mental health system being pursued with the creation of accountable care organizations and the like. Many providers are threatened by these experiments, and some of us who are not providers think that the goals are laudable but that the vast complex organizations being created are impractical. Time will tell.

In my experience over 40 years of mental health advocacy it is occasionally possible to rally the mental health community around a single organizing idea, but more often a laundry list, like the one above, has greater unifying power than a silver bullet.

For example, there’s real tension between the goal of expanding the mental health system and the goal of improving the quality of the system. Can we do both at the same time and hold a coalition of diverse interests together?

Generally speaking, coalitions do best when there’s more for everyone. But addressing the quality of the current system leads to great doubts about doing that. Do we really want to expand the mental health system like blowing up a balloon—more of everything? Does our nation need more use of psychiatric medications, which very clearly are already overused? Do we need more psychotherapy in private offices or in clinics for people who have minor disorders (if any disorders at all)? Or should we give priority to expanding services for people with serious, disabling disorders for whom housing, rehabilitation, outreach and engagement, and improved physical health care are critical? Should we focus on expanding behavioral health services in physical health settings, particularly for people with mild mental disorders, or should we focus on beefing up physical health services in mental health settings for people with serious and disabling mental disorders?

Pretty clearly we ought to be selective about the services we increase. In the process, someone’s ox will be gored, and whoever that is will not happily participate in a coalition.

So, I don’t believe it’s possible to rally around all fifteen of the areas of agreement I’ve identified. But I do believe that there will be opportunities to achieve some of them, and I think we should take advantage of those opportunities as they arise. We should, that is, go after more incremental improvement of the kind we have had for much of the past 45 years. It will not satisfy our hopes for an extensive transformation of the mental health system, but it is likely to be the best we can achieve, so long as the mental health community remains a house divided against itself.

Michael B. Friedman, LMSW, is the retired founder and director of the Center for Mental Health Policy, Advocacy, and Education of MHA of NYC. He teaches at Columbia University. He can be reached at mfb395@colunet.nyu.edu.
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The NYSPA Report — Community Based Extended Inpatient Care

By Barry B. Perlman, MD
Legislative Chair, New York State Psychiatric Association (NYSPA)

A cohort of persons with serious and persistent mental illness (SPMI) will continue to require extended inpatient psychiatric treatment beyond 2015, the year during which NYS will enroll virtually all of its Medicaid insured into managed care. Where their care will be provided remains to be determined. I advocate that community based extended care in specialized inpatient psychiatric units with programs developed to meet the particular needs of the SPMI population should be included among the options along with the appropriate use of state psychiatric centers.

Community based extended care deserves inclusion for four reasons: (1) It is best when persons receive care in or close to their own communities thus allowing for easy inclusion of families as part of treatment planning. (2) The clinical strength of the programs on such dedicated units. It is reasonable to believe that those requiring extended stays receive improved services when cared for on dedicated units than when stays are extended on units meant to provide acute care. (3) The federal government, even under Medicaid managed care continues to pay a significant share of the cost which is not the case when persons receive care in state psychiatric centers. (4) By locating such dedicated units within NY’s Article 28 hospitals it allows for those often stressed institutions to generate needed revenue by returning units to clinical use which may have been shuttered due to decreasing admissions to inpatient medical and surgical services.

Currently, two such units exist in NYS, both located in Westchester County. For the reasons enumerated above, I have advocated for the creation of such units at strategically placed locations throughout our state since I chaired the NYS Mental Health Services Council. Some questions about the added value of such units. The key questions then are does treatment on such units permit more of those with SPMI to be discharged to the community rather than requiring transfer to state psychiatric centers and do they improve the community tenure of those discharged from them?

In an effort to answer those questions I reached out to the NYS Office of Mental Health (OMH). OMH staff was generous in their willingness to collaborate. Provided with the names of 12 persons discharged during an agreed on time period from the extended stay unit at Saint Joseph’s Medical Center (SJMC), OMH captured the cost of care utilized by those persons during the year prior and subsequent to their stay on the unit using OMH’s powerful PSYCKES claims based data base.

These data, based on the experience at Saint Joseph’s Medical Center, offer strong support to the value added by care on the extended stay unit. Dramatically, the total number of inpatient days for the cohort in the year prior to admission was 1,508 whereas it dropped to 623 in the year after discharge. The total expended by the Medicaid system for inpatient care during the year prior to admission was $185,985; the amount paid for prescriptions was $13,622 and the amount expended on all outpatient services was $311,977 whereas it dropped to 623 in the year after discharge. The total expended by the Medicaid system for extended stay units was $892,734; it dropped to $315,473 during the year subsequent to discharge, a meaningful decrease. The year prior to admission the amount expended on all outpatient services was $892,734; it dropped to $315,473 during the year subsequent to discharge, a meaningful decrease. The year prior to admission the amount expended on all outpatient services was $185,985, the amount paid for prescriptions was $13,622 and the number of prescriptions filled was 358. During the year subsequent to discharge the amount expended on all outpatient services rose to $311,977 and the amount spent on the 569 prescriptions filled was $23,643. (Outpatient service use captured included: licensed mental health clinic, continuing day treatment, partial hospital, care management (TCM), community residence, and assertive community treatment (ACT)). Clearly the trends are those which recipients, their families, advocates and policy makers would wish, that are less spent on inpatient care and more on outpatient services, including what appears to be improved adherence to prescribed medications as evidenced by prescriptions filled. (The SJMC unit opened in 2006 at a time when transfers from community hospitals to state psychiatric centers were marked by long delays. The program was meant to avert such transfers and return the vast majority of those admitted to the community without need for state psychiatric center admissions. With regard to this goal, the unit also has met with success.)

I suggest that these data provide a compelling reason for maintaining those extended stay units licensed by OMH to provide these specialized services and considering establishment of such units more widely across NYS.

OMH, I believe, has data which would allow reasonably accurate prediction of the number of extended stay beds which would be likely to be needed in a managed care environment. As for the financing of such units, two approaches seem workable and there are likely others. One would be to include in the per member per month (PMPM) payments to the Medicaid managed care plans either regular or HARP, an actuarial allowance for such stays in a cohort of covered SPMI lives. The other would be to carve out the cost of stays on such units. Under either scenario, but particularly appropriate under the former, managed care plans might reasonably be expected to manage stays on such units as long as those plans were expected to play a collaborative, risk bearing role in implementing appropriate discharge plans for the individuals served and actively working to pave the way for access to the next level of care. (It is worth noting that under the current plan, extended stays in state psychiatric centers will not be managed.)

In conclusion, I assert, for the reasons laid out in this article, that the maintenance of and creation of additional units the mission of which would be to care for those persons with SPMI requiring extended inpatient psychiatric care would represent a win for the persons served, for the state, for the hospitals and even for the plans. They should therefore be considered by those currently working on the redesign of the mental health delivery system as part of the NYS Medicaid Redesign effort and the federal Delivery System Reform Incentive Payment (DSRIP) Program implementation.

Dr. Perlman is the Legislative Chair of NYSPA, and the Director of the Department of Psychiatry at Saint Joseph’s Medical Center in Yonkers, New York

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If you are feeling hopeless, alone and in despair, never give up. There are many behavioral health organizations in the community that can help, several of whom are listed in this issue. It is NOT a sign of weakness to ask for help.

— A Message From the Board and Staff of Behavioral Health News —
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MHA Vet2Vet Program: Leading the Way in Peer Support

By Carl T. Clark, MSG, USA (Ret.), Vet2Vet Program Coordinator, MHA in Orange County, New York

Mental Health Association in Orange County, Inc. (MHA) is pleased to provide Orange County’s only Vet2Vet Peer Networking Program, also known as the PFC Joseph P. Dwyer Peer Support Project. The program is named in honor of Private First Class Joseph P. Dwyer, an Army Medic who served in Iraq, and subsequently passed away from an overdose due to self-medicating his Post Traumatic Stress Disorder (PTSD).

Vet2Vet Peer Networking provides veterans and members of the Armed Forces the opportunity to network with one another in a safe and nonjudgmental environment. Peers share the challenges they are facing and/or have faced and provide solutions and/or support to their peers on topics such as: PTSD, Traumatic Brain Injury (TBI), Military Sexual Trauma (MST), suicide, addiction, VA benefits, employment and education, among other topics. Services exist in the form of peer networking groups which meet in Orange County’s three cities, a 24 hour Helpline at 1-800-832-1200, a Veterans Community Task Force, as well as linkage to a wide variety of resources are among some of the services offered.

When the Military Uniform Comes Off

Every year more than 180,000 people enlist in the armed forces. Soon after enlistment young men and women are shipped off to training and given a uniform to wear. It’s not just a uniform, for many it becomes a protective outer shell, one that makes them stand tall and proud. Self-esteem soars after completion of initial training which comes in two phases: Basic Training (BT) and Advanced Individual Training (AIT). Many who had never accomplished much in their whole lives now have universally understood roles in society. Soldier, Marine, Airman, Sailor, etc. Furthermore, they are called Infantrymen, Intelligence Analysts, Logistics Specialists and more. They have a status that needs no explanation, and is for the most part respected. Now members of their respective teams, these proud young men and women stand strong alongside one another, mutually supporting, encouraging and protecting. Then one day their service is over, and the uniform comes off. Here is how it is after the uniform comes off and why.

Each persons’ uniform becomes a different kind of protective outer shell. Who a person was when they joined the military has a huge impact on how that uniform’s protective outer shell will come off. For those who had some sense of self, status, and what I call pillars of self-esteem, the process will be just another change in life. The pillars of self-esteem I refer to can be many things, but I like to say, recognized skills, experiences, confidences, and who/what they consider themselves to be outside of the uniform.

While the life-change when one leaves military service can be daunting for anyone, most people will adjust in time and be okay with the uniform. For those who joined the military to run from family dysfunction, personal problems, and lesser skills and experiences than others in society, taking off the armored skin that brought them so far is really tough.

Protective shells limit growth as in the case of sea creatures like the crab. It is the same for some men and women in uniform. Whether new enlistees came to the game with adequate pillars of self-esteem or not, putting on a uniform sometimes inhibits personal growth. A period of growth that can last the length of a standard enlistment or one that can last 20 years or more. It’s not the size of the uniform but rather the growth of the individuals self and the individuals expectations.

Sometimes when people grow as a team they fail to grow as individuals. When the military sets up a service member’s bank accounts, feeds them, provides them with free medical services and more, the activity and thought processes of these essential life skills are not etched in the minds of those served. These are basic life skills that civilians must master at an early age. Once out of the military, a veteran’s inclination is to turn to people and systems that served them while they were in uniform. Once individuals leave the military, their trusted provider is no longer there to help. Stepping outside the shell is HARD, but change is hard. Most people know this and military folks know

see Vet2Vet on page 37

Integrating Mental Health Services in a Primary Care Setting for Veterans

By Courtney Glashow, LMSW
Veteran Social Worker
Institute for Family Health

When it comes to the treatment of military veterans, often one provider just isn’t enough. This particular population, which faces disproportionately higher rates of mental illness than others, can benefit greatly from integrative and collaborative treatment by a mental health clinician, in addition to a primary care provider. With stigma still attached to receiving mental health services, the ability to identify and engage more veterans into treatment may hinge on the development of integrated settings. By embedding mental health services that are specialized in the needs of veterans within a primary care practice, more connections to treatment can be made. Federally Qualified Health Centers, with missions to serve the underserved, often serve veterans who are disconnected from traditional veteran services. These health centers, in addition to a primary care provider, who often has a long standing relationship with the patient and/or patient’s family, can play a critical role in engaging a veteran into mental health treatment.

Research suggests that the collaborative management by the primary care provider, who has resulted in a decrease in major depressive symptoms, and has improved patients’ satisfaction with their care (1). Patients feel more cared for when they see both professionals are working together to follow up with them regularly. Mental health services within the primary care setting are greatly beneficial to veterans because they can receive a multifaceted intervention that specifically caters to their needs.

Reference

Optum is honored to announce the retirement of Sandy Forquer, PhD. She has served as senior vice president for National Registry of Evidence-based Programs and Practices (NREPP) at Optum. Sandy has been a passionate advocate for the development of quality behavioral health services and has been a lifelong goal of mine. Designing consumer-friendly and responsive options for persons with serious mental illness has also served as a major driver of all my efforts in whatever positions I have held in the behavioral health field. Sandy has been a recognized leader in the behavioral health field, Sandy’s work in developing the National Registry of Evidence-based Programs and Practices has made a difference in the lives of the people we serve.” We are pleased to recognize her years of service and wish her the best in her future endeavors.

In recognition of Sandy Forquer

By Peter Ashenden

P

people who experience trauma, whether children or later in life, may have behavioral health problems, are at a higher risk of rate, degree, or training. Recently, researchers have identified a present-focused, coping skills model designed for flexible use in group or individual sessions. This is an inspiring model delivered by peer specialists. Each Seeking Safety topic is an inspiring driver of all my efforts in whatever positions I have held in the behavioral health field. Sandy has been a recognized leader in the behavioral health field, Sandy’s work in developing the National Registry of Evidence-based Programs and Practices has made a difference in the lives of the people we serve.” We are pleased to recognize her years of service and wish her the best in her future endeavors.

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Individuals struggling with addiction who also work in a first responder capacity face unique challenges in addiction treatment and recovery. Often referred to as uniformed professionals, these individuals are very likely to work in high-stress environments with an increased risk of physical danger, exposure to trauma and resulting post-traumatic stress disorder (PTSD).

At Marworth Alcohol and Chemical Dependency Treatment Center, we take a specialized approach to treating uniformed professionals, many of whom are typically employed as correctional officers, emergency medical technicians, FBI agents, firefighters, police officers, probation officers and state department employees.

In these professions, trauma can happen in a variety ways. For example, a police officer might be involved in a shooting, and that single event may have a profound traumatic effect. Or a firefighter may routinely see dead bodies after devastating fires, so the trauma builds gradually over many years. If the traumatic experiences manifest into PTSD, symptoms may include flashbacks, sweats and nightmares. By using drugs or alcohol to relieve anxiety, depression or flashbacks, the trauma survivor can often mask the presence of PTSD, but it becomes a dangerous path to addiction.

Addiction and trauma are not mutually exclusive, but for this population especially, the co-occurring disorders are common enough to necessitate specialized programming that integrates trauma treatment with substance abuse treatment.

A key component of integrating trauma and addiction treatment is training staff to identify behaviors that may indicate trauma history and appropriately approach the topic with the patient. Cues of trauma survivors might include frequently displaying extreme emotions without a specific stressor; involvement with abusive or emotionally unavailable partners; engaging in para-suicidal behaviors like cutting; or chronic relapse history. Once identified, staff can implement treatment techniques that help patients learn more adaptive means of containing traumatic memories, self-soothing and regulating emotion.

A common denominator for patients with trauma backgrounds is the basic human need to find or create safety, as outlined in Abraham Maslow’sHierarchy of Needs. With this in mind, Marworth counselors follow the “Seeking Safety” model of treatment with this population. Developed by Lisa M. Najavits, Ph.D. (professor of psychiatry, Boston University School of Medicine; lecturer, Harvard Medical School; clinical research see Trauma and Addiction on page 35
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Responding to First Responders: Even Superheroes Need Help Sometimes

By Kathryn M. Salisbury, PhD
and Christian Burgess, LMSW
Mental Health Association of New York City

As we contemplated writing about the job-related behavioral health needs of first responders, we were reminded of the post 9/11 poster showing two swaggering 6 year old boys wearing blankets as capes with the tagline “Even Superheroes Need Help Sometime.” This poster was part of an advertising campaign developed by the NYC Department of Health and Mental Hygiene in collaboration with the Mental Health Association to de-stigmatize seeking help after 9/11, particularly as it related to behavioral health needs.

This message is especially relevant for our first responders including emergency medical technicians, firefighters and police officers who are the first people to arrive at the scene of an accident, disaster, or other crisis/emergency. First responders may also include military personnel (including the National Guard) depending on the nature or location of the emergency, and can also include trained volunteers. Response may come in second or third waves of assistance as well, ranging from HAZMAT teams to K-9 units, Citizen Emergency Response Teams (CERTs) to Medical Reserve Corps volunteers. Response actions can include attempts to stabilize an otherwise ‘out of control’ situation, first aid, rescue, evacuation, etc. The men and women who are among the ranks of first responders are our present superheroes. First responders save countless lives and work to prevent emergencies from escalating as well as mitigate the effects of disasters that have occurred, all while putting their own lives at risk in service to their communities.

Because the work of first responders puts them at particular risk for emotional distress, trauma, burnout, fatigue and other behavioral health concerns it is important to have behavioral health resources available at the ready for first responders and to make them available, where, how, and when they want them.

Response-Related Distress
Exposure to unusual events/circumstances: Even after extensive training, new first responders may encounter unexpected circumstances on the job, or simply realize that experiencing something directly for the first time is different than simulated exercises. Seasoned first responders with years of experience may still be called to respond to situations new to them, including acts of terrorism, incidents of mass violence, industrial accidents, etc. No matter the degree of training and preparation, sometimes first responders’ minds and bodies can still be overwhelmed during rescue and recovery work which can lead to distress or even trauma.

Longer than average shifts or deployments: Even on a ‘regular’ day, responders often work long shifts and sometimes for days at a time. But during disaster responses, shifts can go even longer – and without breaks or relief. Responders can also be deployed out-of-state (whether assigned or from volunteering), taking them away from coworkers, family and other familiar surroundings.

For additional distress risk factors, visit the Centers for Disease Control and Prevention’s Disaster Mental Health for Responders: Key Principles, Issues and Questions at see Superheroes on page 34

War Impacts Us All: Minding the Gap Among Veterans and Civilians

By Scott Thompson, MS, MDiv, LMHC, Director of the Veterans Mental Health Coalition, Assistant Director of the National Traumatic Brain Injury and Emotional Wellness Alliance, MHA-NYC

Much has been made of the many issues facing veterans in our country and the myriad of services and organizations addressing their needs. In fact, veterans returning from war have all faced similar issues through the centuries. These are the common dynamics of adjusting to civilian life, reengaging with work and education, recovery from injuries, both visible and invisible, and the challenges navigating complex systems of support. At a minimum, it can be a daunting task.

There is a more fundamental need that remains unaddressed in this entire landscape. This is the place of the civilian and our necessary relationship to veterans. One of the most difficult challenges veterans face is the sense that their country doesn’t quite realize that the nation, and not just the soldiers, went to war. The burden of war rests on all our shoulders. The chasm or gap between understanding the war and its aftermath is particularly as it related to behavioral health needs.

Veterans: Key Principles, Issues and Questions at see The Gap on page 34
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The weather report was that the temperature would be in the mid 80s, but on the golf course it seemed as if it had reached about 90 degrees, with high humidity. It turned out to be the hottest day of the year, which further explained why it was a challenge to walk the 9 holes on this hilly course. I also forgot to bring water.

I did not intend to physically exert myself, because I was only interested in playing a relaxing round of golf. It seemed that walking would be easy, and that idea was supported by the finding that the two men I was playing with, Chris and Bob, both of whom seemed to be a few years older than me, had already decided to walk the course. So, at first, all seemed fine.

Things changed, however, on the 6th hole. We were on the putting green when Chris took a long pause before hitting the ball. I thought he was just composing himself prior to his shot; but after finishing he said that he wanted to make his putt because he was feeling light headed. Chris was the most talkative of the three of us. Early in the game he sought to engage me in conversation and to tell me about his golfing experiences in Las Vegas. Chris noted that the temperature reached 105 degrees on the day he played; therefore he was not concerned about today’s heat, even though it was humid.

Chris said that although he did not have to deal with humidity in Las Vegas, he did not believe it would be an issue today, given that he handled the 105 degrees without a problem.

Chris told me that he hopes to retire soon, and that he owns his own business. He also said that he plays golf for free on the NYS course we were on, because he is a disabled veteran. I do not play golf often, but when I do, and when I am paired with someone I do not know beforehand, I usually limit the chatter to golf topics. I am not saying that I am opposed to talking about other issues; it is just not my first inclination.

I have to admit that when Chris mentioned about being a disabled Veteran, it elicited a fondness toward him.

After the experience on hole 6, Chris walked to the 7th hole and sat on the bench. The heat and humidity had gotten to him. Chris said he was puzzled by this development, citing how he did not have this problem in Las Vegas. He did not seem in distress, but he was having some difficulty; so I offered him an aspirin. I always carry a few aspirins with me, in case they are needed. Chris first declined my offer, but within a few seconds he changed his mind. I gave him the pill, accompanied by some words of encouragement that the aspirin will make him feel better, as it will thin out his blood. I trusted that Chris would have told me if he was not allowed, for medical reasons, to take the medicine.

After a few minutes Chris said that he was done golfing for the day, and that he was going to temporarily remain on the bench, and rest. He said he would soon walk back to the clubhouse.

Chris was reassuring that he would be fine but I noticed, as I walked ahead with Bob, that Chris had not started his walk toward the clubhouse. As luck would have it, I was able to get the attention of a groundskeeper who was driving by in a golf cart. I told him about Chris and that he was likely still sitting at the 7th tee box, and that he would benefit from a ride back to the clubhouse. The groundskeeper initially responded with a defensive reaction, stating that he just come on duty, and that whatever I was referring to had nothing to do with him. I re-explained myself, without getting annoyed, and the man eventually understood what I was saying. He then drove off in the direction toward Chris.

About 10 minutes elapsed and there Chris was, sitting alongside the ground keeper as he drove him back to the clubhouse. As Chris passed, he waved as a show of thanks. He seemed OK.

I believe the aspirin probably helped him, and since he had not started his walk, the arranged ride was also needed. I do not know for sure if I saved Chris from a grim fate, but it is very possible. I was largely a stranger to him and we probably will not ever cross paths again. Therefore, for the most part, I was an anonymous helper. Chris, on the other hand, helped countless people through his military service, and paid a price for doing so. He did not know the people he helped, but I was one of them; and I am glad that I could return the favor to a small degree.


By Michael DeFalco, PsyD, Director of Military and Integrative Services, and Ayenisa Leonardo, BC-ICAL, Clinical Coordinator of Military and Integrative Services, Bridge Back to Life Center

Since September 11th, 2001, about 2.5 million members of the Army, Navy, Marines, Air Force, Coast Guard and related Reserve and National Guard units have been deployed in the Afghanistan and Iraq wars. Of those, more than a third were deployed more than once; nearly 37,000 Americans had been deployed more than five times, among them 10,000 members of guard or Reserve units. Records also show that 400,000 service members have done three or more deployments (Adams, 2013). Multiple factors related to the conflicts in Iraq and Afghanistan and the Global War on Terror (e.g., multiple deployments, length of deployments, intensity and nature of combat operations) have led to an increase in psychological disturbance among service members following their deployments (Rand Study, 2008). Behavioral health issues such as posttraumatic stress disorder (PTSD), depression, traumatic brain injury (TBI), and substance misuse have been seen at increasing higher rates not only in active-duty service members, but in our veteran population as well. Obviously, these problems do not end when an individual separates from the military, but the onus of responsibility for who is responsible for their care does. This shift in responsibility does not fall solely on the Veterans Administration (VA), it also falls on civilian providers of healthcare in the community.

President Obama’s signing of an Executive Order to improve access to mental health services for veterans, service members, and military families on August 31, 2012 highlights how these issues have been recognized at the highest levels of government, and that a change in national strategy is needed to meet the needs of our military that have been identified and continue to be unmet. Part of President Obama’s multi-pronged approach asks for partnerships between the VA and community providers to enhance access to mental health care (White House Press Release, August 31, 2012). There is recognition that both within and outside of the VA it can be difficult to identify treatments that work as well as individuals who are competent to provide such treatments.

Examining these challenges for our service members, veterans, and military families on a more local level, the RAND Corporation conducted A Needs Assessment of New York State Veterans in 2011. Sponsored by the New York State Health Foundation, this study found that, among New York State veterans, a significant proportion of those surveyed (56%) were identified as having a need for mental health services. Despite this need, only about half of those individuals actually sought care in the prior year. Most concerning, for the half who sought services, only half received or completed a “minimally adequate” course of treatment. Regarding preference for where veterans want to go for care, 46% indicated they would prefer to receive mental health services from a civilian provider (as opposed to the VA).

Focusing on the area of substance misuse, it has been well documented that the incidence of alcohol misuse and misuse of prescription pain medications (specifically opiate-based pain medications) has increased dramatically for active-duty service members over the past 10 years, and these difficulties often extend to our veterans as they reintegrate (National Institute on Drug Abuse, 2013). There is a strong relationship between posttraumatic stress symptoms and alcohol misuse (binge drinking and dependence), and there is a real need for us to develop effective and accessible outpatient programs to assist our veterans (National Center for PTSD, 2013). When considering integrated treatment for substance use disorders for veterans and military family members in an outpatient setting, a program grounded on the following pillars (such as the one we have developed with the ARCH Program at Bridge Back to Life Center, Inc.) is best suited to address the complex needs of the population under consideration.

Pillar One: Integration of trauma theory into the conceptualization of substance use disorders: Prevalence data and clinical experience working with veterans speaks to the high co-morbidity of traumatic exposure (both developmentally and adult-onset) and addiction. Whether an individual’s capacity to self-regulate inner experience is derailed during key developmental years by interpersonal neglect or abuse (Coz, et al, 2005; van der Kolk, 2005), or is derailed by exposure to trauma related to military life (e.g., combat trauma) (Shay, 1994), addiction is often the result when the individual turns to substance use to modulate their emotional swings, recurring thoughts, and physiological arousal/pain. Substance use see Coming Home on page 28
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www.mhanc.org
By Jennifer DeLucia, MS, ATR-BC, LCAT, Wellness Program Manager
Veterans Outreach Center

While most individuals successfully transition from military to civilian life, a certain number do not—often leading to confrontations with clinicians, law enforcement and the criminal justice system. Understanding these individuals goes a long way towards preventing encounters from escalating into life changing events that lead to prison terms or worse. While a version of this article was directed at the law enforcement community, those of us in the treatment and recovery world can also benefit from a discussion of common Veteran readjustment issues and ways to resolve them.

There are roughly 2.6 million Post-9/11 Veterans in the United States, most of them having served in Iraq, Afghani- stan, or both. These conflicts are different from previous wars, as are the soldiers who fought in them. In both conflicts there were few “safe” areas and the prevalence of Improvised Explosive Devices (IEDs) and ambushes exposed everyone—not just the infantry—to combat conditions. These are also the first protracted conflicts fought with a Volunteer military—unlike the Vietnam conflict when draftees served two years and a single combat tour, these professional soldiers are in for a longer term and many have been deployed to combat theaters multiple times.

We spend a great deal of time, money and effort in turning young high school graduates into highly trained soldiers. Most often we spend less than two days turning that soldier back into a civilian when discharged from the service. Many of the habits that kept them alive in a combat theater are not acceptable behavior in the civilian world. Nearly every new Veteran requires some amount of time to readjust their habits from the combat environment. That combat environment includes constant stress and uncertainty, exposure to injury and death, separation from friends and family, and stress at home. Nobody comes home from that world unchanged.

In general the combat environment can create a constant state of 360 degree situational awareness—there are no safe areas and they are constantly on alert. There is a mistrust of any civilian authority—trusting only your battle buddies. The soldiers on your left and right are looking out for you—everyone else doesn’t matter. There are also grief, guilt, blame, and shame from loss of friends, survivor guilt when others around you are injured or killed, blaming superiors for bad outcomes that occur during a mission, or feeling useless or inferior. There is also a lack of actions that got people killed.

The most commonly diagnosed Mental Health condition for this group is depression; the most commonly diagnosed physical conditions are orthopedic injuries—mainly knees and backs from violent physical activity while wearing over 60 pounds of gear. Add in those with TBI and PTSD and there exists fertile ground for self-medication—through alcohol, substance, or prescription drug abuse.

The military has a tradition of “binge” drinking, despite command efforts to reduce the occurrence. Alcohol is cheap, legal, and easy to obtain—even in combat theaters where the open sale is forbidden. Many of these Veterans become addicted to prescription pain medication from injuries—it’s easier for a soldier to be returned to duty with painkillers than taking time to heal properly. With prescription drugs more difficult to find in the civilian world many turn to other substances such as heroin—which is often cheaper and easier to obtain. Finally, many Veterans use drugs and alcohol as a coping mechanism for undiagnosed and untreated stress.

Post-Traumatic Stress is described as a normal response to abnormal events—and some people adjust better than others. Symptoms exhibited include hypervigilance and hyper arousal—an exaggerated startle response or constant surveillance of surroundings. It also presents as aggres- sive, irritable behavior—overly loud or a response to minor situations. PTSD is frequently accompanied by insomnia—individuals sleeping less than two or three hours a day. Another manifestation is emotional numbness—a lack of engagement with family and friends that is described in the military as the “thousand yard stare.”

see Readjustment on page 30

Creating Home in a Community-Based Art Therapy Program

By Jennifer DeLucia, MS, ATR-BC, LCAT, Wellness Program Manager
Veterans Outreach Center

Recently a veteran referred to our studio as a “second home.” He was referring to an art therapy program that had an opportunity to develop 4 years ago at a community-based organization for veterans in Rochester, NY, Veterans Outreach Center, Inc. During its first year the program more than doubled in size; veterans were hearing about it from friends and came requesting art therapy services specifically. Since its inception, the program has grown to include a fully functioning art studio, three full-time art therapists and a storefront gallery space where veterans can showcase their artwork.

“Home” can be a loaded term for veterans returning from service and reintegration into civilian life. As treatment providers we need more knowledge to promote and advocate for veterans with community practices that encourage healing and reintegration. Building resilience and promoting successful reintegration is a task that reaches beyond the usual scope of mental health providers (Wheeler & Bragin, 2007). It is a calling for mental health providers to involve family, friends, and the entire civilian community. When art therapy incorporates studio engagement and gallery exhibition, veterans receive unique benefits that can address the multiple levels of need starting with the veteran and reaching out into the context of the community or “home” where the veteran returns.

In July 2013 Veterans Outreach Center received national recognition from the White House with an invitation to present a case study of our program at the Veterans and Military Family Mental Health Conference in Washington, DC. The conference highlighted the work of community-based organizations and their vital role in offering complimentary treatments and alternative options to treatment seeking veterans. In our community art therapy has become a sought-after treatment option by veterans working through issues related to readjustment and PTSD. The conference set the stage for President Obama and a White House initiative that directed all VA medical centers nationwide host annual mental health summits. The summits brought together community providers and VA representatives to identify ways to improve collaboration and collectively meet veteran needs.

Readjustment

Veterans experience cognitive, spiritual, emotional, and social challenges that may impact supportive relationships and complicate their reintegration into post-conflict or civilian life (Brunner & Woll, 2011). The impact of these challenges may take many forms including difficulties with finding and sustaining gainful employment; reconnecting intimacy with spouses, children, and close civilian friends; and attending to daily responsibilities (Caplin & Lewis, 2011). There are also certain risk factors associated with the failure to adjust. I have found such veterans to be at greater risk for the development of mental health conditions like depression or substance abuse. Veterans with a diagnosable mental health condition at the time of separation from service often struggle with the tasks of reintegration into routine life, which then leads to greater complications with the readjustment process.

In addition to the mental health and psychosocial issues tied to readjustment, there is a cultural adjustment that veterans may experience when returning home. A military culture is developed as service members are socialized into military culture may present challenges in the process of readjustment to civilian life (Coll & Weiss, 2011). Military culture contrasts greatly with civilian culture in many ways. A strong sense of camaraderie comes from being a member of a military unit, holding a shared mission, and knowing that fellow service members are looking out for one’s safety and well-being; this strong sense of group cohesion is not easily found in civilian society (Coll & Weiss). At home many veterans lack proximity to their military support network and lose the familiar structure of military culture. Veterans must negotiate the gulf of difference between civilian and military cultures while often lacking the much-needed social support to navigate this process successfully.

Art Therapy

Currently, research on art therapy and veterans has focused on the treatment of posttraumatic stress (e.g. Collie, Backos, Collie, Backos, Collie, Backos)
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The military family system deserves to be given easy access to the most outstanding clinical treatments that we now have to offer. We are in the process of developing novel psychotherapeutic interventions for the heroes that have taken on the duty of defending our country with honor, commitment and exposure to trauma. Everyone in the system is impacted. Veterans and their families deserve to be able to make informed treatment choices that provide them with the opportunity to have hope filled, and normal lives going forward. Innovative treatment needs to be inclusive. As clinicians we are not only caring for veterans. When we work from a systems perspective it is abundantly clear that the availability of mental health treatment choices for spouses, children, parents and siblings must always be available.

Resiliency

Veteran resiliency is interwoven with the love, support, encouragement, faith, courage and strength of the social-emotional system. This is a relational model that is driven by our psychological expertise in developmental theory, attachment, biology, technology, ongoing empirical research and exceptional, efficacious clinical care. Optimal multimodal treatment will frequently require and include psychoeducation, individual psychotherapy, psychopharmacologic treatment, group therapy, family therapy, couples therapy, as well as specific clinical services for children and teens. We need to support healthy individual and family functioning.

Deployment

Deployment is a major life stressor that affects the entire family system. The past decade of wars in Iraq and Afghanistan have had more frequent and longer deployments than any other time in history and we have found that Non Deployed Spouses (NDSs) are at increased risk for clinically significant psychiatric distress during and after the spouse is deployed (Bjornestad, et al., 2014). When focusing on the uniformity of evidence based treatments in practice and the psychological consequences of engaging in combat, (Laska, 2013; Sammons, 2008) it is clear that this is the first time in history when psychological morbidity is likely to far outstrip physical injuries associated with combat. The current literature on Post-Traumatic Stress Disorder is extensive. Researchers and clinicians argue that the epidemic of Post-Traumatic Stress and brain injuries has been significant. According to the August Pentagon Report (2012), we are given the news that as two of our longest wars are ending, suicide is now the leading cause of death in the army. The literature on post deployment psychiatric health in Operation Enduring Freedom/Operation Iraqi Freedom have identified high rates of PTSD (21.8% ), depression (17.4%). There are estimates that 1900 veterans from Afghanistan and Iraq in the year 2014 have sadly taken their own lives. Clearly children and families are impacted in profound ways when a parent goes to war (Boberiene, et al., 2014). Children of Service Members are 2.5 times more likely to develop psychiatric problems; there is evidence that 2 million children have been affected by deployment and 30,000 children have had to come to terms with parental death or injury (Lemon, et al., 2009; Gorman et al., 2010; Chandra, 2010).

When focusing on the uniformity of evidence based treatments in practice we find that men are overrepresented within the American Armed Forces, comprising 85% of the population of those returning home. Male veterans are expected to function as husbands, partners, fathers, sons, and workers. In addition they must separate from the military while reconnecting with family and friends and embracing the now unfamiliar civilian lifestyle (Chan, 2014; Cohen et al; 2010; Wells et al; 2010, Defife, 2012).

Innovative Treatment

Innovative treatment and psychoeducation go hand in hand. First and foremost, we must be sophisticated diagnosticians who understand the complexity of a wide range of symptomatology and psychopathology. Not being thorough and working in the dark is far too risky with this
A Bridge to Employment for Veterans

By Lt. Cdr. Brett Morash, U.S. Navy (Retired), PhD (ABD), MBA, MA, BS, Vice President of Veterans Services, Services for the UnderServed (SUS)

While SUS was recruiting for the pilot ‘Tug and Barge’ program run through SUNY Maritime College, John Lang was referred for screening as a candidate. Mr. Lang, a former Army Aviation Mechanic honorably discharged after 6 years of service, had fallen on difficult times which forced him to relocate to a homeless shelter. At his screening, he shared that his ideal occupation would be “Tugboat captain, working on the water and with my hands.”

With the right credentials and an enthusiastic and positive attitude John was accepted into the program. Thanks to a generous grant from the PIMCO Foundation, John’s course was paid for in full. This opportunity became John’s bridge to the job of his dreams.

Many people, when introducing themselves for the first time, give their name and then state what they do for a living, supporting the notion that work not only defines who we are but also, how we think society values us. SUS believes that serving the needs of the individual must go beyond providing shelter and food to helping them secure a job that gives meaning to the day and to life.

A large number of the veterans SUS serves have mental health conditions as well as other comorbidities that affect their ability to obtain and retain employment. In many cases, being unable to retain employment because of these conditions has led to a loss of income, and put long-term housing stability in jeopardy.

In the Fall of 2013, to address this challenge SUS’ Veterans Division brainstormed operational concepts that would increase employment options for this population, through educational programs readily available in New York City. This took into account the following realities:

- The time commitment of an associate’s degree or baccalaureate program necessary to attain the next level of professional potential is often difficult for veterans who are already juggling so much as they reintegrate after service into their families and communities.
- Veterans making the choice to pay for school themselves, in the absence of a Veterans Administration (VA) or state funded opportunity, risk placing themselves in financial straits and therefore are at greater risk of homelessness. (This is particularly true as the VA has defunded the Veterans Retraining Assistance Program (VRAP) as of March 2014.)
- Courses need to be targeted toward employment options that are realistic and available at reputable institutions of higher learning.

Coincidentally, CUNY Hostos Community College’s Continuing Education Department was also grappling with these issues, given the pending sundown of VRAP funding. (Hostos’ Veterans Services personnel was focused on matriculated students and not on the continuing education department, leaving those veterans woefully underserved.) SUS’ Veterans Services staff reached out to CUNY Hostos and together determined that a position was needed on the ground at the college that would help to identify needs that could be met through the breadth and depth of services provided at SUS (housing, mental health and wellness). The creation of the Veteran Education and Employment Specialist (VEES) to ensure that these needs were being met, allowed the veterans to focus resources on education and food security, and to give attention to their studies.

As the veterans approach graduation, the VEES ensures that the SUS Veteran Employment Team, made up of a case manager and employment developer focusing on employment options for the veteran in an associated industry. Provided that the housing stability is adequate, the Employment Team is better informed to help the veteran find placement in their newly chosen profession, with a freshly minted certification from a recognized provider of that training.

Over the past year, SUS has had no less than 50 veterans or their family members served in this manner at Hostos alone. The role of the VEES has since been expanded to include supporting students at CUNY’s Borough of Manhattan Community College and LaGuardia Community College.

Over time, SUS looked at other opportunities in continuing education outside of the CUNY system that could lead to direct employment. This past summer SUS was approached by SUNY Maritime College to discuss the tugboat training program that they had on the books. When this course was last run three years prior it had only a 10% graduation rate. In large part the low rate of success was due to students being ill suited to the rigors of a life at sea, drug use, criminal backgrounds, or mental health challenges that could not be managed in a maritime environment.

Using the experience of Hostos, SUS and the SUNY Maritime College reverse engineered the recruitment process to increase the chance of pre-screened candidates completing the course of study and gaining a high level of confidence of success to acquire foundation funding to support the notion that work not only defines who we are but, how we think society values us. SUS believes this model of partnership between educational institutions and the service provider is a replicable one. By leveraging the unique capabilities that each partner brings to the table a comprehensive approach can be made and hopefully an equally successful outcome for those we serve can be achieved. At the end of the day it is all about ensuring that people like John are able to meet outcomes that give them full and enriching lives.

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New York University Silver School of Social Work recently presented its annual Alumni Awards, honoring six alumni for their contributions to the field of social work and the School. Carmen Collado, MSW ’92, received the Distinguished Alumni Award for her tremendous work as a policymaker, program designer, and advocate for the social work profession. The awards were distributed at a luncheon at the NYU Global Center for Academic and Spiritual Life, hosted by Dean Lynn Videka.

In November, Collado joined ICL as chief network and relationship officer. She is responsible for ensuring that relationships between the organization and government officials, clients, collaborators, and donors remain strong and transparent. Collado came to ICL from the Jewish Board of Family Children’s Services (JBFCS), where she had been chief government and community relations officer since 2002. A member of the New York State Board for Social Work, she serves as a social work representative, advising the Board of Regents and State Department of Education on matters of professional regulation.

“My NYU foundation was so strong that my classes, particularly in casework and social policy, continue to inform my work over two decades after my graduation,” said Collado. She said has received a “100 percent return” on her educational investment.

Since her time at the School, Collado said she has seen immense positive change during Videka’s tenure as dean. She said, “Lynn has transformed the

see NYU Honors on page 35

The Guidance Center of Westchester (TGCW) has named Susan M. Ohanesian, ACSW, LCSW-R, CASAC as Deputy Director for Clinical and Substance Use Services. In her role, Ms. Ohanesian is responsible for all aspects of the Agency’s mental health clinics, school-based mental health programs and substance use treatment programs. Collectively, these programs provide services to more than 1,540 people each year with a combined annual budget exceeding $3.5 million.

A seasoned professional with an impressive background in social services, behavioral health and healthcare, Ms. Ohanesian most recently served as Senior Vice President and Chief Clinical Officer at Daytop Village in New York City. There she developed implemented, evaluated and maintained programs, services and activities.

Prior to Daytop, Ms. Ohanesian held a variety of increasing leadership positions with Palladia, Inc., one of the largest non-profit, multi-service agencies in New York City. She also held posts with Bowery Residence Committee and Palisades General Hospital.

“Susan’s knowledge and expertise will help The Guidance Center of Westchester target strategic opportunities that will enable the agency to grow and thrive by providing integrated services, implementing more business efficiencies and providing high quality services,” says Executive Director Amy Gelles.

Ms. Ohanesian earned her Master of Science in Social Work from Columbia University and her Bachelor of Arts from

see TGCW on page 36

becomes what in the trauma lexicon is called a “survival strategy” aimed not at pleasure-seeking, but rather at diminishing pain and emotional discomfort (Fisher, 2000). For many who have survived trauma and now struggle with addiction, they vacillate between states of physical/emotional numbness while using and physical/emotional pain when not.

Physical/emotional arousal and pain become a trigger for substance misuse, and is part of the individual’s addiction and relapse cycles. Adapting treatment models that educate veterans on this relationship and incorporate these concepts into effective treatments is key.

Pillar Two: Incorporating a working understanding of military life and military culture (and how military may inform treatment) into the therapeutic model and organizational culture: Educating clinical and support staff on military cultural considerations is vital in order to both build trust with veterans (a core issue for many given their experiences in the military and their socialization into a military mindset) and to deliver treatments that take into consideration how military culture may play into the development of certain struggles (including substance misuse) and inform the meaning that these struggles have for veterans.

Outside of the obvious, concrete aspects of military culture that need to be thoughtfully woven into the language and treatment environment (e.g., use and understanding of branches of service and differences between each, use of acronyms, visible displays of military culture and patriotism, structure and timeliness of services), one must also consider the context of each veterans military experience and how this may inform their current difficulties with sobriety and possibly readjustment. For example, there is a clear directive from the Department of Defense and each branch of service that alcohol misuse is unbecoming of one who serves and puts them in violation of both the core values of their branch of service as well as regulations. At the same time, many served in an environment of tacit acceptance of alcohol use or even one where the use of alcohol was part of the social culture and expectation of their unit. Was the discovery of alcohol/substance misuse used punitively to force and individual into treatment or separate them from the military? Has one’s socialization to approaching “problems” with quick, definitive action (i.e., a warrior mentality) cultivated substance-seeking as a “quick fix” to manage physical/emotional pain despite short and long-term consequences. Being able to have an informed consideration of these and other salient points related to military culture for each veteran served allows us to direct treatment and support accordingly.

Pillar Three: Offering a clinically-informed program of evidence-based substance recovery programming and specialized wellness and resilience services that address substance misuse and comorbid struggles on multiple functioning levels: Recovery from addiction not only needs to incorporate trauma theory and the possible role of traumatic exposure in the etiology and maintenance of addiction (see Pillar One), it must also provide a core curriculum of knowledge, structure, and support to assist the veteran to achieve abstinence and initiate a long-term program of recovery. As an example, Bridge Back to Life Center, Inc. has all clinicians trained in the Matrix Model for intensive drug and alcohol treatment (Rawson, Obert, McCann, & Ling , 2005). This model, with a 20-plus year evidence base, allows for the education and teaching of recovery-specific knowledge and skills that are the foundation for abstinence. Staff are also trained in the Duluth Power and Control intervention to assist those perpetrating aggression as part of their clinical picture. Similar evidence-based models are available for those who we driving under the influence, and Seeking Safety (Najavits, 2002) is available for those with identified trauma are part of

see Coming Home on page 37
Families notice when a loved one begins to be different from the child, spouse, sibling or parent that they have known. Their loved one isolates him(or her)self from family and friends; shows persistent changes in sleep, eating and hygiene; says or does odd things that suggest their thinking is off, maybe behaving as if there is danger lurking or hearing or seeing things others are not; is moody, irritable or intolerant of the slightest of questions or statements; or uses or abuses alcohol and drugs.

When mental illness enters a family they soon face two types of problems: The first is how to understand and navigate a broken, confusing and too often exasperating mental health system. The second is to understand what they can do to help a love one who – because of guilt, shame, or illness – won’t help themselves.

These are questions that can be – and must be answered – if families are to do what they want more than anything, namely to help their loved one get the care that will make a difference in their lives and that of their families.

With more than one in five adults and adolescents effected by a mental illness annually, there are few families who are spared. And families are often the greatest resource and source of support an ill person can have, whatever persistent illness they suffer – including mental illnesses.

I have four messages for families: (1) Don’t go it alone. There are people and places to turn to. (2) Don’t get into fights. There are alternatives that work better. (3) Learn the rules of how the mental health system works. (4) Speak up. Your story and your truth can change your loved one’s story and the world.

When Mental Illness Enters a Family

By Lloyd I. Sederer, MD

Fighting For Our Nation’s Veterans

By Wendy Brennan, MS

Executive Director, The National Alliance on Mental Illness of New York City

Family members have a unique role to play in the mental health of our nation’s veterans. With the current system overwhelmed by mental health service needs and unable to provide adequate access, family members serve at the critical front line of our veteran’s mental health needs and are the backbone of veteran recovery.

Readjusting to civilian life for a returning veteran comes with a unique and unexpected set of difficulties that can disrupt relationships with their loved ones. In addition, they live with a heightened risk of Post Traumatic Stress Disorder (PTSD) that could further exacerbate pre-existing mental health issues. Due to the stigma of mental illness and the burden of reintegration, these struggles often go unspoken, leaving both veterans and their family members feeling misunderstood and unheard. For veterans, these feelings deepen an already growing sense of isolation and vulnerability.

In 2009, according to the American Psychological Association, the suicide rate for 18- to 29-year-old male veterans rose to record highs. In fact, veterans have a higher rate of suicide than the national average, reaching a rate of 22 suicides per day. Earlier this year, the House of Representatives passed the Clay Hunt Suicide Prevention for American Veterans (SAV) Act, which requires an annual evaluation of VA suicide prevention programs to determine their effectiveness.

The legislation, now awaiting approval from the Senate for the second time in two months, includes a vital increase in funding.

Family members are the greatest resource and source of support, and their stories and truth can change policy and save lives.

Fighting For Our Nation’s Veterans

By Wendy Brennan, MS

Executive Director, The National Alliance on Mental Illness of New York City

When Mental Illness Enters a Family

By Lloyd I. Sederer, MD
Experience with recent Veterans from related conditions.

Road rage and impaired driving can result in accidents in the civilian world. Common combat driving techniques that include racing, speeding, and skidding to replicate the adrenaline rush of combat. In a similar vein, impaired or aggressive driving is the leading cause of death among recently returned Veterans. High speeds, sudden lane changes, and driving off the road are all common combat driving techniques that lead to accidents in the civilian world. Road rage and impaired driving can result from lack of sleep or drug/alcohol abuse caused by PTS, TBI, or other stress related conditions.

Experience with recent Veterans from a variety of clinical and law enforcement settings indicate that they can be more impulsive and more willing to fight than their predecessors as well as displaying less respect for police or any other type of authority.

A significant group of Veterans are either married or in a permanent relationship. There is a risk of domestic violence if there is significant stress on the family unit as a result of service. Long, frequent deployments can cause significant changes in relationships – if the husband is deployed the wife assumes all the household roles like paying the bills, cutting the grass, etc. Returning home the Veteran finds his role changed and can be unsure how to get back to “normal”. Likewise for National Guard and Reserve soldiers who are deployed they may return home to jobs that don’t pay enough or seem important as those they had in the military – putting stress on everyday living. All of this can be exaggerated if accompanied by PTS or other mental health conditions.

Another potential issue can be firearms. Nearly every Veteran is well trained in their use and they are more likely than the rest of the population to have them. Most have them as a defense and are not likely to pose a threat, but the mere presence of a weapon can escalate a situation.

There are ways for clinicians to cope with many of these issues – the overarching goal being to keep everybody safe and obtain peaceful resolutions when situations arise. These are strategies for low risk events where we are able to work towards treatment and nonviolent resolution. High risk situations require immediate action by qualified individuals regardless of any other conditions.

The first step is to open a dialog – and determine their Veteran status. Visual cues such as vehicle stickers, clothing, or general appearance can help, but the easiest way is to ask “Were you in the military?” Thanking them for their service is a good way to open a conversation.

The objective in this type of dialog is to keep it calm. Maintain a physical space – don’t crowd into the conversation. Keep a neutral tone and posture – not raising your voice or making any kind of gesture that could be construed as threatening. Ask questions that orient the conversation – “What’s going on?” and use restatements to clarify any ambiguities “I understand that you ...” Be absolutely transparent with any actions taken – communicate clearly what your are going to do and provide a rationale for why you are doing it.

There are communication aids that you will possess, prompt, and effective treatment for readjustment issues facing returning Veterans – and better serve those who have served their country.

Training Initiative from page 1

Interventions. In addition, the program offers a primer on military culture and mental health issues. Other key elements of the curriculum include advice on questions to ask and questions not to ask and the importance of evaluating possible co-occurring psychiatric diagnoses.

In order to ensure that the training program meets its goals, participants will be asked to complete a pre-training survey and a post-training survey to assess their level of knowledge of military culture and veteran-specific mental health conditions both before and after the program. A final evaluation will be sent to program participants six months following the program to assess actual implementation. This three-part survey process will permit NYSAPA to measure and track the program’s potential impact on the care of returning combat veterans with mental health needs.

The inaugural training session was held at the Albany Medical Center, Albany, New York, on November 14, 2014. The program was hosted by the Department of Psychiatry and included health care professionals from the Departments of Emergency Medicine, Internal Medicine and Family Practice. The lecture was presented by Matthew Friedman, MD, PhD, a Professor of Psychiatry and Pharmacology at the Geisel School of Medicine at Dartmouth College and a nationally-renowned expert on veterans mental health issues.

The kick-off presentation was attended by several State legislators, including Assemblywoman Patricia Fahy (D-D-Athens), Assemblyman John McDonald (D-Coeymans), as well as staff from the offices of Assemblyman James Tedisco (R-Glenville) and Senator Kathleen Marchione (R-Halfmoon).

A second training session is scheduled for March 2015 and will be held at Stony Brook University Hospital in Stony Brook, New York. Additional training sessions are being scheduled throughout the state. In addition, there will be a comprehensive web-based version of the training made available in early 2015.

For more information about the Veterans Mental Health Primary Care Training Initiative, please contact the New York State Psychiatric Association at (516) 542-0077 or centraloffice@nyspsych.org.

Mr. Gallo is the NYSAPA Government Relations Advocate. Ms. Fernbach is the NYSAPA Deputy Director and Assistant General Counsel.

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In 2010 there were 760,329 homeless Veterans on the streets of America. An astounding number. But what’s more significant is that in 2014 that number was 49,933 (according the statistics collected by the Department of Housing and Urban Development). This astonishing number represents a 35% drop in homelessness among Veterans over the course of 4 years and the success of President Obama’s goal to end veteran homeless by the end of 2015. This drop and continued work has to do with many things which included public funding and support, but also the intermingling of agencies within our communities to build bridges and support those who served. In Westchester County, this has been supported by the Patriot Housing/Employment initiative to house, retrain, and employ (at a livable wage) Veterans who are homeless or at risk of homelessness. This group of agencies (both public and private) has worked to house over 200 veterans and employ over 100 since August of 2013. An essential aspect of this work is to get all the players in one room, to meet on a weekly basis to coordinate housing and services.

Common Ground Community is one of the largest supportive housing providers with over 3,000 units of permanent and transitional housing throughout New York and Connecticut. In 2008, Common Ground opened its Montrose Veterans Program in Westchester County, New York, serving up to 96 homeless Veterans at any given time, the largest Veteran Specific program in Westchester County. Since opening, Common Ground Community has worked diligently within this frame work to graduate homeless Veterans to self-sufficiency (discharging over 300 Veterans to permanent housing).

Through Patriot Housing/Employers, Common Ground recently started to work with one such partner, the Center for Career Freedom in White Plains, New York. The Center for Career Freedom trains individuals in computers at different levels leading up to needed certifications (Microsoft and QuickBooks). The Centers staff has extensive experience in business, as well as counseling and teaching. This unique blend of skills provides clients with a caring and street-smart approach to reaching their employment goals. The Center has assisted over 4,000 persons with both mental and physical disabilities train for today’s work force. Common Ground began to work with Don Fitch, M.S. the Center’s Executive Director, to match Veterans in need of training with the proper resources.

During a tour of The Center for Career Freedom last fall several Common Ground Residents were able to see firsthand their training capabilities. One of the Veterans, “Charlie”, wanted to know how The Center for Career Freedom differed from a Community College. What would it cost? What day/time were the classes? When did the semester start and end?

He was relieved to learn the student-centered learning model meant one-on-one custom classes. Each student works at their own pace, there are no set start or end dates. All training fees for the Vets are funded by ACCES-VR (www.acces.nyserd.gov/vr) or One-Stop (www.westchesterputnamonestop.com). Common Ground arranged for a van to transport for some ten men and women to the Center. Following their Certification, the Center will work with the Patriot Housing & Employment Network, ACCES-VR and One-Stop to secure employment.

The work of ending homelessness among our nations Veterans continues and only as a community will meet that goal. If you are interested in Patriot Housing/Employment you can find us on the web, Facebook and Twitter (http://www.programdesign.com).

If you have any questions about either Common Ground or the Center for Career Freedom programs, you can contact the authors at: hcharton@commonground.org; or donfitch.freecenter.org
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Patriot Housing and Employment Group Leaders

After Meeting Their First 100-Day Challenge of Housing 84 Veterans

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Behavioral Health News
Theme and Deadline Calendar

Summer 2015 Issue:
“Understanding & Addressing the Opioid Epidemic”
Deadline: April 14, 2015

Fall 2015 Issue:
“Caring for Depression in Integrated Settings”
Deadline: July 14, 2015

Winter 2016 Issue:
“Wellness in The Workplace”
Deadline: October 14, 2015

Spring 2016 Issue:
“Preparing The New Behavioral Health Workforce”
Deadline: January 14, 2016

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United States Army soldiers hospitalized with a psychiatric disorder have a significantly elevated suicide risk in the year following discharge from the hospital, according to research from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). The yearly suicide rate for this group, 263.9 per 100,000 soldiers, was far higher than the rate of 18.5 suicides per 100,000 in the Regular Army for the same study period, the study found.

The researchers looked at data from the 12 months following a hospital discharge for more than 40,000 anonymous, Regular Army soldiers (full-time soldiers excluding Army National Guard and Army Reserve) who served on active duty from 2004 through 2009. Ronald C. Kessler, Ph.D., of the Harvard Medical School in Boston, and colleagues, report their findings on Nov. 12, in JAMA Psychiatry. Army STARRS is a partnership between the Army and the National Institute of Mental Health (NIMH), part of the National Institutes of Health.

The Army’s suicide rate began increasing in 2004, exceeded the rate among a similar group of U.S. civilians in 2009, and has remained high through 2014. This study of administrative data shows that 40,820 soldiers (0.8 percent of all Regular Army soldiers) were hospitalized with a psychiatric disorder in 2004-2009, the period covered by this research. Suicides occurring in this group during the year after a hospital discharge accounted for 12 percent of all Regular Army suicides during this period.

Researchers also found that it was possible to identify smaller, higher-risk groups within this at-risk population. Analyzing soldiers’ characteristics and experiences, researchers identified the 5 percent of soldiers with the highest predicted risk of suicide after leaving the hospital. This top 5 percent accounted for 52.9 percent of the post-hospital suicides. Soldiers in the top 5 percent also accounted for a greater proportion of accident deaths, suicide attempts, and re-hospitalizations.

The researchers report that, for this group of hospitalized soldiers, some of the strongest predictors of suicide include being male, having enlisted at an older age, having a history of criminal offenses during Army service, having had prior suicidal thoughts or actions, as well as disorders diagnosed during hospitalization and aspects of prior psychiatric treatment. However, researchers found that many factors contributed toward predicting suicide risk in this group, individually and in combination. This fact underscores the complexity of assessing suicide risk and the added value of developing new approaches to better predict very challenging events.

“ ‘This is the first publication from Army STARRS that reports on the ability to use Army/Department of Defense data to identify specific subgroups within the Army that have very significantly elevated suicide risk,’ ” said NIMH Director Thomas R. Insel, MD. “ ‘However, there are sensitivities to using data to identify high-risk subgroups. It’s important to remember that although a particular population may be at elevated risk, suicide remains a rare event.’ 

Researchers concluded that the high concentration of suicide risk among this study group, and particularly in the smaller highest-risk groups, might justify targeting expanded post-hospital interventions for such people. Researchers continue to develop and refine computer models to help the Army predict suicide risk among soldiers and prevent self-harm.

About Army STARRS: The Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS) is funded by the U.S. Army and the National Institute of Mental Health. The study is led by co-principal investigators Robert J. Ursano, MD (Uniformed Services University of the Health Sciences), and Murray B. Stein, MD, MPH, (University of California, San Diego), with site investigators Steven G. Heeringa, PhD (University of Michigan), and Ronald C. Kessler, PhD (Harvard Medical School), and with collaborating scientists Lisa J. Colpe, PhD, MPH (NIMH), and Michael Schoenbaum, PhD (NIMH). Contact us at www.armystarrs.org/media_room.

Some common ways for first responders to cope include:
- Reaching out to trusted individuals for support, companionship
- Contacting an Employee Assistance Program (EAP) for coping resources and referrals (this can be done confidentially and anonymously)
- Making sure staff/volunteers take scheduled breaks during responses and are provided relief with food, rest, etc.
- Practicing and engaging in spiritual/religious rituals and activities
- Following health and fitness routines, even during breaks in shifts or during deployments; modifying routines for time and location as needed, but always working to get in time for health, fitness and relaxation when possible
- Engaging in healthy coping year-round, to increase one’s resilience and ability to bounce back after particularly stressful or strenuous responses/deployments

For additional tips for Coping with Stress, visit Mental Health America’s Stress: Coping with Everyday Problems at www.mentalhealthamerica.net/conditions/stress-coping-everyday-problems. Sometimes, even when first responders try to practice healthy coping, or if any reason a responder feels that she/he is at risk for depression or other mental health concerns that go beyond coping, it’s important for them to talk to their supervisor or counselor. If officers feel they can’t handle the stress, a trusted healthcare provider, or reach out to a confidential 24/7 crisis/emotional service (see below).

How MHA-NYC Helps First Responders
MHA-NYC has a long history responding to natural and human-caused disasters. For over a decade, the organization and its programs and crisis hotline services have been at the center of the mental health response to many of this country’s greatest tragedies, including providing services for first responders.

The Gap from page 18

Superheroes from page 18

www.emergency.cdc.gov/mentalhealth/responders.asp.

Recognizing the Signs of Disaster Related Distress

Signs that a first responder may be experiencing distress vary person-to-person, but in general can include any one or more of the following:
- Isolation, withdrawal from family, friends or coworkers
- Difficulty concentrating or performing regular routines; faltering performance at work
- “Hyper-vigilance” at work or home
- Increased levels in energy, feeling like one has to keep constantly busy, may volunteer for more work/shifts
- Irritability, mood swings; lashing out at family, friends or coworkers
- “Compassion fatigue” – Doubting the purpose of work, feeling less sensitive to victims’ needs, etc.
- Relying on tobacco, drugs (incl. prescription and over the counter medications), or alcohol as a means to cope with stress
- Other symptoms that may indicate depression, substance abuse or suicidal or homicidal thoughts/behaviors

For more information on warning signs for depression, visit the National Institute of Mental Health Signs & Symptoms of Depression at www.nimh.nih.gov/health/topics/depression/index.shtml.

Tips for Coping with Stress
Like the warning signs of distress, tips for coping for first responders also don’t come in a ‘one size fits all’ package, so it’s important to think about what the unique strengths or personality traits of a person experiencing distress may be and go from there.

Disaster Distress Helpline: The Disaster Distress Helpline is the nation’s only crisis hotline dedicated to providing 24/7 counseling and emotional support. Call 1-800-985-5990 or text “TalkWithUs” to 66746; Spanish-speakers can text “Hablanos” to 66746) are confidential and answered by trained, caring counselors from a network of crisis centers across the country.

World Trade Center Health Program: The World Trade Center Health Program is a free health/mental health program that screens for access to benefits for responders, workers, and volunteers who helped with rescue, recovery, and cleanup at the World Trade Center and related sites in New York City on/after the 9/11 terrorist attacks, as well as for survivors who were working or residing in the disaster area. Call 1-203-594-9787 to learn more and to request an application.

How itHelp: Sandy Stress Relief
Sandy iHelp is a 24/7 online cognitive behavioral therapy (CBT) program that provides easy access to help for New York State residents who are suffering emotional distress as a result of Superstorm Sandy. All that is needed is access to the internet. Sandy iHelp CBT is evidence-based and effectively addresses the most common emotional difficulties that surface after a disaster including insomnia, depression, anxiety and substance misuse. Call 1 (866) 793-2765 or visit iHELPCBT.COM online to learn more and enroll.

iHelp: Sandy Stress Relief is particularly well suited to the needs of first responders who may be reluctant to seek help in traditional office based settings. It is confidential, secure and is available 24/7, anywhere in New York state residents who have experienced the storm, or those who presently suffer from PTSD, through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders (www.ptsd.va.gov/index.asp).

Recovery and Resilience

Just as first responders can experience distress, trauma and other mental health concerns, so too can they recover and even strengthen their emotional resilience over time with support from loved ones and coworkers, by practicing healthy coping and through accessing effective interventions. There is strength and courage in being the first on-scene and saving lives, and there is strength and courage in recognizing when you need help and then taking steps towards healing. After a disaster, emergency or other traumatic event, no one is ever alone— including responders.

Kathryn M. Salisbury, PhD, is Executive Vice President of Strategy and Business Development, Mental Health Association of New York City and Christian Burgess, LMHC, is the Director of the Disaster Distress Helpline at Mental Health Association of New York City/Link2Health Solutions, Inc.

The National Center for PTSD (www ptsd.va.gov/index.asp) offers resources on self-care and stress management, a listing of organizations working with disaster responders, links to webinar and podcast trainings, and a summary of available disaster behavioral health interventions (www.archive.samhsa.gov/dvec/ dibhs/dbhsp_responders_intro.asp).

Friends of Firefighters, is dedicated to addressing the physical and mental health, and wellness needs of New York City’s firefighters and their families with long-term support and services through confidential counseling, wellness services, and other assistance required by firefighters and their families (www.friendsoffirefighters.org).

SAMHSA Disaster Technical Assistance Center (DTAC): SAMHSA’s DTAC Disaster Responder information series offers resources on self-care and stress management, a listing of organizations working with disaster responders, links to webinar and podcast trainings, and a summary of available disaster behavioral health interventions (www.archive.samhsa.gov/dtac/dtac_responder_info.asp).

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We Are Now Accepting Articles and Advertising for Our Summer Issue

“Understanding & Addressing the Opioid Epidemic”

Early Submission Deadline: March 30th - Final Deadline Date: April 14th
NYU Honors from page 28

School since she came here, ensuring the legacy of NYU Silver and the high caliber of professionals entering the field. The School has become more inclusive and trains leaders that can serve all communities.

Major transformations at the School have come by way of research and scholarship growth, rising academic programs, diversity and a more global mindset.

Fighting from page 29

the number of psychiatrists at VA facilities. It was named for the Marine veteran activist who took his own life in 2011 after living with PTSD, an illness that affects more than 20% of service members nationally.

For military families navigating a mental health system where the demand for services outweighs supply, family members often feel as if they must stand in as mental health service providers and experts. This added responsibility can create fear, anger, and confusion for both family members and their loved one. To combat these stressors and be effective partners in the recovery of their loved ones, family members need both informational resources and a support network. At NAMI, we are addressing this need through our new NAMI Homefront program, an adaptation of the evidence-based NAMI Family-to-Family program, a general education program for family members of individuals living with a mental illness. For classes, we are focusing on PTSD, collaborative problem solving, and how to offer constructive support to a veteran.

Since 2008, we’ve worked with our local VA to support military families. Our NYC NAMI Homefront program started as one of 6 pilot programs in the country; the others are Illinois, Maryland, North Carolina, Ohio, and South Carolina. We pay special attention to meeting families where they are in terms of understanding the landscape of veterans’ mental health services and navigation. The resources are quite evident to them. In particular, we are dedicated to creating a supportive social community where family members feel that they have a voice not only in their loved one’s recovery but in their own self-care.

We have also been selected as a beneficiary of the “We Salute You” campaign, the focus of which is to increase the number of practitioners in the field of mental health services. NAMI Homefront does serve as an important component in the recovery process for military families.

As a nation, it’s imperative that we create an environment where veterans feel comfortable speaking up about their mental health without fear of judgment. Family members are a critical component in safety and are paramount. However, we must remember that in order for family members to be effective, they too need education about mental health resources and an active support community.

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See Page 39 or visit: www.mhnews.org

Trauma and Addiction from page 16

psychologist in the Veterans Affairs Healthcare System; clinical associate at McLean Hospital), Seeking Safety is an evidence-based counseling model that guides people to attain safety from trauma and substance abuse. It focuses on the present, meaning patients are not required to review any disturbing traumatic memories in their past.

The Seeking Safety philosophy incorporates both one-on-one counseling and group counseling. Intense group sessions with other trauma survivors can provide an environment especially conducive to opening up, connecting with others and healing.

Part of building safety is to detach from emotional pain, which is often called grounding. Grounding techniques can be mental, physical or soothing in nature. These techniques can be used when an individual has a painful memory or flashback and feels triggered to abuse drugs or alcohol, as well as in group therapy settings. For example, a therapy group may work on the mental technique of describing the room in which they are sitting in detail. A soothing technique may be to mindfully eat an ice cream cone and think about how it feels and tastes. An example of a physical technique is to go out for a walk or run, and again be mindful of how the activity engages the senses. By focusing on the present, the individual is distracted, and in 10 to 20 minutes, the memory and craving should pass.

Uniformed professionals with trauma backgrounds also tend not to recognize when they need help or understand how to ask for it. Counselors can provide guidance and strategies to patients on how to be aware of the need and ask for help from those who are trained.

Anger is another common trait in those with co-occurring addiction and PTSD. By exploring anger as a valid and inevitable feeling, patients see that anger can become constructive instead of always destructive.

In group therapy, patients are also guided to change their thinking through exercises that make them re-envision their future in a positive way. For example, a patient facing a job interview may be instructed to assume that it will go poorly and that rejection is inevitable. Using the recovery thinking technique, that same person changes the scenario by envisioning how he or she will prepare for the interview, get a good night’s sleep, make a genuine effort to connect with the interviewer and be proud of those actions regardless of the outcome.

Other challenges that uniformed professionals contend with throughout recovery include complex family dynamics, the accepted subculture of their professions, losing some control as they transition from a high-pressure work environment to the patient, learning how to normalize their responses to stressors and coping with death and dying. A well-balanced treatment program includes counseling and therapeutic activities for each of these topics.

The connection between addiction and trauma is not a new concept, but we now have a better understanding of how powerful it is and the potential to effectively treat it. To continue moving forward, addiction and mental health professionals should take advantage of opportunities to train in this integrated approach.

With the guidance of trained professionals, individuals struggling with both addiction and trauma can learn to be aware of trauma symptoms as well as to develop effective coping skills in order to live a more peaceful, sober life.

Robert Olinits, MS, CDC, is the Inpatient Counseling Coordinator at Marworth. William Poray, LCSW, CAC, is the Director of Clinical Operations at Marworth. Marworth Alcohol and Chemical Dependency Treatment Center is located in Waverly, Pennsylvania. Visit us online at www.marworth.org.

Mental Illness on page 29

care system works and how to bend those rules. (4) Appreciate that you are on more of a marathon than a sprint. Which means never, ever, giving up.

In the TEDx talk which you can watch at: (https://www.youtube.com/watch?v=NRO0-XuFMY), I talk about these four messages. I hope you will view the talk.

Dr. Sederer’s book for families who have a member with a mental illness, The Family Guide to Mental Health Care (Foreword by Glenn Close), is now available in paperback.

Dr. Sederer is a psychiatrist and public health physician. The views expressed here are entirely his own. He does not receive support from any pharmaceutical or device company. You can follow Dr. Sederer at www.askdrseder.com, and at www.twitter.com/askdrseder.

Treatment Choices on page 26

population. When the process of transitioning to civilian life is occurring, denial, hopelessness, loneliness, self-medication with alcohol and drugs, domestic violence, overcontrol of children and anxiety about the future are quite evident to them. In particular, we are dedicated to creating a supportive social community where family members feel that they have a voice not only in their loved one’s

There is a fear that medical records will be shared without the patient’s consent, that the individual is distracted, and in 10 to 20 minutes, the memory and craving should pass.

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Treatment Resistance

There is a fear that medical records will run careers, there is a low perceived need for treatment and a lack of confidence in the efficacy of mental health treatment due to such factors as cost, convenience, and being stigmatized by members of one’s unit (Espósito, et al., 2011; Gorman, 2010; and Hoge, 2004). Utility and safety are essential in building the treatment framework. There have been many treatment modalities that have worked in tandem with each other, including but not limited to: Restructuring (Carmen, 2009), Dialectical Behavior Therapy (Linehan, 2009), Mindfulness (Kabat-Zinn, 2003) and Mindfulness Based Stress Reduction (Kearney, et al., 2011) have been effective in the treatment of adolescents as well as adults. The innovative treatment strategies of self-acceptance, commitment, awareness, willingness to experience emotional distress and attention to the present can be extremely useful therapeutic tools (Chodnor, 2013). It is our privilege and obligation to pursue our goal of strengthening our military families (Petzel et al., 2014). Continuing to fulfill this clinical and research mission will enhance the functioning of our nation.
Awards Reception from page 6

Mayor’s Office of Jewish Community Affairs. Prior to his stint in government, Mr. Saperia was a public and private school teacher, administrator and gov-
ernment and community relations spe-
cialist for several agencies, including the
American Jewish Committee, the Ameri-
can Jewish Congress, where he directed its
MetroNew York Region and HIAS, the interna-
tional refugee and mig-
ration agency, where he was Associate
Executive Vice President.

Mr. Saperia has been active in
community organizations and Democratic
politics in the brownstone neighborhoods
of Brooklyn. A former Democratic Com-
mittee person from the 50th Assembly
District, he was a long time member of
the local Community Board and President
of The Carlton-Willoughby Block Associa-
tion. He serves on the Executive Com-
mittee and Board of Directors of the for-
mer Brooklyn AIDS Task Force
(Bridging Access to Care) in Brooklyn.

He is a past President and active member
of Congregation Kolot Chayaim, a pro-
gressive and inclusive Jewish congrega-
tion in Brooklyn.

He serves on the Board of Directors of
the Human Services Department of New
York City. He also serves on the
Community Mental Health Advisory Com-
mittee of Visiting Nurse Service of
New York. Phillip has been a member of
the Board of Directors of TCW, the news-
paper’s inception. He and
members of his staff at The Coalition are
featured in current and past issues of
Social Health News and Behavioral
Health News.

Ms. Saperia graduated with a B.A. in
Politics from Brandeis University. She
holds an M.A.T. from Harvard Univer-
sity’s Graduate School of Education
where he was elected to Phi Delta Kappa,
the National Honorary Education Society.

He is married to his life partner of 40
years, James R. Golden, and they live
together in their homes in Brooklyn and
Kingwood Township, New Jersey.

Peer-Led Programs from page 15

make the present and future better
than the past; learn to trust; take good care
of their body; get help from safe people;
heal fully from PTSD, and become sub-
stance-free — living by the adage that if
one method doesn’t work, try something else... and, never, never, give up.

Treatment Services from page 4

determine if the caller is a veteran or a
veteran’s friend or family member. Clini-
cians are trained to make referrals for treat-
ment with providers who have veteran-
specific programs in the state. The HOPE-
line is a confidential, toll-free, telephone
service help line available at 1-877-846-
7369 that people suffering from alcohol
abuse problems or substance use disorders
can call 24 hours a day, seven days a week
for access help. Family members can also
take advantage of this call-in line.

The Path Ahead:
Caring for Veterans with Alcoholism
And Substance Use Disorders

NYS OASAS remains committed to
supporting and fostering the development
of expanded services for veterans with
addiction disorders, promoting the use of
the effective treatment models and thera-
pies within those services, and ensuring the
ongoing clinical competence of its
workforce in working with veterans.

Future plans call for the development
of clinical guidelines for serving veterans
and the delivery of training in advanced topics relating to caring for trauma-
afflicted patients. NYS OASAS continues
to look for ways to continue to maximize its effectiveness in serving those in
New York state who have served in the mili-
tary and are now batting addiction.

For more information, contact
the NYS OASAS Veterans Program at vete-
rans@oasas.ny.gov, call 518-457-5005
or view the Veterans and Military section
on the NYS OASAS’s webpage: http://
www.oasas.ny.gov/treatment/veteran/
dex.cfm.

Art Therapy from page 24

Malchiodi & Spiegel, 2006; Johnson,
Lubin, James, & Hale, 1997; Loban,
2014; Morgan & Johnson, 1995). Litera-
ture in related fields also emphasizes
the development of symptoms and negli-
gence of effective treatment models and thera-
deal with the broader psychosocial impli-
cations of veteran readjustment. Readjust-
ment is impacted by postrans move stress;
however, resilience also can NYS OASAS
indicate in patients with PTSD.

Additional benefits are reinforced in
the gallery components of art therapy.
Gallery exhibits are much more than a
formal display of art work; public exhibi-
tion raises awareness and understanding
within the general public. Formal art
openings validate and legitimize the art-
work of veterans by bringing it into the
broader art community as well (Howells & Zelnik, 2009). The experience of
professionally displaying one’s own artwork
in a public venue can be particularly val-
dating for populations who feel marginal-
ized from the mainstream (Vick & Sexton-
Radek, 2011). As exhibiting artists, vet-
erans self-advocate and inform the public
of their experiences, externalizing and
making sense of their own perspective (Block, Harris, & Laing, 2011). Thus, the
gallery becomes another intervention to
decrease isolation and disconnection be-
tween the veteran and the broader civi-

Based on my experience working with
veterans in a community-based setting, I
have found that these particular app-
proaches to art therapy target treatment
for readjustment that are not addressed in
traditional individual and group therapy
settings. To further investigate the effec-
tiveness of the art therapy studio and gal-

Overall, veterans exhibit a wide range of
emotional and psychological challenges
that require a multidisciplinary approach
to treatment. In this respect, art therapy
has the potential to serve as an effective
adjunct to other therapeutic interventions.

A new art therapy program has been
launched at The Guidance Center of
Westchester in New York state. This pro-
gram is designed to help veterans with
post-traumatic stress disorder (PTSD) and
readjustment.

The program is based on the concept of
social connectedness, suggesting that
veterans who feel isolated and disconnected
from their communities may benefit from
participating in group art therapy. The pro-
gram is designed to provide a supportive
environment where veterans can connect
with others who have shared experiences
and challenges.

The program includes a series of
weekly workshops, each focusing on
a specific aspect of PTSD recovery. The
workshops cover topics such as:

- Understanding and managing trauma-related symptoms
- Developing coping strategies for anxiety and depression
- Enhancing self-esteem and self-worth
- Expressing emotions through creative expression
- Building social support networks

The program is led by experienced art
therapists who are trained in working with
veterans, with expertise in both trauma
and mental health. The therapists use a
range of creative techniques, including

- Art journaling
- Paint therapy
- Collage making
- Drawing and sketching
- Sculpting

These techniques are designed to help
veterans express their thoughts and feelings
in a safe and supportive environment.

In addition to the weekly workshops,
participants are encouraged to engage in
extracurricular activities, such as:

- Art therapy groups
- Creative writing clubs
- Music therapy sessions
- Tai chi and yoga classes

These activities provide opportunities
for veterans to connect with others who
understand their experiences and challenges.

The program is open to any veteran
who has experienced deployment-related
stress, including those with a diagnosis of
PTSD. The program is free to participants,
and all services are confidential.

To learn more about the program,
contact The Guidance Center of Westchester
at 914-946-4000. The center is located at
165 Tappan Road, Purchase, New York.

Jennifer DeLucia is a Doctoral Can-
didate at Mount Mary University. The Vet-
erans Outreach Center is located in
Rochester, New York.
Coming Home from page 28

their presentation. Despite their sound base and application, these models are only part of the clinical program that needs to be offered. Wellness and resiliency interventions that are proven in literacy and experience to assist veterans to manage the psychological, cognitive, and emotional dysregulations related to both substance misuse and traumatic exposure alone are necessary to bear to empower individual to manage their inner experience in a more effective, safer way. Mindfulness practice, yoga, acupuncture, and body-based somatic interventions provided in unison with the recovery approaches above enhance recovery and allow veterans to undue the lasting effects of what they have seen and what they have done. Having the capacity to address existential angst and moral injury related to both addiction and combat/military experiences, as well as identity and role issues related to service and reintegration, allow a program to address the wide range of pressures and challenges that may inform one substance use disorder. Formal and informal access to Chaplaincy and to military and civilian, can also be another avenue for exploration of these higher-level concerns.

Pillar Four: Incorporation of veteran-specific peer support and community reintegration: For many service members and veterans struggling with the crisis of addiction and posttraumatic stress, or reintegrating home from deployment, a sense of separation, alienation, and isolation can set in. Family, friends, peers- even society as a whole- can be experienced as not understanding and not supportive. Creating spaces where veterans can begin to relate to and connect with one another is a crucial aspect of recovery. Assisting those in recovery develop “sober social supports” is a goal of most programs; programs that work with veterans must try and take this one step further a provide peer-to-peer opportunities for sharing, for understanding, and for support.

Of particular benefit are programs that allow for intergenerational veteran peer support; a Vietnam combat veteran who has found the road to recovery from posttraumatic stress and addiction has a unique perspective and frame of understanding to pass on to our younger generation of OEF/OIF veterans. The universalities of brotherhood and esprit de corps crosses all generations of veterans, and allowing this to unfold in both clinical groups and less-formal shared spaces can facilitate recovery and growth for all.

Pillar Five: Family Focused Interventions: When an individual joins the military, their entire family moves in. The service and sacrifices of our Nation’s military is carried squarely on the backs of our military families, and when a service member is suffering from acute behavioral health issues, the family suffers as well. Many family members of wounded warriors are tired from being in a caretaking role, are confused and do not know how to help, or fear that their family members is truly suffering from or dealing with, and are in need to support themselves as they try to keep their familiess intact. Finding ways to have families become an active part of the treatment of their service member, and ways to provide education and support to family members so that they and the entire family is more resilient, is truly necessary to maximize inpatient and outpatient treatment gains. Outside of military service and sacrifice, addiction is also best understood in the context of family, and it is best treated in a program that can educate the family about the disease of addiction and the parts each can play in lasting recovery for our veterans.

Pillar Six: Introduction of Experiential Modalities into the treatment model for veterans: There are many pathways to recovery for veterans, and not all are based in verbal and skills-building inter-ventions. Allowing the use of experiential, and non-verbal modes of therapy and expression benefit our veterans by offering them unique opportunities to engage with each other, to make meaning out of their experiences, and to integrate split-off traumatic memory traces (e.g. affect states, body sensations, image fragments, etc) back into declarative, narrative memory networks so that they are more in the volitional control of the service member and carry less intensity over time. Expressive art therapy is a perfect example of a modality that “taps” into stored experiences, the family’s conscious (i.e., verbally-mediated) yet drives unrest, pain, and addiction. The use of metaphor can allow a veteran to capture in symbolic terms the essence of their life experience and thought, using this as a springboard for healing and recovery. Symbolic work around the nature of addiction itself has been proven effective in promoting increased motivation for treatment, shifts in perceptions of self and the use of substances, and positive outcomes (Collie, Backos, Malchiodi, & Spiegel, 2006). Art therapy for Combat-related PTSD: Recommendations for research and practice. Art Therapy: Journal of the American Art Therapy Association, 23, 157-164.


For more information about MHA’s Vet2Vet Program, contact the Vet2Vet Coordinator at (845) 342-2400 Ext. 237 or find the Vet2Vet of Orange County on the internet at www.mhaorangeny.com/pg/vet2vethp.html.
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