Understanding and Finding Family Mental Health Services

My Aunt and Me:
Implications for Geriatric Mental Health Policy

By Michael B. Friedman, LMSW
Director of the Center for Policy and Advocacy of the MHA’s of New York City and Westchester, and Chairperson of the Geriatric Mental Health Alliance

The theme of this issue of Mental Health News—family mental health—got me thinking about struggles with mental illness in my own family and particularly about my aunt and me. We had quite a time of it after she became seriously mentally ill in her early ’70s, and I think what we went through a decade ago unfortunately illustrates problems meeting the needs of older adults with mental disorders and their families today.

My aunt lived a life she enjoyed until she was about 70. She worked until 62; she never married, but she had friends with whom she went to shows, concerts, and restaurants. They sometimes stayed in and played Scrabble or canasta. She played the piano well enough to please herself. She liked a whiskey from time to time and played the piano well enough to please herself. She liked a whiskey from time to time. At 70 her mother—with whom she had lived most of her life—died. Her life began to unravel. She started to depend on me and a cousin to take care of day-to-day problems. After a few years both of us moved away. She had her first psychotic break—in mobilizing fear. She recovered quickly. But over time the psychotic episodes became more frequent. I went with her on many ambulance rides to the synagogue. Once a month didn’t make a dent. And it was charity, not a real human relationship. I should have spent more time with her, but I worked 12 hours a day, had a family, and lived more than an hour away. Over time I burned out. None of the help givers involved with her noticed. No one suggested that I should get help. Eventually I agreed with her doctor and the social workers at the hospital that she had to be in a nursing home. She lived five more years in a state of indignity and with few people to talk with except the people paid to care for her. They were very kind, like warm, nurturing parents with their child. She died in their care while I was out of town visiting colleges with my daughter. They told me proudly that they had done all they could to revive her. I thanked them and didn’t mention the Do Not Resuscitate Order written in huge letters on the front page of her chart.

I tell this story because I think it illustrates some of the major facts about older people living with severe mental illness. And the therapist knew nothing of cognitive-behavior therapy, which would have focused on getting her to go out of her apartment, to do something, to reclaim her life. I arranged for a friendly visitor from the synagogue. Once a month didn’t make a dent. And it was charity, not a real human relationship. I should have spent more time with her, but I worked 12 hours a day, had a family, and lived more than an hour away. Over time I burned out. None of the help givers involved with her noticed. No one suggested that I should get help. Eventually I agreed with her doctor and the social workers at the hospital that she had to be in a nursing home. She lived five more years in a state of indignity and with few people to talk with except the people paid to care for her. They were very kind, like warm, nurturing parents with their child. She died in their care while I was out of town visiting colleges with my daughter. They told me proudly that they had done all they could to revive her. I thanked them and didn’t mention the Do Not Resuscitate Order written in huge letters on the front page of her chart.

I tell this story because I think it illustrates some of the major facts about older people living with severe mental illness.

1) Mary have had good lives. I think those of us who try to help too often forget that the sad, old person in front of us once led a good life—and might have the potential to lead it again.

2) Losses of family, friends, and work can have a devastating impact on people. Life as one knows it is gone. Shaping a new life is incredibly difficult for some people.

3) Mental illness is major contributor to social isolation, and isolation and inactivity fuel mental illness. People become depressed, lose interest in the things that used to give their lives meaning and pleasure. They lose hope. They become anxious, convinced that no one wants to be with them, fearful of the streets, of crowded places. People become suspicious and distrustful; some develop full-blown paranoia.

4) It is difficult for people to get treatment. Few home-based services are available for people who are not comfortable speaking in English. American professionals are frequently not skilled at engaging people from ethnic and racial minorities.

5) Because I knew my way around they system, access was not a major problem for my aunt, but poor quality of treatment was. She might have benefited from one of the forms of evidence-based treatment for depression, but the mobile mental health service I found for her sent a well-meaning person with out-of-date clinical skills. In addition, my aunt relied more on her primary care physician, whom she had known for years, than on the psychiatrist who would visit from time to time, but was a stranger. I tried to pass information back and forth between them, but as far as I know, they never talked with each other.

6) It is also striking that the home health aides who lived with my aunt much of the time did not have a glimmer how to deal with her psychotic episodes. These women were among the most caring people I have ever met in my life, but they were not prepared. They didn’t even know when they had to call for help, couldn’t recognize the psychotic episode as it began.

7) For my aunt, an alternative level of housing—something between staying in isolation at home and being placed with people with whom she could not communicate in a nursing home—might have helped. We need housing alternatives that can help people who have become socially isolated to develop social connections that are meaningful to them.

8) For my aunt being treated with the dignity owed a mature person rather than with a patronizing semblance of respect could have been very helpful. Once, for example, I visited her at the nursing home shortly after Halloween. A very young rehabilitation specialist proudly showed me a photo of my aunt—who looked very glum—dressed as a pumpkin. A nice idea for a child. For a depressed woman who had once been a competent adult? I don’t think so.

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Summer 2008 Issue: “Employment for People With Mental Illness”
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Fall 2008 Issue: “The Interrelationship Between Physical & Mental Health”
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Winter 2009 Issue: “Understanding & Treating Posttraumatic Stress Disorder”
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Staff Writer
Mental Health News

This October the American Association for Psychosocial Rehabilitation held its Fourteenth Annual United Nations Awards Luncheon. At the event Mental Health News was presented with the organization’s Media Award. In accepting the award Mental Health News Founder and Executive Director Ira H. Minot, LMSW praised the leaders of the mental health community saying, “Mental Health News owes its success to the men and women who are on the front lines caring for people with mental illness each and every day. This award is a tribute to all of these incredible and hard working people.” Dr. Peter Campanelli, President and CEO of the Institute for Community Living, and Chairman of the Mental Health News Board of Directors said, “We are very proud to be receiving this award which is a tribute to Ira Minot’s vision and tireless efforts to bring vital mental health education to the community.”

Other honorees at the event included Michael Hogan, Commissioner of the NYS Office of Mental Health, Assemblyman Peter Rivera, Chairman of the NYS Assembly Standing Committee on Mental Health, The Bronx Mental Health Court, and Deng Pufang, Chairman of the China Disabled Persons Federation.

see Awards Luncheon on page 26

Spotlight on The News at Mental Health News

Autism Spectrum News Project Moves Closer To Becoming A Reality

Staff Writer
Mental Health News

The past several months have seen a flurry of activity and excitement at the offices of Mental Health News. The mental health education organization is embarking on a new project to bring its award-winning newspaper format to the autism community. The new publication will be called Autism Spectrum News, and members of the autism community are abuzz over the project.

Judy Omidvaran, a parent advocate from the Westchester County autism community remarked, “We are really excited that Autism Spectrum News is now in development. It will provide us with a free, readily available and vital resource for news, education, advocacy and resources about autism spectrum disorders and issues of vital concern to our community.”

Heading up the drive to launch Autism Spectrum News is David H. Minot, BA, Associate Director of Mental Health News. According to Minot, “We have taken our plan for Autism Spectrum News directly to the community. We have been attending conferences, meeting with parent advocates, and autism organizations to get everyone’s input and blessings on the project.”

How have members of the autism community reacted to the project? “Everyone has been incredibly interested and supportive of the new project and appreciate us coming to them for advice.”

see Becoming A Reality on page 30

From The Publisher

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

The theme of this issue of Mental Health News is “Understanding and Finding Family Mental Health Services.” I want to thank all of our sponsoring agencies and other contributors for their help in providing our readers with the information and resources that are so vital for us to understand this important part of the mental health care system.

As someone who survived a ten-year battle with depression, I understand the impact that a mental illness can have on the ill person, their family, friends and other interpersonal relationships. The pain and heartbreak is felt by everyone and a great deal of support is needed to help the ill person and those who care for them.

There is great deal of support available to all from the programs and services found in the mental health community. In the pages of this issue you will read about some of these vital programs and services. People with mental illness and those who care for them need to realize that people do recover from mental illness and can again become meaningful members of the community. However, the road to recovery can be a difficult one, but one that need not be traveled alone. Many communities are fortunate to have a chapter of The National Alliance on Mental Illness (NAMI) and a regional affiliate of the Mental Health Association (MHA).

At Annual United Nations Awards Luncheon, the Westchester County autism community is abuzz over the project.

David H. Minot, BA

Ira Minot, Peter Campanelli and Commissioner Michael Hogan

Ira Minot, Assemblyman Peter Rivera and David Minot

NAMI, parents may find invaluable support from other parents who have struggled with their own child’s mental illness. The MHA is a place where you can find programs and services related to most mental health issues and to learn about other services that are available in the community.

When an mental illness strikes it is so important for everyone involved to have the right and as much information about the disease and its many twists and turns as possible. Like other serious illness, mental illness is nobody’s fault, but rather caused by a chemical imbalance in the brain that can be addressed with treatment. Sometimes the course of treatment can be slow and frustrating, so it is incumbent upon the person with mental illness and their loved ones to be as patient as possible. Scientific research is constantly unlocking new mysteries to the causes of mental illness and every day progress is being made toward a brighter tomorrow.

Some of the things we can all do right now is to continue to learn about the harmful effects of stigma towards people with mental illness and to speak out against it. The other thing we can all do is support our mental health community. More funding for programs and services in communities everywhere is needed.

Ira Minot, Peter Campanelli and Deng Pufang, Chairman of the China Disabled Persons Federation.
An Exciting New Newspaper
From The Publishers of Mental Health News & Salud Mental
Is Now in The Exploratory Stage of Development

The mission of Autism Spectrum News will be to provide a readily available and up-to-date source of News, Information, Education, Advocacy and Resources about Autism Spectrum Disorders and the Autism Community.

Our primary audience will be parents, families, and individuals whose lives are directly impacted by autism spectrum disorders. Our secondary audience will include, treatment professionals, provider agencies, educators, and legislative decision makers.

Your input will help us determine how to best serve the autism community. Please send us your comments and ideas in the questionnaire below.

Your input and ideas are vital to our project’s success - we thank you for your help!!
Cut out and mail to: Mental Health News, 16 Cascade Drive, Effort, PA 18330, or E-mail your responses to: mhnmail@aol.com

| YES I am interested in the Autism Spectrum News project: please contact me. |
|---|---|---|
| Name________________________________________ | Telephone___________________________________ |
| Address______________________________________ | E-mail______________________________________ |
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| Reason for Interest__________________________________________________________________________ |
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I can be helpful to the Autism Spectrum News project in the following areas:

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Open Access: for the patients, for the people

All too often, people who depend on public assistance are denied access to newer, safer, and more effective treatments for mental illness. This inability to obtain the treatment they need can trigger a pattern of deterioration — becoming unemployed, being hospitalized, imprisoned, and often ending up homeless. This destructive cycle is costly for taxpayers and devastating to the families of people with mental illness.

That’s why Eli Lilly and Company continues to support open and unrestricted access to all available treatments for mental illness.

Scientific advances have resulted in medications that are effective in delaying relapse¹, provide more effective symptom control, fewer side effects, and offer longer-term treatment than in the past.

Give them access to the treatments they need, and give them hope for taking their lives back.


Lilly
Answers That Matter.
On an average day, nearly 1.2 million teenagers smoked cigarettes, 631,000 drank alcohol, 586,000 used marijuana, according to the latest data, in a first-of-a-kind report from the Substance Abuse and Mental Health Services Administration (SAMHSA).

The report, which highlights the substance abuse behavior and addiction treatment activities that occur among adolescents on an average day, draws on national surveys conducted and analyzed by SAMHSA’s Office of Applied Studies.

The report, A Day in the Life of American Adolescents: Substance Use Facts, presents a stark picture of the daily toll substance abuse takes on America’s young.

Among the report’s major findings is that on any given day during 2006 nearly 1.2 million adolescents ages 12 to 17 smoked cigarettes, 631,000 drank alcohol, 586,000 used marijuana. In addition, each day nearly 50,000 adolescents used inhalants, 27,000 used hallucinogens, 13,000 used cocaine and 3,800 used heroin.

To provide some perspective on these figures, the nationwide number of adolescents using marijuana on an average day equals more than half the total number of students enrolled in New York City’s public school system during the 2006-07 school year.

“While other studies have shown that significant progress has been made in lowering the levels of substance abuse among young people in the last few years, this report shows many young people are still engaging in risky behavior,” said SAMHSA Administrator Terry Cline, Ph.D.

Cline spoke at the Double Jeopardy CASACONFERENCE on co-occurring substance abuse and mental health disorder in young people at The National Center on Addiction and Substance Abuse at Columbia University.

“By breaking down the day and analyzing it on a day-to-day basis, we gain a fresh perspective on how deeply substance abuse pervades the lives of many young people and their families,” Cline said.

The report also sheds light on how many adolescents ages 12 to 17 used illegal substances for the first time. On an average day in 2006:

- Nearly 8,000 adolescents drank alcohol for the first time;
- Approximately 4,300 adolescents used an illicit drug for the first time;
- Around 4,000 adolescents smoked cigarettes for the first time;
- Nearly 3,600 adolescents used marijuana for the first time; and
- Approximately 2,500 adolescents abused pain relievers for the first time.

The report also analyzes the most recent available data to indicate how many people under age 18 were receiving treatment for a substance abuse problem during an average day in 2005. These numbers included:

- Over 76,000 in outpatient treatment,
- More than 10,000 in non-hospital residential treatment, and
- Over 1,000 in hospital inpatient treatment.

This report was drawn from SAMHSA’s National Survey on Drug Use and Health, Treatment Episode Data Set and the National Survey of Substance Abuse...
Sometimes you can’t go it alone...

When someone suffers from depression or a problem with drugs or alcohol, taking the first step toward feeling better can be the toughest part. For more than 125 years, St. Vincent’s Westchester has provided compassionate care for many thousands of people dealing with mental health and chemical dependency problems. The hospital offers a complete range of behavioral health services, including:

- 24/7 walk-in evaluation service
- Individual, group and family therapy
- Partial hospital and day treatment services
- Inpatient mental health services and a chemical dependency rehabilitation program
- Specialized services for women, older adults, children and adolescents, and Latinos

Call (914) 925-5320 for more information, or visit www.svcmc.org.

Winner of the 2004 Pinnacle Award for Quality Improvement from the Healthcare Association of New York State.

Setting the Standard for Behavioral Health Services

St. Vincent’s Hospital Westchester

275 North Street  Harrison, New York 10528
Each fall the Congress debates whether the automatically mandated changes in the Medicare Part B fee schedule (MFS) will take effect or be altered. Medicare Part B services are those provided by physicians, including psychiatrists, as well as other healthcare professionals, including psychologists and social workers. Physicians, in an effort to seek remuneration and be competitive with other healthcare providers in attempt to influence the legislative outcome. The debate is informed by the advice of the Medicare Payment Advisory Commission (MedPac), an independent federal advisory body, which provides analysis of the arcane elements of the Medicare reimbursement methodology and makes recommendations to the Congress. Much rides on the outcome.

The question at hand is why the readers of this column, which includes persons receiving mental health care, their families and other interested parties, should be as concerned with the outcome of this annual Congressional exercise in fee setting as much as the members of the New York State Psychiatric Association, the organization which sponsors this column? The answer is that many of the readers who are insured by the Medicare program are rightfully concerned about having adequate access to psychiatrists and other mental health professionals in the years to come. The potentially impacted groups include the aged and those under 65 years of age with disabilities, including those suffering with serious and persistent mental illness.

Other reasons for concern include the nationally recognized need for geriatricians and geriatric psychiatrists at a time when the population is rapidly aging with the enrollment in Medicare of the “baby boom” generation rapidly approaching. Demographic data and projections make the trend clear. In 2005, 12.4% of the population was over 65 years of age. That percentage is expected to increase to 20% by 2025 and even then will not have reached its peak. The percentage of the old, is also expected to rise dramatically. This data explains the basis of the call for national political and healthcare leaders, including psychiatrists, with specialty training in the care of this population with its special needs.

Why raise this issue at this time? The matter is now of great concern because without Congressional legislation it is anticipated that, based on what is acknowledged to be the flawed “Sustainable Growth Rate” (SGR) methodology, there will be a 9.9% decrease in funds available for Medicare Part B services in 2008 and a further 5% reduction is predicted for 2009. Indeed, from 2006 to 2007 Medicare reimbursement for psychiatric services decreased by an average of 5% in a year when total Medicare Part B expenditures were held essentially constant due to a legislatively mandated shift of resources away from the service codes used by psychiatrists. As readers may be aware, based on 1989 and 1994 legislation, Medicare annually sets the fees which both participating and non-participating physicians may charge. NYS further limits the amount non-participating providers may charge. Thus, at a time when the cost of practicing is rapidly accelerating, as evidenced by the Medicare Economic Index (MEI), which reflects the cost of malpractice, rents, labor and other practice related costs, physicians practicing within Medicare are facing large reductions in fees. For example, liability insurance rates climbed an astounding 13% this year in New York State which prompted Governor Spitzer to create a Blue Ribbon Commission to study the problem which is rapidly becoming a crisis in our state. Even if Congress passes major Medicare legislation in 2007 that updates physician fees and the draconian reductions are postponed, the increases in fees will be only 0.5% in each of the next 2 years. It is hoped by those sponsoring the legislation that the methodology can be “fixed” during those 2 years. With either 2 years of cuts or minuscule increases, the calculus of the cost of practice may lead some or many physicians, including psychiatrists, to “opt out” of the system. While many practitioners say they will opt out of the system or stop accepting new Medicare patients, it is difficult to obtain reliable data on their actual practice decisions. Interestingly, it is known that psychiatrists more than physicians in any other field have felt compelled to “opt out” of Medicare. A 1981 study demonstrated that psychiatric participation in Medicaid was directly correlated with reimbursement, albeit modest, as long as it was reasonable. The same can be expected of decisions regarding the inclusion of Medicare enrollees in practices today. What is certain is that the threat of rate cuts or flat fees has discouraged medical students from pursuing specialties in geriatrics and fellowships in geriatric psychiatry have chronic problems in filling their slots. The fill rate for fellowships in geriatric psychiatry declined to 61% in the years 2001-2002 from 84% during 1999-2000. While there may be interest, the decision to seek more lucrative specialties is understandable when one considers the debt load of graduating medical students. Eighty-six percent of graduates carry significant debt with 41% carrying debt of more than $150,000. With that burden, choosing a specialty like geriatric psychiatry whose practitioners are among the lowest paid is a difficult one. Gone are the days when there was an articulated goal of shoring up reimbursement for so called “cognitive specialties”, such as psychiatry, internal medicine including geriatric medicine, and other lower paid specialties whose practice revenue is not contingent on performing well remunerated procedures. Indeed, one might say that at this time Medicare reimbursement provides a clear disincentive rather than a seduction for those considering training in the needed specialty of geriatric psychiatry.

If we are serious about this situation and remediating it so that broad access is preserved and needed medical manpower trained in the necessary fields of geriatric medicine and psychiatry are available when they will be needed, we must start to take action now. Groups advocating for the elderly and for those with serious mental illness must advocate for the passage of Medicare legislation to avoid damaging physician fee reductions and then raise these broader concerns about the issues identified in this piece with their members of Congress. Once the problem has been identified for legislators and other opinion shapers, advocacy must be turned to finding solutions such that young physicians will be able to pursue their interest in these fields and not be forced by an economic calculus to preferentially choose procedure based specialties. First among the solutions will be identifying a fair alternate to the “SGR” methodology which includes enhancements for the “cognitive” specialties. Working together, medical and psychiatric professional associations and organizations speaking for the needs of the elderly and those with serious mental illness can begin to shape the debate and make a tangible difference.

Dr. Perlman is the Chair of the Committee on Legislation and Immediate Past President and Mr. Stein is the Executive Director and General Counsel, New York State Psychiatric Association.
By Donald M. Fitch, MS
Executive Director
Center for Career Freedom

The Economics of Recovery:
The Homeless of Westchester County: Trapped in The System

A t the urging of those of our students who reside in Westchester’s Homeless Drop-In/Shelter System, the Center initiated a survey this past summer of some sixty single adult residents, and twenty-three one-to-one in-depth interviews of local County and NYC Providers, Advocates, Government Agency Administrators, Business/Real Estate Executives and Home Owners.

Our objectives were to quantify how effective the counties and providers’ social services were in helping the homeless become self-sufficient again. By way of comparison, New York City’s Department of Homeless Services Model Program was included in the study.

The interviews yielded well rounded perspectives from Providers, Consumers and Regulators which enabled us to create the flow chart below; “Recovery in a Cycle of Homelessness.”

Beginning with the loss of permanent housing, we found the homeless person is initially confronted with three options: jail, the hospital or the streets. In Westchester County, of the estimated three-hundred fifty-cots adult homeless, about half chose not to “cooperate” i.e. refuse to be assessed or to accept psychiatric or medical treatment.

These people are offered “three hot and a cot, no questions asked” at a Drop-In. They are our highest risk and least served population. (Incredibly, beginning 11/1/07, the County plans to replace some one-hundred fifty cots with chairs “to encourage the population.” (Incredibly, beginning 11/1/07, the County plans to replace some one-hundred fifty cots with chairs “to encourage the population.”

In spite of the millions spent for Social Service programs for the homeless, we found some three-quarters asking for help with psychiatric counseling. Service programs for the homeless, we found some three-quarters asking for help with psychiatric counseling.

The study also found half of Westchester’s homeless take prescription medications for psychiatric diagnoses including Seroquel, Depakote, Risperdal, Zyprexa, Abilify, Klonopin, Thorazine, Haldol and Trazadone.

Shelter residents who don’t cooperate with the rules or are sanctioned for “bad behavior” are returned to the Drop-In and the streets.

The Homeless of Westchester County: Trapped in The System

In/Shelter System, the Center’s Homeless Drop-In/Shelter System is three years. At a total per person cost of about one-hundred fifty thousand dollars, the cost for all three hundred homeless persons in Westchester County is about forty-five million dollars.

For Westchester’s Drop-In/Shelter care is about fifty-thousand dollars per year per person. Our study also found the average length of stay in the County’s Drop-In/Shelter System is three years. At a total per person cost of about one-hundred fifty thousand dollars, the cost for all three hundred homeless persons in Westchester County is about forty-five million dollars.

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In Westchester, the hospital or the streets.

Because most of the Drop-Ins and Shelters are closed during the day, residents spend their days “walking around” (62%), “at the library” (52%), “in program” (40%), or “at the park” (30%).

About one-third say they pan handle.

In winter and summer, we hang out in the library and read the newspapers and magazines or go to the Food Court at the Galleria where you can use the bathrooms. The Security Guards chase you out after a few hours. In nice weather, we sit in the parks and by the fountain.”

“Some just ride the bus; it is comfortable, you can bring your stuff, no one bothers you. You ‘B.S.’ your Case Manager to get a MetroCard – tell them you have a court date or have to go to a relatives’ funeral – you save $38./Mo (1/2 fare).”

Pan Handle – to buy liquor: For $4 I can get a bottle of Devil Springs Vodka – it lasts all day.”

Another question we asked was “how do you survive on $1.50 a day?”

“Pick cans on trash days – you can make about $30/day plus collectables if you are lucky. I sell the stuff to antique dealers.”

“Dumprster diving at schools can get you stuff when the maintenance guys clean out kid’s lockers; knapacks, sneakex, CD’s and sport equipment, clothes.”

“Caddying: $150. a loop plus tips – you can get $300-$400/day cash.”

“Take opinion polls at the Mall – they will pay $5 to $25.” “A few of the women do tricks.”

“Some go do odd jobs; painting, handyman stuff – but you better not get caught.”

“Benefits counseling.”

“Addiction counseling” or “health care and medical treatment.”

Nine out of ten residents were “definitely interested” in getting assistance in obtaining a Photo ID, Birth Certificate and Social Security Card. Without these documents, they cannot file applications for permanent housing in the community.

They feel, and effectively are, trapped in the system.

By comparison, the homeless in New York City’s Department of Housing Services (DHS) program stay an average of three months at a cost of less than five thousand dollars per person.

DHS achieves these remarkable numbers through an aggressive outreach program, performance based contracts, weekly on-site shelter supervision, daily census data, daytime service access and a rental assistance program which prevents housing evictions from happening in the first place.

Under Mayor Michael Bloomberg, DHS’ leaders have transformed how New York City copes with their homeless. Hopefully, Westchester will be able to learn from their success. □
The Teacher's Role

Teachers in all three ISP settings (elementary, middle and high school) maintain an ongoing dialogue with parents to keep them informed on the student’s academic and behavioral progress. Communication may take place through logs that are used to develop regular means of providing information for parents. Parents receive written information several times each week on their son/daughter’s achievements and problem areas or special issues that are affecting the student. Teachers also will phone parents as needed and will arrange for conferences where achievement and other issues can be discussed. Parents are encouraged to be actively involved in overseeing students’ completion of homework. Parents are asked to sign school behavior sheets so they have an awareness of the student’s day-by-day behavior.

Some classroom teachers use behavioral target sheets and other working documents to provide parents with continuous information on their son/daughter’s academic and behavioral progress. Classroom teachers and social workers meet briefly throughout each day to exchange necessary information that can impact a student’s school and family life so that the teacher is always informed about special circumstances that can influence a student’s performance.

At all three program settings, parents are encouraged to become part of the school’s PTA demonstrating to students the parents’ support for their education.

The Social Worker’s Role

Social Workers employed by NSC&FGC, are members of the collaborative program staff in all three settings where the program is provided. They maintain ongoing contact with parents to provide general information, discuss program issues that may arise during the year, and provide support for families. Social workers also discuss individual students with their parents.

Social workers provide family therapy for students and their parents on a regular basis. Social workers form parenting groups for the parents/caregivers of students. The parents groups are psycho-educational that provide information (e.g. about medication or parenting skills) and support. Social workers also are in regular phone contact with parents to provide information on students’ achievements and difficulties. Social workers collaborate with families and the program staff in developing home behavior plans for students.

Parent Meetings

Meetings between ISP staff and parents ensure a consistency between the intensive support program and the home environment. The frequent interaction of classroom teacher and social workers, and vocational counselors in the high school, provides them with additional information about school progress and school environment. This also contributes to the effectiveness of the parents/family meetings.

Parent groups also offer an orientation to the program, information about problems and their origin, recognition of effects on caregivers, and psycho-educational material that will assist parents in supporting their children. Parents also learn about complementary services that may be available for their son/daughter. Staff may recommend to parents that they explore community resources, such as youth groups for their sons/daughters. Staff also provides information on how to secure outside assistance, such as Supplemental Security Income (SSI).

Groups of parents that share the same stress can be an invaluable resource by contributing emotional support and reducing isolation. These groups can also offer parents an opportunity to find avenues that will allow them to influence the mental health needs of their children.

Vocational Rehabilitation Counselor’s Role

Vocational Rehabilitation Counselor’s work closely with parents to gain an understanding about the aspirations they have for their high school aged children, and to facilitate appropriate employment placements for them. Partnering with parents of children with serious emotional disturbances in the vocational arena is very delicate work. Parents’ hopes and dreams for their children do not always match with their children’s abilities. Children and youth with serious emotional disturbances don’t often appear, on the surface, to be limited. Translating to parents (and the youth themselves) how their children’s limitations are manifested and how their strengths are expressed is a vital role of vocational rehabilitation counselors in the ISP program.

Parent-Staff Interaction

Good lines of communication between staff and parents are the key to developing a working partnership. Just as mutual respect is important to developing the collaborative program’s central team, parents and staff understand that they must develop mutual respect for one another and they must work together in a cooperative effort to achieve a successful program for students.

In ISP, social workers, teachers, psychologists, and pupil personnel work on an ongoing basis with parents. Members of the staff regularly communicate with one another about their work with students so that they can offer parents a comprehensive view when they meet with them on an individual basis.

Parent-Staff Interaction

Guidance Center

By Andrew Malekoff, LCSW, CASAC
Executive Director and CEO
North Shore Child and Family Guidance Center

Since 1996 North Shore Child and Family Guidance Center (NSC&FGC) and Nassau BOCES have worked as partners in the development of a school-based mental health program that works with students (ages 5-22) and families from all 56 school districts in Nassau County. In the Nassau BOCES/NSC&FGC collaborative, known as the Intensive Support Program (ISP), parents are partners throughout the education of the students, their sons and daughters. A school-based mental health collaborative must not only have the cooperation of parents but must be sure that parents consider themselves members of the overall program team. Parent participation must be an integral part of the program design and implementation.

Partnership with Parents

In ISP a family centered, collaborative, strengths focused approach has been adopted. This means respecting and supporting parents, decreasing blaming the parents and increasing parent involvement. When a student is referred to ISP at any age level, parents are asked to make a commitment to participate in mental health services and educational program so that the best possible opportunities for success can be available to their sons or daughters. The goal is to achieve a working partnership between staff and parents. Parents are seen as part of the helping system.

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Since 1996 North Shore Child and Family Guidance Center (NSC&FGC) and Nassau BOCES have worked as partners in the development of a school-based mental health program that works with students (ages 5-22) and families from all 56 school districts in Nassau County. In the Nassau BOCES/NSC&FGC collaborative, known as the Intensive Support Program (ISP), parents are partners throughout the education of the students, their sons and daughters. A school-based mental health collaborative must not only have the cooperation of parents but must be sure that parents consider themselves members of the overall program team. Parent participation must be an integral part of the program design and implementation.

Partnership with Parents

In ISP a family centered, collaborative, strengths focused approach has been adopted. This means respecting and supporting parents, decreasing blaming the parents and increasing parent involvement. When a student is referred to ISP at any age level, parents are asked to make a commitment to participate in mental health services and educational program so that the best possible opportunities for success can be available to their sons or daughters. The goal is to achieve a working partnership between staff and parents. Parents are seen as part of the helping system.

Parent-Staff Interaction

Good lines of communication between staff and parents are the key to developing a working partnership. Just as mutual respect is important to developing the collaborative program’s central team, parents and staff understand that they must develop mutual respect for one another and they must work together in a cooperative effort to achieve a successful program for students.

In ISP, social workers, teachers, psychologists, and pupil personnel work on an ongoing basis with parents. Members of the staff regularly communicate with one another about their work with students so that they can offer parents a comprehensive view when they meet with them on an individual basis.
Emergency Medical Technician

By Colm James McCarthy

Every home contains dangerous, potentially poisonous chemicals. This also includes medications as well as non pharmaceutical agents such as household cleaners, paints and solvents. In 1998, the National Poison Data System reported that for children under 6 years old, 60% of all reported poison exposures involved non-pharmaceutical substances. The remaining 40% were due to over-the-counter and prescription medications. Just because medicine can be good for us does not mean it is danger free.

Poison prevention starts with the proper storage of all potentially dangerous chemicals and medications. Children cannot not be poisoned by agents they can not get to. All house hold chemicals including cleaning agents, paints, solvents for the home and car should be kept in a locked cabinet or drawer. If you are unsure if it is poisonous, lock it up. Children seem to be able to get into almost anything and put almost anything in their mouth. The younger the child, the worse this can be, so lock up everything.

Colm James McCarthy

Medication storage is more complicated. Medications must be readily available for those who need to use them, particularly if they taken daily.

see Prevent Poisoning on page 28

Take Your Medication Properly

By Richard H. McCarthy, MD, CM, PhD

Research Psychiatrist

I initially I was going to call this column, “How to take Medications,” but I realized that it would be a very short column indeed. All it would say is “Take your medications exactly as your doctor tells you to do so for as long as you are told to do so. Do not stop your medications, even if you feel better.” Since that is way too short, and way to directive, I thought that I should talk about why you should take your medications exactly as directed, for as long as you are directed.

Medications can only work if they get into the body and are present at a high enough concentration at the right place for a long enough period of time. While this also sounds simple and obvious, it is the reason why doctors order medications the way that they do. There “route” how and where a medication it gets into the body. All medications must get into the blood stream to get to where they need to be. They can be injected directly into the blood (known as intravenous) or they can get there indirectly by being swallowed, absorbed through the skin (this includes suppositories, patches, salves and medications that dissolve under the tongue), or by injection just under the skin or into the muscles. The route is chosen based on.

see Your Medication on page 28
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1 in 4 adults suffer from a diagnosable mental disorder in any given year.¹

Open access is especially important in the treatment of mental disorders because the response to therapy can vary greatly from individual to individual and from one medication to the next. Restrictions in the form of prior authorizations and preferred lists may have the unintended consequence of jeopardizing patient health while failing to reduce costs.

Open Access. Because different people have different needs.

Bristol-Myers Squibb supports open and unrestricted access to mental health medications. For people with mental illness, having access to newer and potentially more effective medications can be a crucial component of treatment.

SUPPORT OPEN ACCESS AND GIVE PROVIDERS THE FREEDOM TO FIND THE MOST APPROPRIATE MEDICATION FOR EACH INDIVIDUAL.

Creating a Culture Change: Implementing a Family Psychoeduction Program

By Ellen Stoller
F.E.G.S. Health and Human Services
System Behavioral Health Division

Not that long ago, the families of people who have a mental illness were often blamed for their loved ones’ problems. The staff of Continuing Day Treatment Programs did not look forward to family sessions or involvement—feeling that the families were difficult, chaotic, dysfunctional, confused and demanding. Families were often relieved to turn their relatives over to professionals because they couldn’t deal with the family member who was creating problems for everyone. Many staff mistakenly thought that clients had no family, or they had burned all their family alliances and “It was easier to work with the identified patient.”

Today we at F.E.G.S. use psychoeduction as a psychosocial intervention for families where one member has a diagnosis of schizophrenia or another major mental illness and co-occurring substance abuse. This means teaching families about the illness, devoid of blame, helping them learn how to reduce stressors and adopt problem-solving strategies in a group with others who have similar experiences. Based on Dr. William R. McFarlane’s groundbreaking work, our Family Psychoeduction Program was first instituted in three outpatient programs for adults with mental illness in 2003.

Some new initiatives make you look at yourself and your organization with new eyes. Family Psychoeduction did that for us.

Four years later, our three Family Psychoeduction programs, in Brooklyn, Queens and Suffolk County, are such an integral part of those programs that most people don’t remember a time when we didn’t see the family as part of the recovery process.

We were trained in Family Psychoed as part of a New York State Office of Mental Health initiative. The training was many days; the model was very strict, with lots of videos, manuals, guidelines, principles and rules. But with organization and commitment and support we jumped in with both feet.

“The family came into the multifamily group saying that for all the years their son Donald was in therapy no one had ever explained his illness to them. They rarely, if ever socialized, because of Donald’s illness. The other families in the group became their family too. They had two sons, Donald had schizophrenia, the other son, Thomas was diagnosed with cancer soon after the family had joined the group. Throughout the long months of Thomas’s battle with cancer the group witnessed the family’s sorrow, their hope, their pain and now their resilience. When this family faced having to bury their son the group stood by them and attended the funeral. We are now all struggling together with the stress Thomas’s death has put on Donald. Without the Multi-Family Group Donald and his parents would be struggling alone.”

Noemí Velazquez and Richard Renauro, co-leaders Suffolk PROS Multi-family Group

William McFarland’s original work with families took place when one family member was in the hospital. Families came to the hospital to see their relatives and doctors, so McFarland had a captive audience. Out-patient programs face very different obstacles. Ed Dunne, Ph.D., the consultant assigned to us by OMH for our implementation phase suggested we form a Family Psychoeduction Steering Committee comprised of managers and people who could “make decisions.” This emerged into the group that began to define the “barriers” to implementing Family Psychoed. I didn’t think there would be many barriers, because we generally have a “just do it” mentality. I was not banking on the many difficulties of offering services to families would stress our system, and not seeing all the nuances and shifts that needed to occur.

For starters, there was the issue of scheduling the joining sessions. We had already begun talking to clients differently about their families. We sent letters out to family members, we had family nights, we were making progress but now we had to phone the parents, adult children, spouses and significant others who might not be available to talk or return our calls during our typical 9-5 program hours. We were faced with the issue of staff needing to make some of these calls in the evening. Staff had concerns. “I don’t want to make these calls from home, everyone has caller ID and the family will have my
Chronic, Life-limiting Illness and End of Life: F·E·G·S’s Partners in Dignity

A Vital Resource for Families

By: Kathy Rosenthal, LCSW  
Vice President – Long Island Regional Operations, F·E·G·S Health and Human Services System, and  
Lori Hardoon, LCSW, Director,  
F·E·G·S Partners In Dignity Program

At 10 months of age, doctors diagnosed Benjamin with advanced neuroblastoma, a cancerous tumor in his abdomen. Benjamin’s parents were in shock, filled with despair and fear at a time that should have been full of joy for them and their four-year-old son. Three years of complex medical treatment protocols ultimately led to their son being currently cancer free, but the stress of negotiating that journey left the family in financial crisis and emotional turmoil.

At 24, Susan was two years out of college, living with her 87-year-old father who had been employed in a job that helped pay the household bills until he was diagnosed with advanced lung cancer and cardiac problems. Suddenly, Susan was sole caretaker and breadwinner, overwhelmed with the medical as well as financial and emotional issues.

A strong independent 60-year-old woman, the matriarch of her family and head of the family-owned business was suddenly diagnosed with a rare disease and died within eight weeks of falling ill. Through the disease’s rapid progression, the adult children were shocked at the fractured nature of the medical system. The biggest challenges are responding to the increasing complexity of the medical system. The biggest challenges are responding to the increasing complexity and disparate systems that deliver services to those with serious illness and end of life with a seamless continuum of services, including assistance navigating the healthcare system; advocacy, information and referral; entitlements/benefits counseling; individual, family, pastoral and bereavement counseling; volunteer services; community education; and emergency assistance. Since its inception in 2003, PID staff has served nearly 2,000 individuals ranging from 10 months to 98 years of age and facing various conditions, including advanced cancers and life-limiting and terminal illnesses. Among PID clients, approximately 5% have been children/adolescents up to age 17; 10% young adults ages 18-29; 35% adults ages 30-54; 35% older adults ages 55 to 75; and 15% adults older than 75. A majority of clients served by F·E·G·S’s Partners in Dignity program are coping with anxiety, depression, grief, PTSD, relationship problems and other issues that are clearly mental health concerns.

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see Partners in Dignity on page 30
Don’t let Bulimia take your child.
The NYU Child Study Center is dedicated to preventing, identifying, and treating psychiatric and learning disorders. We give children back their childhood. To learn more, please visit aboutourkids.org
New Anti-Bullying Initiative Opens Dialogue for Latino Families

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

T he Mental Health Association of New York City (MHA of NYC) is a key participant in helping to reduce bullying of Latino youth about their sexual orientation or sexual identity within New York City’s Latino communities. An anti-bullying outreach and education project, What Does Gay Mean?, is a city-wide effort to engage Latino parents in preventing anti-gay bullying to their children and to others. The need to reduce the amount of harassment and bullying of Lesbian, Gay, Bisexual and Transgender (LGBT) students in New York City is well-documented in In Harm’s Way: A Survey of Lesbian, Gay, Bisexual and Transgender Students Who Speak About Harassment and Discrimination in the New York City Schools, a report issued by Advocates for Children of New York. Nearly 20 percent of the youth who completed the survey reported being called offensive names because of their sexual orientation or gender identity, and 26 percent of them reported being physically threatened or hurt in school because of their sexual orientation or sexual identity.

A recent national study of Latino parents by Mental Health America revealed that, despite the fact that nearly all surveyed parents believed that sexual orientation information should come directly from them, 64 percent have not spoken to their children about the subject. It’s a troubling reality that is borne out by the study’s findings. Seventy percent of polled Latino parents are not prepared to discuss homosexuality with their children. And yet, more than 60 percent feel that it is important to teach their children that it is wrong to treat other people differently because they are gay.

LGBT youth who lack adequate support or who have no readily-apparent options to participate in positive lives of acceptance tend to adopt negative behavioral patterns that persist long after adolescence. The result is that they are at increased risk of developing serious mental health problems that include depression and suicide. The problem is exacerbated when LGBT youth are members of an ethnic and/or minority group. Latino teenagers, in particular, are under emotional and social stress within their family and ethnic community. Trying to “fit in” often forces Latino lesbian and gay adolescents to suppress the key aspect of their sexual identity.

Parent Education Workshops and Literature Promote LGBT Youth Mental Wellness and Reduce Anti-Gay Prejudice

The project enables the MHA of NYC to help New York City’s Latino communities reduce bullying due to sexual orientation or perception of youth as being gay or lesbian. MHA’s Coordinated Children’s Services Initiative (CCSI), a family programs service program for children who are affected by multiple city agencies – the courts, child welfare, and the school system, for instance – also provide care coordination services to LGBT youth and has established linkages to other community-based organizations that serve LGBT youth.

The campaign is targeted toward the Latino families and is supported by the Parent Resource Centers in Manhattan, Queens and the Bronx and CCSI. In addition, the program reaches out to Latino parents of LGBT youth served by the Bronx Community Pride Center and the Brooklyn Community Pride Center that host meetings of Families of Color, a Latino group of Parents, Families and Friends of Lesbians and Gays (PFLAG). Parent education workshops that are facilitated by Spanish-speaking counselors for Latino parents have been held in MHA’s Manhattan, Bronx and Queens Resource Centers. The workshops address issues related to bullying of gay youth and what being gay means in the context of a broader focus on bullying in school and on the Internet. Each workshop addresses how children are impacted by bullying; bullying of youth and children, youth who are perceived to be gay; how to talk with your child about what it means to be gay; what to do if your child has been a target of bullying; and; actions parents can take to help prevent their child from becoming a bully, and how to defend themselves against bullying.

Two workshops specifically designed for Latino parents of LGBT youth were offered at Bronx Community Pride and at the LGBT Community Center. These workshops focus more specifically on how parents can help their children who have been bullied because of sexual orientation and available protections offered to their children under New York City and State Law.

The “What Does Gay Mean? Initiative” will help to foster an environment of understanding and respect for all people, helping Latino parents communicate with their children early in life and in a responsible way to reduce anti-gay prejudice and bullying and promote mental wellness for LGBT youth.

For information on upcoming workshops and copies of the workshop materials, contact Monica Cuevas by e-mail at mcuevas@mhaofnyc.org or by phone at 212-786-6795.

Kathryn Salisbury and Angela Morav-Vargas of MHA of NYC’s Coordinated Children’s Services Initiative (CCSI) contributed this article.

Parent education workshops and copies of the workshop materials, contact Monica Cuevas by e-mail at mcuevas@mhaofnyc.org or by phone at 212-786-6795.

Kathryn Salisbury and Angela Morav-Vargas of MHA of NYC’s Coordinated Children’s Services Initiative (CCSI) contributed this article.

Culture Change from page 15

home number.” What to do? We brainstormed and decided to give two staff members agency cell phones so they could make calls from home. It worked.

“Mark is 57 and his Aunt Louanne is in her 80’s. Mark moved in with Aunt Louanne after his mother died. Mark had been dealing with having schizoaffective disorder for his entire adult life. He was working as a messenger until 9/11 when he lost his job, became depressed and was hospitalized. He enrolled in the FEPS Brooklyn Continuing Day Treatment Program in 2002. He was sad over his loss of independence. His job had meant a lot to him but he had developed some medical issues and was still having trouble coping with anxiety and aggressive impulses. Aunt Louanne and Mark gained a lot from the Multi-Family Groups. They could talk about some of the challenges of living together and through the problem solving exercises they worked out many issues. Mark began to take on household chores again, felt more independent and the group helped Mark learn coping strategies.”

George Brown and Miranda Williams, co-leaders Brooklyn Day Program Multi-family Group

The hardest part seems to be getting clients to sign the authorization form to contact and involve their family. It may be that our adult clients who have a mental illness feel it’s a sign of weakness to talk to their family members. However, after family members get involved, these same clients have an improved relationship with their worker and with the program and with their families. They feel better understood; they really feel they have a team of people working with them and for them and that team includes their family members who now better understand mental illness and have more skills to be supportive and helpful.

It is now our expectation at intake to talk to clients about contacting their family. We do a genogram in the first few visits and call family members right away.

We also do an ecomap so we can see who and what resources the client is close to in their community.

Family Psychoeducation has very clear procedures. The core elements are:

• Joining
• Education
• Problem-solving
• Interational change
• Structural change
• Multi-family contact

“Joining” with the family before they join the multi-family group is a skill with many components that clinicians must learn. For some staff the hardest part to learn is “chatting.” It is critical to the success of the program for the family to feel relaxed and comfortable with the clinician. Related social interactions are built into the joining sessions and the multi-family groups. Staff are not used to socializing with clients and families; they are used to working on “problems” and being the expert. Helping staff get comfortable with sharing a little about themselves was a challenge for our consultant Ed Dunne, but with much awareness building, role playing, coaxing and cajoling, everyone became better at it and immediately saw the benefits.

Families share very difficult things with us. They need to feel our humanity not just our professionalism.

“Paul is 34. Argentinean and married. He is bright and educated but his mental illness and addiction to cocaine brought him to FEPS’s Project COPE, a program for people with dual disorders. Paul’s parents were glad to come to a place where people explained both mental illness and addictions to them. They felt the support of program staff and the other families in the multi-family group who were all dealing with the same issues. Paul’s debts to drug dealers had caused his family to fear for their lives. Eventually it was thought best that Paul return to South America.
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**JBFC\'s Puts Family Mental Health Services in Action**

By Staff Writer

**JBFC\'s**

Sylvia felt overwhelmed by her son’s angry outbursts at home and at school.

John and Maria worked long hours to pay the bills and spent less time than they might have liked at home. Increasingly, their teenage daughters were out past their curfew.

A year ago, Thelma and Mike were thrilled when their son was born, but they noticed recently that he rarely made eye contact. They were worried.

Where can parents turn to find the guidance they need for themselves and their children? At the 12 JBFCS community counseling centers located throughout New York City’s five boroughs, a wide range of mental health and support services are available for families.

“At every JBFCS counseling center, a family who seeks help has support from a team of social workers, supervisors and a psychiatrist who collaborate to offer the most effective services possible,” says Robin Brinn, LCSW, Director of the Alan and Kathryn Greenberg Counseling Center of JBFCS in Manhattan. “We offer individual, couples, family and group therapy at a sliding scale fee that is very affordable. We also accept Medicaid, Medicare and many insurance plans.”

And community is key. Often families learn about JBFCS services through public schools, hospitals, local Ys and community centers, churches, or synagogues.

“Sylvia (not her real name) came to the Counseling Center in a way that’s typical of many of our clients,” explains Pamela M. Lotenberg, PhD, LCSW, Director of the JBFCS Bay Ridge Counseling Center. “A school guidance counselor referred her son to us because of his behavior at school.” Sylvia’s son Joseph (not his real name) was unable to get along with other children and struggled with hyperactivity. Joseph began to receive immediate help at the Bay Ridge Counseling Center in individual therapy. He was evaluated by a psychiatrist and it was determined that medication could reduce his hyperactivity. In addition, he was enrolled in a therapy group with other boys his age who were dealing with similar socialization issues. Under the guidance of a therapist who was keenly attuned to the dynamics of the group, Joseph was able to learn how to manage his frustrations and impulses differently so he could be more successful when he encountered socially challenging situations at school.

“The therapist also had “collateral” sessions with Sylvia on a regular basis to help her better understand Joseph’s problems and how to manage differently at home in response to his issues,” continues Dr. Lotenberg. Sylvia was invited to participate in a parenting group which helped participants explore the issues that affect their parenting. “As Sylvia began to trust us more, she revealed a history of domestic violence in the household and her belief that Joseph would become a violent person like his father.”

When the therapist learned about Sylvia’s trauma associated with domestic violence and her belief that her son would repeat his father’s behavior, the therapist encouraged Sylvia to see her own therapist, on-site, to help her explore her ideas about Joseph’s behavior and how her own beliefs contributed to Joseph’s negative-attention seeking behavior.

Sylvia’s experience reflects how often parents may not see problems as originating with themselves, but begin to identify their own problems after being shown evidence of it in the child’s behavior. While the child is the first person to be engaged in treatment, from there JBFCS therapists can work cooperatively with the parent around the child’s issues – and to the extent that the parent trusts the therapist and the services – the parents will then begin to share more of his or her own vulnerabilities and enter treatment themselves, as Sylvia did.

While this is an example of a parent with a school-age child, Robin Brinn also notes that just because someone is 18 and an adult does not automatically mean family therapy is not recommended. In New York City, as more three-generation families live together, or in the same building or neighborhood, it is important to understand the dynamics of the different generations and how that has an impact on family members. Family therapy can be a useful technique in this process.

JBFC\'s offers training in family therapy to staff at all of the counseling centers.

“Family therapy helps us to understand patterns of interaction that families have developed, between parents and their parents, and between parents and their children,” explains Joe Markowicz, LCSW, Social Worker Supervisor at the J.W. Beatman Counseling Center of JBFCS in Riverdale. He instructs the Riverdale staff in monthly family therapy training sessions. “We begin to understand these patterns of interaction and see if the patterns are creating part of the problem at hand, and if they are, to change them. By involving the whole family, it is possible to get to a better outcome sooner.”

This article touched on a few ways JBFCS offers services to the whole family. Yet staff at the agency understand that each family is unique and faces its own particular struggles at different times. JBFCS has many resources available to help with different life challenges, from developmental delays in early childhood to the depression of older adults. For more information about how JBFCS can help you or someone you love, please call (212) 582-9100.

**Having a Mental Illness Hurts. You are Not to Blame for Having a Medical Illness. There are Programs and Services Available That Can Help You Through These Trying Times. The Holiday Season Can Be Especially Difficult. Never Give Up in Your Journey Towards Recovery.**

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• The Housing Services Program, available to low and moderate income individuals and families in Port Chester through the Neighborhood Preservation Company, includes tenant assistance, eviction prevention, home ownership counseling, landlord-tenant mediation and housing court assistance.

• Hope House is a place where persons recovering from mental illness can find the support and resources they need to pursue their vocational and educational goals. Located in Port Chester, the Clubhouse is open 365 days a year and draws members from throughout the region.

• In the Case Management Program, HDSW staff provides rehabilitation and support services to persons recovering from psychiatric illness so that they may maintain their stability in the community.

HDSW
930 Mamaroneck Avenue
Mamaroneck, NY 10543
(914) 835 - 8906

HOPE HOUSE
100 Abendroth Avenue
Port Chester, NY 10573
(914) 939 - 2878
Family Support and Education Center of Syracuse New York
Supporting Families of Persons Diagnosed With Serious Psychiatric Disorders

By Sheila Le Gacy, Director
Family Support and Education Center

This article describes one community’s approach to providing supportive services to the families of persons diagnosed with serious psychiatric disorders. In Syracuse, New York, the Family Support & Education Center at Transitional Living Services has operated for over twenty five years to provide families with essential information and support.

The Problem

The total number of people directly affected by mental illness is astronomical. Taking the most conservative statistical approach, if 26 million Americans (less than 10% of the population) currently have some kind of incapacitating mental disorder, and, if each of those citizens has two parents, one sibling, and one child, that means that over 100 million Americans have mental illness in their immediate families – and that’s without counting grandparents and spouses.

Families play a key role in the support system that is needed to sustain their ill relatives. Their ability to provide an emotionally supportive and predictable environment can be a key factor in the ability of the patient to achieve any significant level of independence.

More than a third of adults who have severe mental illness live with their families, primarily aging parents. Although they need for their ill relatives from the mental health and ancillary service systems.

Support and care for a relative who has severe mental illness is demanding for parents of any age, the burden increases as the care givers age and experience physical decline and other losses associated with old age. Even when mentally ill relatives live separately, family members give a great deal of themselves in terms of time, money and social supports.

Although the care giving burden in all chronic illnesses has certain commonalities, persons who suffer from psychiatric disorders present unique burdens that call for specific interventions. The presence of a relative with mental illness in the home has profoundly disruptive effects on family life and severely strains the family’s capacity to provide a rehabilitative environment. Studies show that caregivers experience substantial increases in family conflict, economic difficulties and social isolation.

A Solution

There are effective ways of helping these families. The efficacy of education and training has been firmly established. Research has shown conclusively that education and training for families prevents relapse, reduces hospitalization, improves medication compliance, reduces family disintegration, improves patient outcomes, and is cost effective.

In our community, we are fortunate in having an established center for the support of families. Families who call the local NAMI affiliate or the Mental Health Association are referred to the Family Support & Education Center. The Center provides consultation, education and individualized support to families of persons diagnosed with schizophrenia, bipolar disorder, clinical depression, obsessive compulsive disorder, and other serious psychiatric disorders. For over 25 years we have worked closely with parents, siblings, grandparents, spouses, adult offspring, and concerned friends. Our services are designed to help families cope with the pain, frustration, bewilderment and stigma that accompany the severe psychiatric disorders. We have found that a blend of education, support and advocacy training best helps families meet the challenges of caring for their loved ones and themselves.

We offer a free 12 week course (Supportive Family Training) combining education, advocacy and group support. Families are taught communication techniques and coping and management skills, provided information about serious neurobiological brain disorders, and taught practical problem solving. In addition to teaching about the causes and treatments of the major psychiatric disorders, we incorporate information on ways for families to gain access to services. We help families devise strategies to obtain what they need for their ill relatives from the mental health and ancillary service systems.

In addition to helping families access services for their relatives, our program provides support during critical periods and ongoing support for the stress, confusion and despair that families routinely experience. A significant amount of time is spent listening to family concerns, helping them deal with the emotional upheaval in their lives, and being empathetic and sensitive to their pain.

The Center is located in a large rehabilitation and residential agency. Our experience working in a not for profit community agency which provides a range of services (residential, social supports, case management, vocational) has demonstrated the usefulness and practicality of family support and education being located close to other services. Family support should be an integral part of psychiatric rehabilitation. It is time for it to have its deserved place as a central component in the totality of treatment options provided to persons recovering.
Making Peace In The Family: Six Easy Steps

By Dr. Brenda Shoshanna

Until we come to peace with our family, it is inevitable that conflict and upset will arise in many of our lives. It is natural to unconsciously and automatically play out the difficulties we had in our families over and over again. Some keep craving the love and approval they never received and demand that they receive it now, often in inappropriate ways in their present day relationships. Even when they do receive it many do not feel satisfied. The love and approval received in the present cannot make up for what was missing long ago. We have to return to the source of the difficulty and make peace right there.

Sadly, however, some thrive on conflict. They do not realize that conflict is a lethal force that undermines their lives in all kinds of ways. Sometimes it erupts openly and other times it camouflages itself, causing the person to sabotage themselves and others, preventing them from having what they most desire.

Others hold onto conflict to get revenge, or to feel a sense of power they may not have. Some feel conflict is necessary in order to get what they want out of a situation. They have to fight for what is important to them, overpower their opponent, receive their good at the other’s expense. These individuals feel that anger and domination provides a sense of strength. It can take awhile to realize that the strength that anger provides is false and temporary. When it passes, the individual often feels weaker and more confused than before. And whatever decisions were made under the influence of anger often have difficult consequences.

When we think only of our own welfare in a situation, our ability to see the large picture is diminished and our solutions are partial and faulty. They rarely bring the fulfillment we desire.

It’s time to look at conflict in a new way and understand what it really is. Then we can take new steps to make peace with our family, ourselves and with relationships that appear in our lives. We can find solutions where all benefit. Every time conflict is resolved for the good of all, real growth, strength and fulfillment become available.

Here are some specific steps to make to start the steps of making peace with your family and within yourself.

Step 1: Realize that conflict is a choice you make. Conflict is not a form of power, strength, or control. It is a toxin, which creates confusion, narrowed focus, and defensiveness. When conflict arises, stop, breathe deeply, and immediately look at the larger perspective. Put the incident in context. For a moment, allow the other person to be “right”. Tell yourself you have plenty of time to be right later. Your main goal is to have the conflict subside so you can see what is best for all.

Step 2: Learn about the 24 forms of anger. Anger camouflages itself and manifests in many ways. Unrecognized anger turns into all kinds of unwanted behavior that become impossible to stop. We have to become aware when we or another person is angry and find a different response.

Some of the 24 forms of anger are: depression, hypocrisy, self-sabotage, low self-esteem, burnout, passive aggressive behavior, compulsions, perfectionism, gossiping, lying, and various addictions. When we realize that these behaviors are being fuelled by anger, it is easier to take appropriate steps to handle them.

Step 3: Give Up Being A Martyr – Stop Giving and Taking Guilt. Most martyrs do not think of themselves as martyrs. They may describe themselves as long-suffering, giving much more than they get. There’s a huge difference between giving and manipulation. Martyrs manipulate with guilt. But guilt is a lethal toxin. When we make someone feel guilty, we are harming them. When people feel guilty they find some way to punish themselves and others.

Give up giving guilt and also give up taking it. Recognize this as toxic behavior, which has no constructive outcome.

Step 4: Create Realistic Expectations. There is nothing that makes us more angry and hurt than expectations we’ve been holding onto that have not been met. It is important to become aware of our expectations. Are they realistic? Does the other person hold similar expectations in the relationship? Once we let go of unrealistic fantasies, clarity about what to do in present time is greatly increased. As this happens, spontaneous, healing solutions become available on the spot.

Step 5: Stop Casting Blame. Blaming others (and ourselves) is an expression of hurt, disappointment and helplessness and never leads to a constructive solution. Stop casting blame. By blaming others you are disempowering yourself. By taking responsibility you are taking back control. Stop a moment and see the situation through your opponent’s eyes. When you do this blame dissolves on the spot. The best defense against being hurt is to feel good about yourself, to remember that the way a person responds to you says more about them, than about you. As you stop casting blame you will be letting go of all kinds of resentments. Resistance inevitably affects our well-being and constricts our lives. Look for and find what is positive in each individual and situation. Focus on that.

Acknowledgment: A) Describe each member of the family, what you wanted from them, and how you wanted them to be. B) Acknowledge each member of the family for who they were. C) Allow them to be exactly who they were. Realize that who they were was not a reflection of you. D) Describe how you were in the family. E) Allow yourself also to be exactly as you were, no matter what others felt about you. F) Describe what each family member values and gives you, and the ways in which they supported your life. G) Describe what you gave them.

Apologies: Contrary to popular opinion, we do not need to receive the apologies of others as much as we need to apologize to feel free and happy and allow ourselves to go forward in life. A) Rather than dwell upon how they hurt or disappointed you, look and see if there may be some way you need to apologize to someone for something. If there is, do it. Write a note of apology. Ask for forgiveness. This will be very healing for you. It will also mean a great deal to them. B) Find out how you can make it up now. (You can ask this, or think of a way to make recompense). Do it as soon as you can. (If you cannot do it with a member of your own family, perhaps you can do this with someone else).

Giving Thanks: A) Write a formal thank you letter to each member of the family for something important you received from him/her. B) Are there any gifts you may want to give these members? Give one today. Once wrongs are corrected in our family, it is amazing to see how they straighten out in all other areas of our lives as well.

Step 6: Develop An Attitude of Gratitude. We often take many things for granted and are even unaware of all that we are receiving day by day. Now that you see all that you received from this person, and may even be receiving today, take time to feel grateful. Make a point of giving thanks. Acknowledging all you have received will not weaken you, it will strengthen the entire relationship, and ease the process of making peace.

In this vein, it is also very helpful to write down all you have given to that person as well. Conflict can often be unconsciousely escalated by guilt a party feels. We often think we are giving so much and receiving so little. This is a great cause of anger and feelings of deprivation. However, when we take time daily to look carefully, we are often surprised and how
My Aunt and Me from page 1

9) I think that my aunt’s case also illustrates that family caregivers need support. I was viewed as intrusive by the mental health professionals involved with my aunt because I had strong views about how she should be treated and insisted on being involved in treatment decisions. It never occurred to either the social worker or the psychiatrist whose opinions I questioned that I was reaching a point of personal desperation, that I might be depressed myself, that I needed help. I was just a pain in the behind who didn’t visit enough. I am entirely clear in retrospect that ultimately my aunt went to a nursing home at least as much because I burned out as because of her physical and mental infirmities.

10) One last thought. I had enough money to arrange whatever my aunt needed. Still it wasn’t good enough. I hate to think of what befalls people without money. Medicare and Medicaid do pay for some services, but there are huge problems financing appropriate services.

Clearly, this is not just a story about my aunt and me. The issues that defeated us are among the major issues that most older adults who are disabled by severe mental illness and their families routinely encounter. And it is clear — it’s clear that these are cross-system issues, straddling the mental health, health and aging systems. And isn’t it clear as well that these are family issues as well as issues for individuals? Family members provide 80% of the care for people with disabilities. They do the bulk of the job, but they need—and deserve—help to do it.

We have made some progress in New York State towards getting the service systems to work together. But there is so much more to do and so little time to do it before the elder boom hits in force. We really have to move faster.

Michael B. Friedman, LMSW

NYC Empowers from page 15

Families on the Move of New York City, which advocates both for the rights of children and families who are challenged with emotional and behavioral issues and for full participation in the decisions that affect them.

Data indicates that CCSI improves children’s mental health and school performance. For example, Columbia University researchers who are conducting an ongoing evaluation of 200 of the initiative’s families and youth found the youth were less impaired at 18 months than when they first engaged with CCSI. In addition after 12 months, the percentage of youths failing most or all of their school subjects decreased by one-third.

In the Columbia study, most youth reported they are getting along better with family members after CCSI involvement.

Prevent Poisoning from page 12

When medications are hard to get to, people often do not take them as they should, and sometimes they do not take them at all. However, if medications are out in the open, children can get to them and bad things can happen. We need a balance. Lock up all medications not just those from your doctor, especially over-the-counter medications. Over-the-counter does not mean safe; it only means that they can be purchased without a prescription. Aspirin, acetaminophen (Tylenol(R)) and even vitamins can be lethal in overdose situations. So, all over-the-counter medications should be kept in the “child proof bottles” they are sold in; stored in a locked box which is kept in a secure location out of sight and out of a child’s reach. Only take out medications out of the lock box for one or two days at a time. Do not leave medication bottles out to remind you to take medications.

Your Medication from page 12

how the body will break down (metabolize) the medication. Some medications will be digested just like food if they are swallowed. This will not help those with an illness. Sometimes, medications have special coatings so that they dissolve in different parts of the digestive system at different times. This allows medications to avoid digestion in the stomach and to be available for a longer period of time. Most time release medications work this way. Sometimes medications must be taken with or without food. This has to do with decreasing side effects of the medication and increasing the amount of medication that gets into the body. The reasons medications are sometimes taken several times a day is that medications must be at a certain level or concentration for them to work properly.

Substance Abuse from page 7

Treatment Services, and contains many other important facts about adolescent substance abuse, treatment and treatment admissions patterns.

The full report is available at http://oas.samhsa.gov/2k7/youthFacts/youth.cfm. Copies may be obtained free of charge by calling SAMHSA’s Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727). For related publications and information, visit http://www.samhsa.gov

SAMHSA is a public health agency within the Department of Health and Human Services. The agency is responsible for improving the accountability, capacity and effectiveness of the nation’s substance abuse prevention, addiction treatment, and mental health services delivery system.

There are better, safer ways to remind yourself, for example, leaving a note on the bathroom mirror.

If potentially dangerous substances are ingested, assume there is a poisoning emergency. Call the Poison Control Center at 1-800-222-1222. You will be directed automatically to the local center where professionals can tell you what to do. Over the counter does not mean safe; it only means that they can be purchased without a prescription. Call 911 immediately. When you go to the hospital, bring the bottle of medication and any remaining pills or substances with you. This will help the doctor decide the amount taken, the seriousness of the problem and what may be started. If you do not have the bottle or know what was taken try to describe the substance. Color, shape, size, texture, taste and purpose of the pills or substances are all helpful.

Barriers to Finding Services

Programs like the Family Support & Education Center are unique. It would be simple if the answer to the question “How do I find family mental health services?” was “ask your relative’s therapist, or doctor, or case manager.” Unfortunately, it is not common practice for clinicians to suggest concrete ways for families to find support for their own needs. Indeed, so focused are clinicians on their relationship with their patients that they often minimize the critical role the family plays in the support of that individual in the community. This is also true of case managers and staff in residential programs. Many of these providers have no idea of the time, money, energy and other resources families expend on their relatives. Most often the person receiving services does not communicate their reliance on their families.

Mental illness is a family issue. Unfortunately, this obvious fact of life is not sufficiently addressed in conventional service design which conceptualizes the client as the person receiving the services. In fact, advocating for the client often cannot be separated from working with the family. We feel that it is imperative that service providers approach the person to be served in the context of his or her family. By giving family concerns attention, you legitimize family needs, acknowledge their stress, and ultimately become more helpful to the client.

The Family Support and Education Center is located at 420 East Genesee Street, Syracuse, New York and can be reached at (315) 478-4151.

A psychologist, certified divorce media
tor, family mediator, speaker, trainer and award winning author, Dr. Shoshanna brings East and West together in providing creative and holistic ways of making peace and finding fair and healing solu
tions. Her most recent book is The Anger Diet, (30 Days to Stress Free Living), McLeod was awarded the best book of the year (Spirituality and Health Magazine). Subscribe to her free E-zine or reach her at www.brendashoshanna.com. Contact her at topspeaker@yahoo.com. and at (212) 288-0028.

Peace in The Family from page 27

much we have received and how little given in return. As we see how much we receive daily, anger naturally subsides. If each person feels satisfied with what they have given, self respect increases, and all aspects of one’s present life improves as well. Once we make peace with ourselves and our family, there is no end to what is possible for us now.

Dr. Shoshanna, is founder and direc
tor of Peaceful Harbor, Center for Discovering and Developing Peace of Mind.

Michael B. Friedman, LMSW

Families also report feeling less stress and less pressure caused by their child’s mental health problems 18 months after initial involvement with CCSI.

DOHMH also funds and oversees family support services that provide information, referrals, support and advocacy to families in NYC whose children have mental health challenges. After receiving input from families and providers, DOHMH will refine these services with an eye toward buttressing CCSI’s efforts.

The federal grant that funds CCSI runs out next year. Our next challenge is to ensure that the successes achieved become a self-sustaining, permanent part of our vision for New York City’s future.

Myla Harrison, MD, is Assistant Com
missioner for Child and Adolescent Serv
cices in the Division of Mental Hygiene at the New York City Department of Health and Mental Hygiene.
As I write this, the fires in California are still burning, and like everyone else, my heart goes out to those who have lost their homes, or suffered injuries in this tragedy. Because I work for NAMI (National Alliance on Mental Illness of Westchester), the devastating fires remind me of the damages wrought by mental illness on families. Whoever we are, mental illness almost always takes us by surprise, upends our lives, and leaves nothing the same.

The experience of mental illness is catastrophic, not only for the ill person, but also for each member of the family. If an ill family member needs to be hospitalized, all involved experience isolation, shame, anger, and confusion. Parents feel they have somehow failed their child. Siblings fear that “it” may happen to them. Spouses question themselves. Adult children put their lives and emotions on hold as they care for a parent. Indeed, the experience of mental illness brings unexpected and unbidden life-changes to everyone affected by brain disorders.

NAMI Westchester is an education and advocacy organization founded by families of people with mental illness. One of our key programs is called “Family to Family”, a 12-week course that educates and empowers family members. The course was developed by Dr. Joyce Burland, and was originally offered in Vermont under the name, “Journey of Hope.” Over 100,000 people have completed the course in the U.S., Canada, and Mexico.

The “ticket” to NAMI’s Family to Family course is that one be a family member or close friend of someone with a serious mental illness. There is no charge for the twelve week course, except for the requirement that one show up for each class. Most people arrive at the first class feeling exhausted and alone, yet hungry for anything that can help. The teachers hand them thick notebooks and reading assignments, tell them that the classes will last for two and a half-hours, and will be crammed with information. (Amazingly, despite this, they return!)

Because this is a peer-based program, the two teachers are trained family members of individuals with mental illness. They follow a curriculum that includes the medical, psychological and social effects of serious brain disorders. There are stages that families go through on the way to acceptance and empowerment. Complex information about the illness is presented as a “feast of facts” in which participants can select the information that is relevant to them. Coping skills, self-care, and community resources are key presentations. One of the highlights of the course is a presentation of “In Our Own Voice”, another NAMI program in which consumers of mental health services speak about their experiences of illness and healing.

We think of the classes as a compassionate learning environment. Members reach out to each other with information and concern. Whatever their backgrounds, they become a community based on shared experiences and understanding. As individuals they become stronger, yet gentler with themselves and others. Best of all, they become allies with their ill loved one in a common understanding of the forces of the illness.

In speaking of his mother’s participation in Family to Family, Garth House, a writer from Ohio, said, “Her understanding of serious brain disorders gained through the program has helped me better accept and understand my own illness and permitted me to let go of the shame and guilt that haunted me for so many years.” Yes, mental illness can be compared to a natural disaster, but there is so much more that can occur. Through Family to Family, people learn that healing, change, hope and community are still possibilities — even in the face of catastrophe. I have taught this class for several years, and I currently direct this and other family education programs. After all this time, I can honestly say that I have more hope than ever for the healing of those with mental illness and their loved ones.

The Family to Family Course is offered two times a year in various locations in Westchester. It is also offered in Spanish as “De Familia a Familia”. For more information, call NAMI Westchester at (914) 592-5458, or find us online at www.namiwestchester.org.
Families as Partners from page 11

health and educational systems, policies and regulations that impact on their children’s education and emotional health. Parents provide mutual aid for one another and engage in a valuable exchange of resources. Parent advocates from NSCA&GC are available to assist parents who need additional support in accessing resources, for example.

Enriching the Program

The close relationship that the school-based intensive support collaborative has established with parents of the students who attend the program has demonstrated that students definitely have a better response to the program when their parents/family are actively involved. Issues that may arise during the school year are set- tled on a more immediate basis when the family is actively involved. This keeps less serious issues from becoming serious ones.

Developing a good working relationship with parents is a key protective factor that can mitigate against high levels of risk. Partnership with parents also serves to reinforce and support the development of assets in their children. Students experience greater success because their parents/family understand and participate in the achievement of the academic and therapeutic goals of the program.

A good partnership with parents mod- els healthy communication for the student, demonstrating that adults can get along and work together for their interest. Good working partnerships serve as a counterforce and as an important means to prevent relationships that can be characterized by unhealthy communication. Healthy communication by all adults in the school community and families is a must for school-based mental health programs. We cannot afford to replicate dysfunctional patterns of communication that too many of our students have experience throughout their short lives. This requires a commitment from all who are involved on the treatment team, including top administrative staff.

The Parent’s Role in Program Evaluation

Consumer satisfaction surveys are completed by parents. The survey enables parents to give voice to their experiences and opinions about the program. These surveys are collated and analyzed as a means of evaluating the program and then modifying it as needed.

Parents are encouraged to voice their satisfaction with the aspects of the program they find most helpful to them and to their sons/daughters. They are also encouraged to suggest ways the program could be improved.

Celebrating Your Child

ISP provides multiple opportunities for parents and family members to celebrate their children and support their strengths and assets, open new doors, play art shows, and other special events offer opportunities for parents to celebrate what their children have to offer.

Sad events can also provide this opportunity. In the ISP high school, after the death of student who had a chronic medical condition, the students planned a memorial and invited their deceased classmates’ family. They sang, planted trees, and dedicated a bench in his memory. The memorial was a moving event that allowed all students involved to express their humanity and provide the grieving parents and siblings with a lasting memory of the kind of school community in which their son and brother had belonged.

In Conclusion

A strong partnership is especially critical when working with students with a history of serious emotional disturbance. For many of these students ISP is the last chance for them to stay at home and in the community. They evoke strong feeling in the educational and mental health staff. Sometimes the power of what they generate can lead to a splitting of staff, family and other collaborating systems. A strong team approach, anchored in a group structure enables us to prevent and splitting that divides instead of unites staff, parents, and students.

Most staff in ISP will say it is a privilege to work in the program. They will also tell you that it is one of the hardest things they’ve done in their professional careers.


Stress Study from page 7

mice, many more genes in the VTA than in the NAc went into action in stressful situations, compared with vulnerable mice. Gene activity governs a host of biochemical events in the brain, and the results of this experiment suggest that genes in the VTA of resilient mice are working hard to offset mechanisms that promote vulnerability.

Another component of the study revealed that mice with a naturally occurring variation in a part of the gene that produces the BDNF protein are resistant to stress. The variation results in lower production of BDNF, consistent with the finding that low BDNF activity promotes resilience.

The scientists also examined brain tissue of deceased people with a history of depression, and compared it with brain tissue of mice that showed vulnerability to stress. In both cases, the researchers found higher-than-average BDNF protein in the brain’s reward areas, offering a potential biological explanation of the link between stress and depression.

“The fact that we could increase these animals’ ability to adapt to stress by blocking BDNF and its signals means that it may be possible to develop compounds that improve resilience. This is a great opportunity to explore potential ways of increasing stress-resistance in people faced with situations that might otherwise result in post-traumatic stress disorder, for example,” said Nestler.

“But it doesn’t happen in a vacuum. Blocking BDNF at certain stages in the process could perturb other systems in negative ways. The key is to identify safe ways of enhancing this protective resilience machinery,” Nestler added.

Becoming A Reality from page 4

The regions of New York, Long Island, Connecticut, and New Jersey have very active and involved autism communities, and host some of the country’s major centers for autism treatment and research. One of the goals of the development phase of the project is to meet with representatives of the regions major agencies that serve the autism community. Preliminary meetings have been held with the Orange and Westchester County Offices of Mental Health, the YAI National Institute for People with Disabilities, Westchester ARC, and the NYU Child Study Center. Future meetings are planned with CO- SAC in NJ and with The Seaver Center at Mount Sinai Hospital, the Yale Center at

Andrew Malekoff, LCSW, CASAC

Andrew Malekoff earned his Master of Social Work with a concentration in Mental Health from Yeshiva University and a Bachelor of Science from NYU. He is a licensed Clinical Social Worker in the state of New York and has worked with individuals and families over the past 10 years. He joined the agency in 2004 as a clinician and is now the Program Director of the Westchester Program.

Stoller at 212-366-8038.

Stoller at 212-366-8038.

Culture Change from page 18

and enter an in-patient program. He returned to New York recently and came to the program to say hello and report on his progress. He feels the program helped him and his family get on the right track and he is optimistic about getting a job.”

Joe Fergason, Kay Huynh, Sofia Shalminyev, co-leaders, Project COPE Multi-family group

Implementing the McFarlane model of Family Psychoed in three of our programs lead to a survey of how we involve families in all our programs. We are now more keenly aware of the benefits for our consumers, their families and our programs when we partner families. At Riverdale Manor, an adult home where F.E.G.S. operates a psychosocial rehabilitation program,

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Partners in Dignity from page 16

demand for services as the program becomes more widely known, and sustainability. To date, Partners In Dignity services have been delivered free of charge, supported largely by philanthropic funding from UIA-Federation of New York. As more and more individuals come to us with concomitant mental health issues, FEGS will look to deliver some of its end of life services under the auspices of its network of licensed behavioral health clinics.

For more information about F.E.G.S’s Partners in Dignity program, call (516) 496-7550.

Culture Change from page 18

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case management, and a mental health clinic, our regular Family Night is looked forward to by staff, clients and families alike. In our Bronx Intensive Psychiatric Rehab Treatment Program for young adults the kids planned their own activities for a hugely successful Family Night.

Just like any culture change, it takes time but it also takes the commitment of every level of an organization. FEGS Behavioral Health Programs have made Family Psychoeducation programming an integral part of three of our programs. We know what it takes and we have seen the benefits. We are now working on integrating the model all over.

For more information about F.E.G.S. Health and Human Services Behavioral Health and Behavioral Health Residential Programs call Ellen Stoller at 212-366-8038.
**Deadline Calendar & Ad Size Specifications**

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