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Health Care Reform and Mental Health Parity And Their Impact on People and Service Providers

Mental Health in Health Care Reform: High Hopes But Big Battles Ahead

By Michael B. Friedman, LMSW
Mental Health Policy Advocate

Federal health care reform promises health coverage for most of the 50 million American citizens and documented immigrants who are currently uncovered. This will include coverage of mental health and substance abuse treatment. It also promises improved quality of physical and behavioral health care, which is much to be desired given the fact that the World Health Organization (WHO) ranks the health system in the United States 37th in the world.

Unfortunately, realizing these promises will be far from easy because of the great complexity of the health care system that is envisioned and because of the tremendous political effort that will be needed to fight off conservative attacks designed not only to reverse health care reform but also to roll back Medicaid and Medicare.

Under the provisions of The Affordable Care Act (ACA), as it is known, over 32 million Americans who do not have coverage soon will. In addition, the ACA assures that coverage will be in effect when people need it most by forbidding refusal to cover pre-existing conditions or termination of coverage for people who develop a condition requiring substantial medical care.

Health care reform also includes specific benefits for people with mental or substance use disorders, who at best have had coverage for treatment of these disorders far more limited than coverage for physical disorders. At last federal law provides full "parity," requiring (1) that coverage include mental and substance abuse conditions and (2) that it be equal to coverage of physical health conditions.

In addition, health care reform calls for improvements in quality of care, including integrated delivery of primary physical health care and behavioral health care, as well as an emphasis on health and mental health promotion. Goals include increased identification of mental and/or substance use disorders in primary care settings, access to good behavioral health care for those who need it, access to good physical health care for people with serious behavioral health problems, and changes in behavior and lifestyle so as to combat the obesity epidemic and promote physical and mental health generally.

In short, more people with mental disorders will have health coverage. They will have coverage regardless of when their disorders began. Their coverage will be equal for mental and physical conditions.

see High Hopes on page 20

How Health Care Reform Affects Providers and Consumers

By Andrew Cleek, PsyD, Director and Nisha Beharie, MPH, Senior Project Coordinator, The Urban Institute For Behavioral Health

Health Care reform has been vigorously debated. Many have attributed the deficiencies in the health care system to various causes including Lack of Access (48 million citizens without insurance), overuse of unnecessary, high cost tests and procedures, underuse of prevention, early intervention primary care and behavioral health services, and medical errors due to poor coordination among providers, and poor communication with patients etc. (1) The 2010 Affordable Health Care Act attempted to address these root causes of the inefficiencies in the health care system in four ways.

The first strategy proposed in the National Health Care reform bill is coverage expansion. This is achieved by requiring most individuals to have coverage, implementing Coverage Requirements employers for (>50 employees), and most noticeably, expanding Medicaid. The second related strategy is insurance reform, which prohibits all annual and lifetime limits, bans pre-existing condition exclusions, and creates an essential health benefits package that provides comprehensive services including mental health and substance abuse at parity. The third and fourth strategies are delivery system redesign and payment reform. (1) These are manifested in a transition from traditional division between mental health and behavioral health services and medical services to a more comprehensive patient centered care coordination model (otherwise known as Health Homes) as well as a shift from a traditional fee-for-service model to a capitation payment model.

Health Homes

Many recipients of Medicaid suffer from many chronic conditions (including mental health and health conditions). In order to provide better coordinated care for such individuals, the Patient Protection and Affordable Care Act (ACA) enacted on March 23, 2010 (and became available to states on January 1, 2011), provides states with a new Medicaid option to provide "health home" services for enrollees with chronic conditions. These will be systems of care centered around the patient that facilitate access to and coordination of primary care, acute physical health services, behavioral health care, and long-term community-based services and supports. As an additional incentive for states to take up the new option, ACA authorized a 90% federal match rate (FMAP) for health home services specified in the law for two years. This national initiative gives individual states the flexibility in the manner in which they implement it. (2)

Health Care Reform in New York State: Creation of the Medicaid Redesign Team (MRT)

In New York State, Governor Cuomo challenged the state to reduce Medicaid expenditures by approximately 3 billion while simultaneously maintaining access and improving the quality of services. To meet this challenge he formed the Medicaid Redesign Team (MRT) by joining

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— From the Publisher —
Health Reform Must Not Jeopardize The People We Serve

By Ira H. Minot, LMSW
Executive Director
Mental Health News Education, Inc.

Budget cutting has become a top priority for virtually all political leaders from the President on down to every Governor, County Executive, and Mayor in the land. As a result, health care reform and the effort to transform America's behavioral health systems to promote recovery (both of which offer great promise for improved care) are being compromised by the demand to save money. No one can predict how all of this will affect the people we serve—today and for years to come.

I can't help but recall the promise of the "community mental health" movement of the 1960s and 1970s which (rightly) moved to eradicate the deplorable conditions at most state hospitals for people with mental illness. The plan called for treating people in local communities rather than warehouse them in hospitals. State hospitals were emptied except for the most seriously ill. Tens of thousands of people with serious mental illnesses across the country were released from, or denied admission to state hospitals. Care of this population became the responsibility of local communities rather than of institutions. The Community Mental Health Act called for funding of community mental health centers to carry the load. On paper the idea seemed to herald a more therapeutic and humane system of care. Sadly, the community mental health centers were never fully funded and expansion of services in the community did not keep pace with the need created by de-institutionalization. There were a few

Ira H. Minot, LMSW

genuine community success stories, but many patients fell through the cracks. Over time they became the nation's new homeless population and the now skyrocketing and disturbing prison psychiatric system population.

Will this happen again? There are reasons for concern. In order to hold down Medicaid expenditures for behavioral health services, New York and other states are expanding the use of managed care. In his article, *Whatever Happened to Community Mental Health?* (Psychiatric Services, May 2000), Steven S. Sharfstein, MD stated: "In the cost-driven medical marketplace, psychiatry and, more broadly, mental health have suffered more than the rest of medicine. Private health insurance benefits have been cut significantly, and the public mental health system is in a state of collapse that varies only by degree from state to state. Two sectors of care in particular have been under attack in the managed care revolution: hospitals and physicians. Managed care has taken on many of the rhetorical flourishes but none of the substance of the community mental health revolution of the 1960s and 1970s. Managed care emphasizes lower levels of care and lower-cost professionals as a way of saving money and enhancing stockholder value, which has led to an increasingly consolidated behavioral health industry. But in the face of cost cutting, what about access and quality?" Dr. Sharfstein concludes his article saying, "Community mental health battles for survival in the rapidly changing public and private marketplace. Many of the old federally initiated community mental health centers are now called community behavioral health care organizations, or CBHOs, with a principal function of coordinating and integrating aspects of mental health treatment, addiction treatment, and primary care. The success of psychosocial rehabilitation approaches coupled with supervised housing stands in contrast to the continuing public health disaster of seriously mentally ill persons who are homeless or in prison. Dorothea Dix would be shocked if she revisited America today. As Geller (Geller JL: The last half-century of psychiatric services as reflected in Psychiatric Services. Psychiatric Services 51:41–67, 2000) understates, "We remain entrenched in our concerns about locus of care, confusing it with the humaneness, effectiveness, and quality of care." Because most care will take place in the outpatient arena, a great challenge for community mental health in the 21st century is to address the issue of people who are not in treatment, who resist treatment, and who become marginalized and destitute. Without reinventing asylums or discovering a magic bullet or cure for schizophrenia and other serious mental illnesses, we must rely on mental health policies and services with adequate financial support for community care. Barton's "service follows the dollar" maxim is important if managed care is a temporary aberration in mental health policy, as I believe it to be. We still must find a way to set priorities, allocate resources, and ensure delivery of high quality scientific and humane care to people in need."

Sharfstein wrote the above 11 years ago, yet much of his analysis still applies today. However, managed care for people with mental illness is not a temporary aberration as he thought it would be, but a present-day reality which holds the promise or the doom for the people we serve.

In addition to managed care, major changes to our healthcare systems are coming into being at a fevered pace. As Barry B. Perlman, MD, Director of Psychiatry at St. Joseph's Medical Center, Yonkers, New York, Legislative Chair of the New York State Psychiatric Association, and esteemed member of the Board of *Mental Health News* recently stated: "In my 30 years of practice in psychiatry, I have never seen so many balls up in the air at the same time."

I believe that if health reform, the emergence of behavioral health care networks, and the disappearance of separate silos for departments of mental health, substance abuse, and primary medical care, are to succeed, stakeholders of mental

see The People We Serve on page 23

— Editorial —
The Pace of Medicaid and Health Reform Quickens in New York State

By Peter D. Beitchman, DSW
Executive Director, The Bridge
and Board Chair, Mental Health News
Education, Inc.

The pace of health and Medicaid reform in New York State has increased dramatically over the past few months as several of the recommendations of the Governor-appointed Medicaid Redesign Team (MRT) move toward implementation. The establishment of regional Behavioral Health Organizations (BHOs) and health homes are occurring over the summer with full implementation expected by October 1st.

BHOs will monitor psychiatric and substance abuse emergency room and inpatient stays and, to address continuity of care, will monitor the hand-off from inpatient to outpatient services. Heath Homes will establish and coordinate networks of service providers for

Peter D. Beitchman, DSW

selected Medicaid recipients (including persons with serious mental illness and substance abuse), offering care coordination for behavioral, primary health and specialty care. When full Medicaid reform is implemented in 2013, the MRT has recommended that behavioral and health care services be offered on a capitated basis through either specialized managed care entities created for behavioral health clients or in general managed care.

With so much change occurring in the system, the entire mental health community—recipients, families, providers, advocates and policy makers—is moving into largely uncharted territory. Certainly many MRT reforms are welcome—establishing care coordination with a goal of providing comprehensive, integrated care; addressing the discontinuity that too often exists between the inpatient and community-based outpatient systems. There is broad concern, however, about other aspects of the emerging system; whether managed care companies will restrict access to services for persons with serious mental illness and whether the full range of community mental health services (treatment, rehabilitation, vocational, peer services and housing) will be viable.

While theses major reforms take shape, the mental health community is also concerned about immediate matters: Medicaid rate reductions; the imposition of visit thresholds and rate reductions in clinics; the impact of clinic restructuring on an already fragile system.

As this issue of *Mental Health News* demonstrates, we intend to closely monitor developments on both the national and state levels. We also urge our readers to share thoughts and experiences as the emerging system takes shape. In a time of unprecedented change, *Mental Health News* intends to be a forum for the exchange of information vital to mental health recipients, those who serve them and those who advocate on their behalf.

How Will Health Care Reform Affect Older Adults with Mental Health Problems?

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

Even though the recent health care reform legislation substantially neglects mental health concerns, older adults with mental health conditions will benefit from it in four ways. First, they will benefit from improved coverage of physical health care, which is of considerable importance to older adults with mental and/or substance use disorders because they are highly likely to have co-occurring chronic physical disorders. Second, they will benefit from improved coverage of mental health conditions. Third, they will benefit from efforts to enhance integration of health and mental health services. Fourth, they may benefit from the opportunity to buy long-term care insurance through work.

Unfortunately, there are also certain risks that will affect all older adults, including those with mental health problems. Most notable is the funding reduction for Medicare Advantage plans, which will probably result in some loss of covered services, though there is no way of knowing yet which they will be.

(1) General health coverage improvements that will benefit older adults with mental and/or substance use disorders include:

- Improved Medicare coverage of prescription drugs
- Medicare coverage of some health promotion and illness prevention measures

Kimberly A. Williams, LMSW

- Insurance reforms for older adults with employer-based health coverage, including coverage of pre-existing conditions, community rating, and maintenance of coverage during long illnesses
- Eligibility to purchase, and to get subsidies for, health coverage through the health exchanges

(2) Improved coverage of mental health services

- Just last year new federal laws required "parity" in the coverage of mental and physical health conditions in employer-based health benefits and Medicare. The health care reform legislation carries parity forward and ends the option for employers' not to provide behavioral health coverage.
- Improved coverage of psychiatric medications, benzodiazepines and barbiturates

(3) In addition, a number of provisions in the health care reform law establish grants programs to promote the development of models of care that integrate physical and mental health care delivery. The concept of a "medical home" is particularly important in this regard.

(4) Even though the health care reform legislation did not go far in addressing long-term care reform, it did include what is known as the CLASS provision, which will allow employers to make long-term care insurance available to employees and their families at a reasonable cost. The legislation also expands home and community based waiver opportunities to encourage states to use Medicaid to cover in -home care that makes placement in institutions unnecessary. In addition, the legislation includes provisions to improve the quality of care in nursing homes.

Since mental and behavioral disorders are among the major reasons for placement out of the home, older adults with such disorders and their family caregivers, who are at high risk for depression and anxiety disorders, can benefit from these long-term care provisions.

Implementation and Future Improvements

Although the provisions of health care reform noted above can be helpful, whether they are or not will depend on effective implementation. Particularly important will be the development of a clinically, culturally, and generationally competent workforce that is large enough to meet the needs of elder boomers and that is prepared to address behavioral as well as physical health needs. We have a long way to go before the promise of parity and health care reform is achieved. Advocates for older adults will need to be vigilant to assure implementation. In addition, advocates need to continue to speak out that health care reform is just the beginning of addressing behavioral health and long-term care needs of an aging society.

Kimberly A. Williams is the Director of The Geriatric Mental Health Alliance (GMHA) of New York and Director of the Center for Policy, Advocacy, and Education at the Mental Health Association of NYC. Michael B. Friedman is the Honorary Chair of the GMHA. Contact them at: kwilliams@mhaofnyc.org or mbfriedman@aol.com

This article was previously published in the American Society on Aging (ASA) Mental Health and Aging Newsletter. Reprinted with permission.

Taking Stock: Mental Health in the Workplace

By Shawn Nowicki, MPH
Director, Health Policy
Northeast Business Group on Health

Mental illness has a broad reach in the workplace. From corporate boardrooms and your accountant's desk to the fields of star athletes, this set of diseases can take many forms. It doesn't discriminate either. Mental illness affects men and women, rich and poor, entry-level staff to senior executives, young and old, and people of all races and ethnicities. The median age of onset for major depressive disorder, for instance, is 32 years. In other words, people are affected in their prime working years.

Employers are well aware that a healthy and happy workforce is critical to running a productive and successful business. This is one of the many reasons why they offer health care coverage in the first place. Among employees, mental illness, in particular, is serious, common and expensive. A report by the National Business Group on Health (NBGH) noted that mental illness and substance abuse result in an approximate loss of 217 million work days annually and comes in at a cost of $17 billion a year to employers.

Shawn Nowicki, MPH

Hence, it has implications for a company's bottom line. An article appearing in the journal Health Affairs showed that over the ten year period of 1991-2001, 8.2 percent of full-time employed adults were diagnosed with a mental illness. Efforts in the past decade to more effectively identify, diagnose and treat and manage mental illness have likely caused an uptick in this figure, though.

Not only are direct costs incurred, but indirect ones as well. Yet this is where employers feel that the cost of mental illness is harder to measure. Presenteeism, absenteeism, turnover and low job satisfaction levels are elements that factor into these calculations. A recent research study by the Partnership for Workplace Mental Health, an initiative of the American Psychological Association, notes that these indirect costs account for approximately 70 percent of employers' mental illness expenditures. Estimates of these indirect costs range from $79 billion to $105 billion per year nationally, according to the U.S. Department of Health & Human Services.

Clearly, there is a business case for employers to actively seek to improve mental health clinical outcomes and reduce overall costs.

Ignoring mental illness can be even costlier; individuals with untreated mental illness consume more medical services and are often diagnosed with costly and chronic co-morbid conditions. Employers should thus not limit access to behavioral health services but rather encourage and facilitate it; doing so will reduce long-term costs related to mental illness and other chronic conditions.

When it comes to addressing mental illness in the workplace, the most traditional interaction between employers and their employees is a health benefit plan. Yet until recently, employers were able to structure benefit plans so that medical benefits were provided inconsistent with mental health and substance use disorders benefits.

All that changed in 2008. In October of that year, Congress took action to end that practice. Both chambers approved legislation requiring all large group health plans – with 50 or more employees – to provide parity between medical and mental health and substance use disorders benefits. The law took full effect on January 1, 2011. Implementing mental health parity at firms was projected to be neither costly nor antithetical to employers' workplace culture. The Congressional Budget Office – the non-partisan official budget scorekeeper for Congress – estimated that mental health parity would cause employer premiums to rise only 0.4 percent. And the aforementioned study by the Partnership for Workplace Health noted that most employers view equalizing medical and mental health benefits as being, "a good fit with the company's workplace culture and/or company leadership values."

see In the Workplace on page 28

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- Research insurance options; low-cost or private, medication assistance programs, resources for the uninsured, and help for veterans.
- Take action by following local, state and national bills focused on behavioral health, and by contacting elected officials to voice your opinions on how to improve the behavioral health care system.

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No More Flying Solo: Why Integration Works

By Linda Rosenberg MSW
President and CEO, National Council for Behavioral Healthcare

Linda Rosenberg MSW

This will be the ninth time you've visited your primary care doctor in three months. Your arm rests on the chair, and you wonder why your fatigue has not subsided despite different treatments she has tried with you. You considered seeking out a second opinion, but you stopped yourself since you've been seeing this doctor for more than 20 years. What you don't realize, and what your doctor has been unable to see, is that you're suffering from depression, of which fatigue is a classic symptom. Without this knowledge, you would likely continue to see your doctor and only grow more frustrated or to seek out a second opinion from someone who may or may not screen you for depression. Common mental disorders like depression and anxiety can present with somatic symptoms like headaches, fatigue, pain, gastrointestinal problems, and this makes an accurate diagnosis in an exclusively primary care setting challenging.

The scenario described above is not unusual. As many as 70 percent of primary care visits are estimated to stem from psychosocial issues, with underlying mental health or substance abuse issues often triggering these visits rather than physical health needs alone. Additionally, the Agency for Healthcare Research and Quality estimated in 2007 that nearly 13 percent of ER visits (about one in eight) are related to a mental health or substance use disorder. More broadly, nearly one-third of adults and one-fifth of children had a diagnosable addiction or mental health problem in the last year, according to the Kaiser Commission on Medicaid and the Uninsured.

Despite the prevalence of patients with behavioral health conditions in primary care, not all primary care providers are actively screening for behavioral health. This lack of screening is notable because the majority of patients will not receive behavioral health treatment from a specialist for a number of reasons, including excessive costs due to a lack of insurance or inadequate coverage for behavioral health services, or perceived stigma associated with mental illness and/or substance use disorders. The lack of access to treatment is a significant concern, considering how few patients receive the care they need. According to SAMHSA, only 4.1 million of the 9.8 million Americans that needed treatment for a serious mental illness received it in 2009, and only 4.3 million people received treatment for an illicit drug or alcohol problem among the 23.5 million Americans who needed it.

The passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act in October of 2008, was paramount in ensuring increased access to behavioral health services as well as improved insurance coverage. The law dictates that insurance plans are required to offer comparable levels of behavioral health service coverage as they do for physical health if they already provide behavioral health service coverage. Additionally, there cannot be differential annual or lifetime caps on coverage for physical and behavioral health. For consumers, this means that mental health and substance use services may be more accessible than before if a major barrier to their use of mental health or substance abuse treatment services was insurance that such a barrier is rapidly going away.

The good news for consumers –and the system as a whole—is that attitudes and incentives are changing. Many individuals in healthcare services, both primary care and behavioral health care, have been envisioning and implementing a system of integrated care where you and your condition would not slip through the cracks. The National Council for Community Behavioral Healthcare has been leading the conversation regarding the integration of behavioral healthcare with primary care for the last ten years. But a funny thing has happened recently — many more people are becoming engaged in the conversation, including federal policymakers. More people are convening around the idea of integrating these often separate worlds to provide better care for patients while at the same time, reducing costs in the process.

There is now broad recognition that behavioral health services are a fundamental part of the healthcare system, helping move our system toward better integration of physical and behavioral health services to both improve the quality of care provided and reducing costs. For generations, care has been provided in a fragmented system where individual specialties have operated in virtual silos, but

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New Directions in Healthcare and the Promise of Recovery

By Yves Ades, PhD
Senior Vice President
Services for the UnderServed, Inc.

Yves Ades, PhD

In case you didn't notice, this is a time of radical change in the behavioral health and health fields. However challenging the policy and fiscal landscapes have become, it's important to remember that we're all still in the business of helping people to recover, achieve goals, and be part of a community. The notion of recovery for the person with serious mental illness is empowering simply by virtue of the hope it implies about the future. Belief in the ability to recovery by all who engage to achieve it, however critical, is not enough; there must be substance and structure to support the process.

Long before the Medicaid Redesign Team came into being, SUS has been making significant inroads toward addressing disparities in health outcomes for people with behavioral health challenges. In fact, for the past ten years, we have worked as an organization to transform our practice values and treatment philosophy to position the person receiving services at the center of practice and desired outcomes. Consistent with this orientation, Services for the UnderServed (SUS) has established a Recovery Center in the heart of Bedford-Stuyvesant, one of New York City's most underserved areas. Launched in 2009, The SUS Recovery Center represents the next evolution of our housing, community support and treatment services for people with mental illness and multiple co-occurring primary health and substance abuse disorders, and HIV-AIDS. Consisting of our Wellness Works Mental Health Clinic, Brooklyn Clubhouse, Assisted Competitive Employment Services, Homeless Veterans Reintegration Program, Assertive Community Treatment (ACT) and a Peer Counselor Training Academy, as co-located services, all operating from a platform of recovery, we are able to offer an integrated approach to achieving and maintaining wellness and recovery, while simultaneously providing the requisite flexible structure to promote hope and recovery.

The substance of the recovery platform shared by all Recovery Center service components is a tool kit composed of seven evidence-based practices: Wellness Self-Management (WSM), Integrated Dual Disorder Treatment (IDDT), Diabetes Self-Management, Family Psychoeducation, Trauma-Informed Care, Cultural Competence and Peer Counseling. With few exceptions, the individual Recovery Center enrollee can participate in as many Recovery Center services as he/she needs to stay engaged and achieve improved overall health. For high utilizers of emergency rooms and hospitals, the Recovery Center serves as both an anchor to less costly community-based health care and a sustainable alternative to managing health and well-being outside of institutional settings. While the greater majority of 1200 individuals who live in SUS supportive housing are not enrolled at the Recovery Center, those who pose the greatest risk for recidivism to institutional settings (e.g. hospitals, shelters, prisons), are encouraged to enter the Center through any of its service doors. For some, the entry point is through employment, while for others it is simply an opportunity to enjoy lunch served at the Clubhouse.

Developed throughout over 30 years of experience in treatment, support and housing programs, particularly through the integration of embedded nursing, care coordination, mobile wellness teams and Wellness Recovery Action Plans (WRAP) in supportive housing, we've come to understand well the presenting priorities of people in recovery from mental illness and co-morbid health conditions. Despite an emergent physical health care condition, the effects of poverty, substance abuse and the symptoms of mental illness most often take precedence in the "hierarchy of needs" among those that come to SUS for help. In essence, it is only subsequent to deep investment in the engagement process and ensuing behavioral health treatment and recovery, that physical health needs are considered and ultimately addressed. The physical co-location of services under a single roof, however necessary to service integration, is insufficient toward providing truly integrated care. Even more important to the recovery process and the achievement of integrated wellness is the shift in clinical culture that ensues when health and behavioral health services are down the hallway from one another; social workers, internists, nurses, peers, and psychiatrists

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NEW BEGINNINGS BEGIN HERE.

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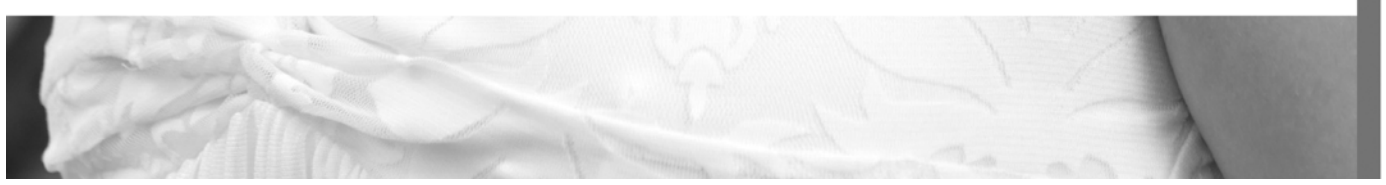

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Parity for Consumers: What We Learned, and Where We Go from Here

By Wendy Brennan, MS
Executive Director
The National Alliance on
Mental Illness of New York City

State and federal parity laws help end decades of discriminatory insurance coverage for mental health and substance abuse services by insurance companies. Historically, families with mental illness have faced terrible choices, from skipping care altogether to facing bankruptcy to pay for it. In New York, we know the O'Clair family, for whose son Timothy New York State's parity law is named, faced an unconscionable decision: whether to turn over custody of an ill child to secure appropriate treatment.

Achieving mental health parity in New York State was a truly heroic effort, led by a coalition of effective and organized advocates. NAMI-NYC Metro was proud to be a part of that coalition, and has followed through on that work with the first-ever qualitative study of Timothy's Law since its implementation. The results of this study, which was published in *Psychiatric Services* this past April, suggest that while we have taken a huge step forward together, there is a lot more work to be done.

Wendy Brennan, MS

Parity in Context

The Mental Health Parity Act of 1996 prohibited health plans from imposing annual or lifetime dollar limits on mental health benefits that were less favorable than those imposed on medical-surgical benefits. However, it did not prevent plans from imposing disparate treatment limitations on the number of annual mental health visits and hospital days covered, nor did it make cost-sharing requirements equal.

The federal Mental Health Parity and Addiction Equity Act of 2008, which went into effect on January 1, 2010, prevents such disparities in coverage. The law covers health plans with more than 50 employees and mandates equality in treatment limitations for mental health and medical-surgical benefits, as well as in the cost-sharing requirements and managed care practices used to regulate the benefits.

Moving from federal to state law, 49 states have passed mental health parity laws that vary in terms of the size of companies and range of diagnoses covered by the law and the mandated level of mental health coverage stipulated in the law.

Timothy's Law, which became effective in January 2007, mandates all fully insured companies that issue health insurance regardless of size in New York State to cover a base benefit of 20 outpatient mental health visits and 30 inpatient hospital days for all members. It requires parity between cost-sharing requirements for mental health and medical-surgical coverage.

In addition, for companies with more than 50 employees, Timothy's Law extends full mental health parity coverage for a number of biologically based diagnoses and childhood emotional disorders by mandating equality between the treatment limitations imposed on coverage of these conditions and medical-surgical coverage.

NAMI-NYC Metro's Benefits Project

The fight for mental health parity has been viewed by many of us as a civil rights issue. The lack of parity highlighted the artificial distinction between health and mental health, and was a clear manifestation of the stigma associated with mental illness. For all of these reasons, NAMI-NYC Metro has focused on mental health parity as a key advocacy issue for over a decade.

In 2002, with the support of the van Ameringen Foundation and the New York Community Trust, we launched the Mental Health Benefits Project. At its inception, this project focused on achieving parity in mental health benefits by advocating for the passage of New York State's parity law and for the voluntary adoption of such benefits by companies in New York City. Through the course of our work, we learned that while good mental health benefits are necessary, they are not sufficient to ensure access to quality mental health services.

We worked with large and small businesses to encourage them to manage mental health effectively in the workplace, with a primary focus on issues of access and quality.

In 2006, we formed the Small Business Workgroup to define and address the barriers and opportunities for improving mental health management and resources for this category of businesses. Following the recommendation of this workgroup and interest expressed by several health insurance companies, we developed resource guides for small businesses –one for employers and another for employees. We ultimately distributed over 22,500 guides and made them available to the public for downloading on our website.

Meanwhile, to continue our learning and to provide a forum where key stakeholders could exchange ideas about mental health and the workplace, we convened

see Parity for Consumers on page 28

APA's Muszyniski Discusses Parity Law at Annual Maniscalco Lecture

Staff Writer
Mental Health News

Irvin "Sam" Muszyniski, J.D. presented the 22nd Annual Anthony Maniscalco, M.D. Lecture in Public Psychiatry to the Department of Psychiatry of Saint Joseph's Medical Center in Yonkers, N.Y. on June 9, 2011. The lecture was created in honor of Dr. Maniscalco who had been the Director of the Department of Psychiatry from 1970 until 1980, a period during which many of the full range of mental health services currently available at Saint Joseph's were established.

Mr. Michael J. Spicer, President and CEO, Saint Joseph's Medical Center, in his welcoming remarks noted the dramatic developments of the past year during which the St. Vincent's Hospital – Westchester was acquired by SJMC, thus making the it a preeminent provider of behavioral health services in New York State and the region.

Dr. Barry B. Perlman, Director of the Department of Psychiatry, introduced this year's lecturer. Mr. Muszynski is the Director, Office of Healthcare Systems and Financing of the American psychiatric Association (APA). An important aspect of the work of his office is spearheading the APA's effort to gain the compliance of entities covered under the Mental Health Parity and Addiction Equity Act (MHPAEA) more commonly referred to as the Mental Health Parity Law. Dr. Perlman took note of the common saying when something is wrong that, "there ought to be a law". He said that he now realized that even when there is a law, that was not enough. The road to its being actualized could still be a long one.

Dr. Barry B. Perlman, Irvin Muszynski, JD, and Michael J. Spicer

Mr. Muszynski described the passage of the Parity law as the culmination many years of work by the APA along with a coalition of mental health advocacy organizations. He explained that the law and the accompanying federal final interim regulations established a requirement for both Quantitative and Non Quantitative Treatment Limitations (QTLs and NQTLs) which require that mental health and addiction services be provided in a manner comparable to and no more stringently managed than limits applied to medical and surgical care under managed healthcare plans. He explained that the substance of the parity law had been well preserved under the Affordable Care Act, the national health reform bill passed in 2009. Outlining the APA's approach he described the challenging of managed care plans which had not moved towards an adequate level of compliance, the need to educate persons receiving mental health care and the professionals providing their care so that they can alert the APA/Parity Implementation Coalition when they are being adversely impacted due to lack of compliance by their insurers, and raising concerns with the state and federal agencies charged with compliance enforcement. (For those interested in more detailed information about the MHPAEA, please see Mr. Muszyniski's article in the Summer 2011 issue of Mental Health News under "The NYSPA Report: Parity & Addiction Equity Act".)

Saint Joseph's Medical Center's Department of Psychiatry provides a wide and comprehensive array of outpatient and inpatient mental health services as well as substance use disorder treatment programs at its campuses in Yonkers and Harrison, New York.

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New York, NY 10021
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White Plains, NY 10605
888-694-5700

— The NYSPA Report —
Medicaid, Behavioral Healthcare, and The 2011 NYS Budget: Taking Stock

By Barry B. Perlman, MD, Director
Department of Psychiatry
Saint Joseph's Medical Center

Barry B. Perlman, MD

There can be no question that 2011 has been a tough budget year all around, including in New York State. The end of the legislative session provides an opportune time to take stock and see where we are. When our new governor, Andrew Cuomo, took office in January, New York State was facing a $10.5 billion short fall. Cuts were inevitable and the governor and legislature had to look to Medicaid, education, corrections and state workers' salaries and pensions. In order to balance the budget, the governor and legislators had to turn to these sectors as the ones where the state's biggest expenditures were to be found. By mid-April an on time budget had been passed which included a 2 year Medicaid budget incorporating caps on that program's global expenditure. Inpatient psychiatric costs were targeted and outpatient mental health clinic visit thresholds were established which incorporated decreased payments for visits exceeding those limits. Certainly these changes were not what advocates for persons with mental illness wanted.

However, as with so many things in life, in order to know how one is doing one must view one's position relative to others. From that perspective, NYS behavioral health providers and advocates must count themselves as relatively fortunate. A quick glance around the nation makes clear that due to the fiscal consequences of the recession, Medicaid, a large and rapidly growing part of most states' expenditures, is under assault at state as well as at the federal level.

A brief tour of the states highlights why New Yorkers should feel relatively sanguine about how Medicaid has been dealt with in our state. Across the country governors from liberals such as Jerry Brown of California and Deval Patrick of Massachusetts to conservatives such as Jan Brewer of Arizona and Rick Scott of Florida are resorting to a wide array of approaches in their efforts to significantly reduce their state's Medicaid budgets. Their strategies include capping Medicaid enrollment, taxing 'unhealthy' behaviors, rolling back reimbursement rates to levels below those which already discourage provider participation, eliminating non required services such as dental, vision, podiatric, and hospice, targeting women's reproductive services, capping numbers of doctor visits, raising enrollee co-payments, and hastily enrolling eligibles into managed care plans in order to cap costs to the state. The above cited states are only a few of the many worthy of notice in their attack on Medicaid.

To some extent the current attacks on Medicaid has to do with the sun setting on July 1, 2011 of the 2 year, $90 billion dollar federal subsidy of Medicaid costs. As a result of that reduction as well as a political "ideological" antipathy to the program as currently constituted, 29 Republicans governors wrote a letter requesting radical changes to Medicaid which included their call for use of payment methodologies such as 'block grants' with the goal of capping state expenditures. The attacks on Medicaid seem especially problematic in view of recently published research by the National Bureau of Economic Research documenting the multidimensional benefits which accrue to enrollees in the areas of health, outlook, and their financial stability. On the other side, Senator Jay Rockefeller and 36 senate colleagues have written to the President commending him for his opposition to arbitrary "block grants" which would undermine the "fundamental guarantee of Mediciad coverage" to the program's 68 million beneficiaries. The Obama administration is also pushing back by trying to maintain access by proposing rules which would make it more difficult for states to reduce reimbursement to doctors and hospitals by fulfilling the program's mandate for access to care comparable to others. Unfortunately, it has been reported that the administration too may be willing to entertain steep reductions in funding for Medicaid as part of the negotiations related to raising the nation's debt ceiling.

At this time, it is impossible to know how things will work out, especially as they are playing out against the multiyear phase in of the 'Patient Protection and Affordable Care Act.' However, for New Yorkers concerned about behavioral healthcare it seems that we are fortunate that our leaders approached their task thoughtfully and with balance. Certainly serious 'hits' have occurred, such as reduction in payments to institutions which treat a 'disproportionate' share of uninsured patients, reimbursement cuts which have led to the closing of many Continuing Day Treatment (CDT) programs and perhaps dooming those remaining, the creation of preferred drug lists for psychotropic medications and the ending of "physician prevails" in prescribing, continued reductions of numbers of beds in the state psychiatric centers, and payment thresholds for clinic level of care.

While we would have hoped for less severe reductions to CDT programs which for many fragile persons with serious and persistent mental illness (SPMI) represent a modern form of 'asylum' and for a continuation of "provider prevails" in prescribing in order to better protect our patients, from a 'macro' perspective, we appreciate that there will be no enrollment limitations and most core services have been reasonably preserved. Even where thresholds have been initiated, regulators have been able to preserve and extend access to services by counting multiple clinic visits on a given day as a single encounter for purposes of reaching threshold trigger points.

Indeed, it is possible that some of the items of concern in the 2011 budget may be revisited next year, such as the loss of the "provider prevails" requirement for prescribing within the Medicaid formulary. Furthermore, a 2 year transition has been established prior to the time when persons currently insured under the existing Medicaid fee for service arrangements will be mandated into joining managed care arrangements. The effort to create a more seamless system of care within regional behavioral networks while avoiding the depredations which have occurred too frequently when persons with SPMI have been forced into managed care plans will be overseen by the Behavioral Medicaid Redesign Taskforce. That group's members represent a broad array of stakeholders from advocacy groups for persons with SPMI, their families, and provider organizations. Other interested parties, such as NYSPA, will also be watching the process closely and working to improve its outcome. It is the resort to a public process which will play out over time, rather than one which is rushed, secretive, and radical, which gives interested New Yorkers hope that the end result will be one that reasonably serves both those receiving and those providing services in our state. Advocates of all stripes will also need to closely monitor and vigorously advocate at the federal level to avoid draconian reductions which would inevitably adversely limit the preservation of adequate services in New York and other states.

Dr. Perlman is the Director of the Department of Psychiatry at Saint Joseph's Medical Center, Yonkers, New York. He is the Legislative Chair and a Past President of the New York State Psychiatric Association. He is a past Chair, New York State Mental Health Services Council.

The NYSPA report was received on July 18, 2011. Dr. Perlman wants readers to know that there may be changes at the federal level as part of the efforts to raise the national debt ceiling which may significantly impact the picture he has presented.

THE MENTAL HEALTH LAWYER

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

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

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

Timothy's Story

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

Although the O'Clairs had health insurance, they quickly learned that the coverage they received for the treatment of physical ailments was vastly different from the coverage provided for mental health issues. Timothy was allowed only 20 visits per year for psychiatrists and psychologists combined. And after only a few visits, the co-payment rose from $10 per visit to $35 per visit. The O'Clairs suffered significant financial difficulties trying to pay the medical bills, and worse, they were not able to obtain all of the treatment their young son needed. The cause of this was the fact that they used the allotted number of visits and further treatment was too costly for them.

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

Carolyn R. Wolf, Esq.

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

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

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

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

The State of the Law Prior to Timothy's Law

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

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

Timothy's Law

At last, in the final days of 2006, the New York State Legislature passed, and the Governor signed, Timothy's Law. Under Timothy's Law there is a requirement for a base benefit for all employer based insurance plans, regardless of the size of the employer. This benefit requires that the insurance plan provide a minimum of 20 out-patient mental health visits per year and 30 inpatient mental health days per year. Often this is referred to as the 20/30 base benefit. Most importantly, the co-payments for this mental health coverage must be equal to the co-payment for any other medical visit.

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

Unquestionably, this change in the law is not only equitable, but cost effective as well. A 2002 study conducted by PricewaterhouseCoopers, based upon 34 states

see Timothy's Law on page 30

Medicating Mindfully: How Your Doctor Thinks

By Jonathan Bauman, MD
Chief Medical Officer
Four Winds Hospital

It's been said that prescribing medication for our patients is as much art as science. Certainly, the science of psychopharmacology has exploded over the past three decades. Our understanding of how and where medications work has become identifiable and precise. Effects and side effects have been studied and catalogued. The "artful" application of this knowledge requires keen awareness of these effects combined with intimate knowledge of the patients whom we are treating.

Medical training promotes the growth of decision trees - called algorithms - in the minds of physicians. When your doctor conducts an evaluation, he is - ideally and automatically - identifying signs and symptoms of disorder or disease; sizing up your temperament, beliefs, prejudices, opinions, and fund of knowledge; placing these observations in the context of your family and social milieu; and drawing a developmental timeline between where you are from and where you are now. Some of the questions that form the branches of the decision tree are:

- Do you have symptoms of a disorder (e.g., anxiety, depression, insomnia, disorganized thinking)?
- If so, do you have symptoms of a disorder that could be helped by medication?
- If so, would you be willing to take medication to alleviate symptoms?
- If so, what are the chances of having side effects that you would not be willing to live with in order to alleviate symptoms?
- What medication is most likely to have the desired effect and least likely to cause you troubling side effects?
- What factors in you or your environment will interfere with your ability to remain adherent to a medication regimen (e.g., ambivalence about taking medication, forgetfulness/ distractibility, distracting/chaotic environment, financial issues)?

Jennifer is an 18 year-old college freshman who is home after her first semester away. She is distressed by her inability to perform up to her standards and talks to her parents about withdrawing from school. She breaks down in tears as she describes waking up each morning with a feeling of nausea in the pit of her stomach. Several times a week she has episodes where she struggles to catch her

see Medicating on page 18

The World of Bullying

By Lisa Pasch, PsyD
Supervising Psychologist,
Comprehensive Adolescent Rehabilitation and Education Service,
St. Luke's - Roosevelt Hospital Centers

The topic of bullying is one that has garnered a lot of attention in the last few years. Events like the shooting at Columbine High School, and the tragedies that were the deaths of Pheobe Prince and Tyler Clementi certainly helped move the topic to the front page as opposed to page six. Bullying is violence; a violence that is pervasive, painful, and that negatively impacts all involved, not just the victims. For many individuals, their more traumatic memories of childhood are those of being victimized, or bullied, in school. While bullying can occur throughout age ranges, it is the bullying that transpires during childhood and adolescence that will be the focus of this article.

But what really is bullying? Every time you turn on the television, or read an article in the paper, it seems that someone else is creating a definition of what bullying is and what it can do to individuals. So, let's break it down. Bullying is a form of aggression that is directed toward the dominance of another person. A person is considered to be the victim of bullying when he or she is repeatedly and over time exposed to negative actions (the intentional infliction of injury or discomfort) by one or more other people. As we know bullying is an aggressive behavior, but it is important to truly understand what an aggressive behavior is and how it does not only mean pushing a kid down in the playground. Aggressive behaviors can be either direct (e.g. open attacks, both physical and verbal) or indirect and psychological (e.g., intentional exclusion from a group, starting rumors, etc.). Indirect bullying centers more on impacting social relationships than direct bullying. Cyber bullying can fit into either category, depending on the form and content of the act.

Now that we know what bullying is, we have to understand the players. We used to believe that there was a bully, there was a victim and that was that. More recently (late 1980's early 90's) we realized that there was more to the story. In reality, there are the people that are "pure" victims; those that are only the victims of bullying. There are also those that are "pure" bullies; those that only bully others. Also discovered were people who can fall into both the victim and bully camp, depending on the day, the situation and those they are around. Those people get called bully/victims customarily. Finally, we have the bystanders. There are several types of bystanders, but in general, they are the people who are around when the bullying happens and are engaged in the act in one way or another (all the way from helping the bully to standing up for the victim). While as a community we are highly aware of the impact of bullying on the victims, we must remember that bullying has negative consequences for the victims, the bullies, and the bystanders and therefore it must be understood and taken seriously by all of us.

In the mental health world, we have long been aware of the negative impact of bullying on those that are victimized. The largest impact, and the one so often portrayed on TV falls onto the so called "passive victims." The characteristics of these passive victims are that they tend to be submissive, nonassertive, socially isolated, physical weak and have low levels of self esteem. When such individuals are the victims of bullies, the results can be anxiety, depression, loneliness, truancy and dropping out of school. Such consequences do not end when the bullying

see Bullying on page 18

FOUR WINDS HOSPITAL • FALL 2011

OCTOBER 2011

A COMMUNITY SERVICE

Thursday, October 6, 2011
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National Depression Screening Day

Free Depression Screening for Children, Adolescents and Adults

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NOVEMBER 2011

A SPECIAL COMMUNITY AND PROFESSIONAL EDUCATION EVENT

Friday, November 4, 2011
9:30 – 11:30 am

KIDS ON MEDS: Up-to-Date Information About the Most Commonly Prescribed Psychiatric Medications

Kevin T. Kalikow, MD, Child and Adolescent Psychiatrist, Private Practice, Mt. Kisco, New York; Assistant Clinical Professor in Child Psychiatry, New York Medical College; Author, *Your Child in the Balance: An Insider's Guide for Parents to the Psychiatric Medicine Dilemma* and the newly released, *Kids on Meds: Up-to-Date Information About the Most Commonly Prescribed Psychiatric Medications*.

Dr. Kalikow will review the basics that are crucial in deciding whether a child should be prescribed a psychiatric medicine and will discuss the risks and benefits of the commonly prescribed medicines, such as those that treat ADHD, depression and anxiety.

At the conclusion of this program, participants will:

- Learn to think "psychopharmacologically."
- Learn the risks of the medicines that are commonly used in child psychiatry.
- Learn the benefits of the medicines that are commonly used in child psychiatry.

Books Available for Sale

Fee: $15, payable to Four Winds Hospital

2 CME Credits Pending
2 CASAC Section 2 criteria and CPP/CPS
Section 1 criteria clock pending*

Albert Einstein College of Medicine designates each continuing medical education activity for a maximum of 2.0 category 1 credits towards the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity.

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Albert Einstein College of Medicine and Four Winds Hospital. Albert Einstein College of Medicine is accredited by the ACCME to provide continuing medical education for physicians. These programs will be of interest to: physicians, physician's assistants, psychologists, nurse practitioners, social workers, mental health providers, EAP's, education professionals, school counselors, RN's and consumers.

FOUR WINDS HOSPITAL • FALL 2011

DECEMBER 2011

GRAND ROUNDS

FRIDAY, DECEMBER 9, 2011
9:30 – 11:00 AM

THE APPLICATION OF DBT WITH FAMILIES

Alec L. Miller, Psy.D, Professor of Clinical Psychiatry and Behavioral Sciences, Chief, Child & Adolescent Psychology, Montefiore Medical Center/Albert Einstein College of Medicine; Co-Founder, Cognitive & Behavioral Consultants of Westchester, LLP, White Plains, NY.

DBT has become a leading evidence-based treatment for individuals with significant emotional and behavioral difficulties. Since 1995, Dr. Miller and colleagues have adapted DBT for adolescents and families. In this presentation, Dr. Miller will describe the theoretical frame as well as specific treatment strategies relevant to applying DBT with families.

At the conclusion of this program, participants will:

- Be able to describe the modes and functions of DBT with youth.
- Better understand the theoretical relevance of involving families in DBT.
- Learn specific strategies used when working with families in DBT.

Fee: $15, payable to Four Winds Hospital

1.5 CME Credits Pending
1.5 CASAC Section 2 criteria and CPP/CPS
Section 1 criteria clock pending*

All of the Grand Rounds, Special Trainings and Special Events will be held at the Four Winds Hospital Conference Center unless otherwise noted. Registration is Required for All Programs.

Please Call 1-800-546-1754 ext. 2413.
Register online at www.fourwindshospital.com

*** This training is provided under New York State Office of Alcoholism and Substance Abuse Services (OASAS) Education and Training Provider Certification Number 0815. Training under a New York State OASAS Provider Certification is acceptable for meeting all or part of the CASAC/CPP/CPS education and training requirements.**

A SPECIAL EVENT

FRIDAY, DECEMBER 16, 2011
9:30 – 11:00 AM

A Four Winds Foundation Presentation

THE MIND AND MUSIC OF RACHMANINOFF

Richard Kogan, M.D., Director of the Human Sexuality Program, Weill-Cornell Medical Center and New York Presbyterian Hospital; Private Practice, New York City.

This program will enable participants to:

- Recognize the psychological factors that influenced Rachmaninoff's artistic development.
- Understand some of the fundamental concepts about creativity.

Fee: $50.00, payable to the Four Winds Foundation, a not-for-profit organization

1.5 CME Credits Pending

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Medicating from page 15

breath, feels her heart racing and has to sit down because she feels faint. She started seeing a therapist at the student counseling center but had to stop at winter break. Her parents arrange for a consultation with a psychiatrist. Upon evaluation, it turns out that Jennifer had milder episodes during her last two years of high school. Her mother had similar episodes in college but "toughed it out." Later on, as an adult, she had several severe episodes shortly after starting a new job. She was treated with fluoxetine (Prozac), which seemed to help. As a psychiatrist you're thinking, "This sounds like a pretty typical Panic Disorder." Further questioning confirms this impression, including consideration of medical illness that might present with similar symptoms. Talk therapy, such as CBT (Cognitive Behavioral Therapy) is a treatment option, but the therapy your patient has had so far hasn't helped much and she is eager for symptom relief so she can get back to school.

In the case study above, we have symptoms of a disorder, symptoms that could be alleviated by medication, and a patient willing to choose this option. Your doctor could choose from various SSRI's (Selective Serotonin Reuptake Inhibitors), but since a close relative (her mother) responded well to fluoxetine, there is reason to believe that this patient would also respond well. You present this recommendation to the patient and her family, carefully reviewing the therapeutic effects and side effects. Her mother's prior favorable experience helps with acceptance and "buy in." Because the medication is available as a generic, cost will not be an impediment to treatment. You stress the importance of adherence to the medication regimen, set up an easy to remember plan for taking the medication, discuss a time-line for treatment, and make follow-up plans.

Admittedly, this is a fairly uncomplicated, "softball" scenario. Psychiatrists are usually faced with much more complicated scenarios that require mindfulness of much more complicated decision algorithms. Because psychiatric disorders appear as an amalgamation of symptoms that are often difficult to categorize into discernable and discreet diagnosis, sometimes the best we can do is to make an educated hypothesis and then use medications to best address particular symptoms. Multiple symptoms may be symptomatic of a single disorder, or there may be multiple symptoms that are symptomatic of two or more disorders. Such situations may require the use of multiple medications. In these circumstances. Your psychiatrist must be mindful of principles of rational combined psychopharmacology: the use of two or more psychiatric medications combined in a rational way.

The brain is a highly complex organ with numerous circuits, neurotransmitters (chemicals that transmit nerve impulses from one cell to another) and receptor sites (places on the nerve cell where neurotransmitters act). An understanding of this complexity is essential for combining medications in a rational way. For example, sometimes Major Depression will respond better to two medications than to one. Choosing two antidepressants that work in the same way would not be rational because you would just be duplicating effects. Choosing two that work on different neurotransmitters or on different receptor sites would make sense because you would be adding something different. This sort of strategy is done all the time in medicine, as in the treatment of hypertension or in the use of chemotherapy for cancer.

Medicating mindfully is interplay between art and science. The art is comprised of the skill with which the practitioner uses this knowledge to grow and prune their own mental decision tree, plus the skill with which they are able to elicit their patient's personal data to populate the tree and come to a rational treatment recommendation.

Bullying from page 15

does, but rather can remain with an individual for most of their lives. As I mentioned earlier, though, the lasting impact is not only on the victims.

Bullies across the world are characterized by three distinct features. For one, they tend to have little control of their emotional and behavioral responses. Secondly, bullies typically have an aggressive personality pattern, coupled with a tendency to act aggressively in many situations. Finally, they have both an accepting and promotional attitude towards violence. Bullies tend to display the need for dominance and self-assertion as well as having a propensity to be impulsive in their actions. For the bullies, the value in their behavior lies within the control over others that they receive. While it would be very easy to villainize a bully and wish for their downfall, as many reality TV shows do, we must remember that there may also be negative consequences for those that bully. Overall, being labeled as a bully when younger may be a significant predictor of dropping out of school, increased engagement in criminal activity, as well as having an increased likelihood of substance abuse. As for the bystanders, the negative consequences they may face depends on the type of bystander that they were.

While the outcomes of bullying behavior can be quite scary, it is not set in stone that this must occur. Everyone plays a role in what direction bullying takes. Schools, parents, children, mental health workers, and really all humans must take a stand against bullying if we are to make real headway into solving this epidemic.

The responsibility of the schools (administrator, teachers, etc.) is to provide a safe school environment in which teachers can teach and students can learn. There are many ways by which schools can create a safe environment. However, some of the most important traits are that the entire school staff is committed to the anti-bullying campaign and that there is a strong declaration (with clear definitions and rules) in the school that opposes bullying and harassment in any form. Coming up with such declarations can be very difficult; therefore, it is often useful to employ a consultant to help determine the individual needs of each school and each district.

Parental responsibility can begin with being aware of not adopting the "kids will be kids" attitude and thereby inadvertently condoning bullying behaviors. Talking to your children about bullying and helping them understand why it can be so destructive may also play an important preventive factor, as well as teaching children to stand up for themselves in prosocial ways. Additionally, taking actions if and when your child has been identified as a bully, victim or a bystander and assisting them in "doing the right thing." Learning that your child is involved in bullying, regardless of the manner in which they are involved, can be a very disconcerting thing. Know that it is ok to feel overwhelmed and ask for help from those who can guide you in the best responses. When in need, involve mental health workers who can help you and your child navigate the vicious world that is bullying.

The world of bullying can be cruel and complex. Many have questioned if anything can be done to prevent the tragedies that seem to be all over the place. The great thing, however, is that it only takes one person who will stand up for another, one person who will look at their own behavior or one person who will say no more for themselves to make a local difference. Just imagine what could happen if we all did it.

Can New York State Healthcare Reforms Advance Recovery?

By Harvey Rosenthal, Executive Director
New York Association of Psychiatric Rehabilitation Services (NYAPRS)

In 1971, I spent 6 weeks in a Long Island hospital psychiatric ward for severe depression, the beginning of my long and rewarding personal recovery journey. In the ensuing years, I learned hard lessons about the great limitations of traditional treatments and the critical role hope, dignity, work, self-care, spirituality and alternative treatments played in my healing.

Six years later, I took a job working as a ward aide at the state psychiatric hospital in Albany and got an expected but no less jarring introduction to a system that, based on the understandings of the time, told people they would never recover or work or have families, and that they'd be dependent on powerful medications with damaging side effects, living impoverished lives on disability and on staff direction for the rest of their lives.

When I struggled several years later as an outpatient clinician to prevent or understand people's returns to the hospital, I was told there was nothing we could have done…that it was "the illness."

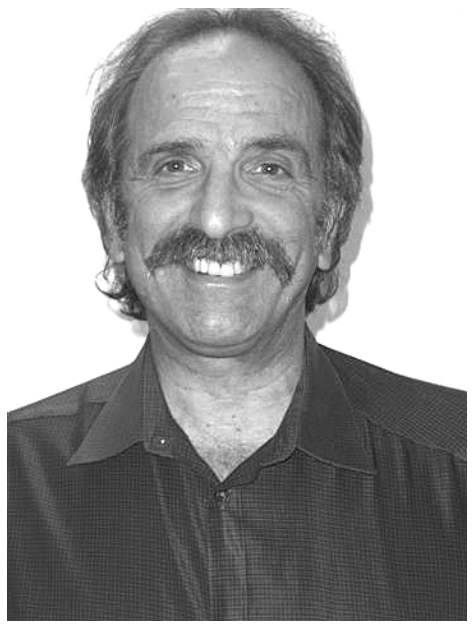
Thanks to the recovery, rehabilitation and consumer/survivor movements, the field was encouraged to recognize every person's great potential and the crucial importance of hope, of what we now call person directed planning, on skills and supports and a focus on full community integration.

But change has been very slow and our academic and state and local treatment institutions continued to predict and candidly, profit from this expectation of lifelong relapse and readmission.

It has taken national and state fiscal crises to bring true muscle to 'transformation.' This has been fueled by the recognition that these recurrent emergency and hospital costs for upwards of a half million New Yorkers with ongoing mental health, substance use and medical conditions swell Medicaid costs for those individuals to 15 times the average beneficiary and contribute to hundreds of millions worth of 'avoidable readmissions' each year.

We've at long last been joined by the often highest forces in government, the Medicaid Director and the budgeteers, in wanting to help people to live in community. The new systems they and we are developing will:

1. Bring in *Behavioral Health Organizations* over the next 2 years to improve hospital discharge planning in each region of the state for those individuals to try to improve follow up care and avoid readmissions.



Harvey Rosenthal

2. Create new integrated networks of medical, mental health and substance use providers called *Health Homes* that are aimed at helping to improve care engagement and performance for 'high cost/high needs' individuals.

3. Move all of our outpatient and medication treatment systems by 2014 from pay per service systems to *Managed Care* styled systems that will cap Medicaid dollars but direct them more flexibly to meet health care improvements associated with a more integrated and accountable system that focuses on outcomes rather than service visits.

Will these changes improve the care and the lives of the half million New Yorkers who rely on that care? It might… but, in my mind, only if:

(1) *Savings from decreased Medicaid and state hospital use are reinvested into key areas that research clearly demonstrates are central to preventing readmissions, stable housing, job readiness and support and a broad array of peer support.* The state must not repeat the sins of the deinstitutionalization era and take too much savings without redirecting sufficient funds to build up improved community systems of care. It's clear that hospital recidivism is closely associated with what are often called the social determinants of illness like housing instability, poverty and the loss of hope and personal supports. While those are not funded by Medicaid, they are critical to the success of these Medicaid reforms. Accordingly, New York must commit itself to creating reimbursement systems that transfer Medicaid and state hospital savings to these domains.

(2) *Hospitals don't run the new systems.* Health homes and managed care reforms are heavily intended to help keep people out of needless ER and inpatient visits….in hospitals! But hospitals have deep pockets and strong political connections and are angling to run the new 'community based' alternatives to….. themselves. It's critical that new networks are run by enlightened innovative wellness and recovery based medical and mental health/substance use providers who are major partners in any new networks or systems of care.

(3) *A full array of peer run peer fidelity service innovations are prominent.* Over the past decade, peer organizations in New York and nationally have birthed exciting and highly effective new models of outreach, engagement and health promotion (peer wellness coaching), hospital to community transitional support (peer bridging), personalized wellness systems (WRAP) and an array of relapse prevention and crisis assistance (peer crisis respite, ER workers, first break residential alternatives and warm lines). These are not services that can or should be operated by traditional providers; e.g. peers should not be embedded in traditional systems as assistant case managers who are supervised by social workers. And peers must not be considered cheap help who will get people to take their medications! Further, these services must not be co-opted or Medicalized by straight Medicaid funding. Accordingly, New York must fund and explicitly require managed care plans to contract with these groups to assure the provision of fidelity-level peer services that will play critical roles in improving outcomes while reducing overall systemic costs.

(4) *We must move from person centered to person directed planning…and budgeting.* There's a lot of talk about person centered medical homes and person centered treatment planning. But to move beyond just talk and ongoing practices that primarily continue to get people to sign off on provider generated treatment goals and plans, we must include training and oversight requirements that launch system wide use of tools that truly draw directly from individuals served, like Wellness Recovery Action Plans and Advance Directives. And there's nothing in the country more powerful than self directed care models that place pooled service dollars in the hands of consumers and assist them to buy the treatments and resources they need to get and stay well. Just look at the startling results several managed care pilots in Texas and Pennsylvania are having with individualized budgeting based projects supported by peer brokers at http://www.cmhsrp.uic.edu/nrtc/sdcwebpage.asp. The flexibility in these systems are allowing Medicaid beneficiaries unprecedented crucial access to alternative treatments that have been so crucial to my own recovery and are currently only the privilege of the middle class and the wealthy.

(5) *Health care reforms must provide more than lip service to address tragic health care disparities.* The state must explicitly direct managed care plans and new provider systems to provide the kinds of outreach, engagement and service strategies that will truly reach and work for communities of color and to diversify their workforces accordingly.

(6) *People must be able to access the medications that work best for them.* In the state's plans to move Medicaid pharmacy to the control of managed care plans, there are no safeguards in place to assure that people will be able to stay with or get access to a medication they know are best for them, if that medication is not on the plan's formulary. We must continue to assure open access to medications of choice that work for those who want and need them.

(7) *OMH case management dollars must follow the people and not be lost to our system.* Current plans are to move $120 million worth of OMH case management to become the care managers of the new Health Homes for the next two years, if only to capture a richer federal payment level provided under the Affordable Care Act. We must do so in ways that allow the people served by those case managers to retain those crucial relationships and supports and to follow them into the Health Homes. We must assure that OMH case management dollars return to our system after the two years and aren't lost to other systems or state savings.

If we fail to adopt these kinds of measures and simply rearrange the players, provide insufficient clear direction to the new managed care systems that will take over and take huge savings out of the system without strategic reinvestments, we will squander this unprecedented opportunity to truly transform our systems of care and support.

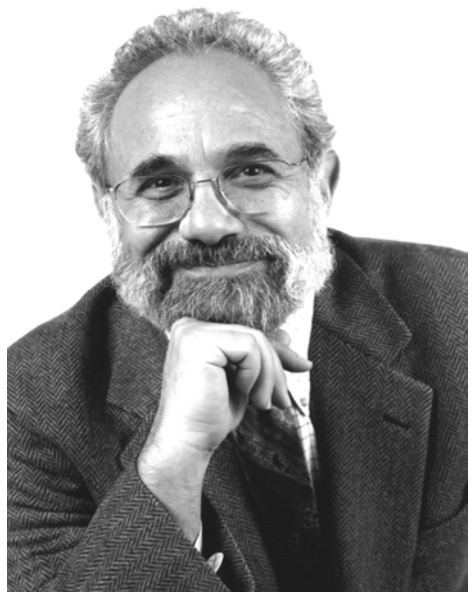
Finally, too many of the most affected people know far too little of what is coming and the level of informed self advocacy they must take to ensure these changes and these new service designs will work for them. New York must find ways to educate Medicaid beneficiaries and get their input as the ultimate stakeholders. For our part, NYAPRS is poised to launch a statewide series of regional forums on these topics. For more information, look at our website in the coming weeks at www.nyaprs.org.

High Hopes from page 1

They will be more likely to be identified as needing treatment and to get treatment through primary health care. Those with serious psychiatric disabilities will be more likely to get good physical health care. Everyone will benefit from preventive interventions and "wellness" initiatives.

Specifically, The Affordable Care Act provides:

- More extensive eligibility for Medicaid and State Child Health Insurance. An additional 16 million people will become eligible.
- Improved coverage of medications and preventive care by Medicare
- A mandate that all employers provide health and behavioral health coverage, except some small employers, who either will get subsidies to provide coverage or whose employees will be eligible for help to purchase coverage.
- A mandate that all individuals have coverage, which they will purchase themselves if they are not covered by a governmental or employer-based health plan.
- The establishment of State health insurance marketplaces (called "exchanges") where individuals can purchase insurance (including coverage of mental health) at prices that reflect the benefits of purchasing by a large group and through which plans will be guaranteed to provide what they promise.



Michael B. Friedman, LMSW

- Extensive health insurance reforms outlawing refusal to cover pre-existing conditions or people who develop serious medical conditions after they are enrolled in a plan. Reforms will also guarantee "transparency", i.e., that you get what you pay for as well as prices that reflect health risks in your community, and more.
- Efforts to increase integration of health and behavioral health service delivery through structures called "patient-centered medical homes", "health homes," and "accountable care organizations," and more.

Implementation of these provisions will be exceedingly difficult because they are so complex and require the coordination of state and federal governments as well as numerous state and federal agencies.

In addition, it will not be easy to develop true integration of physical and behavioral health care. The rhetoric of integration is promising, but the requirements that are emerging to translate rhetoric into reality leave much to the imagination. For example, the criteria for recognition as a "medical home" that have been issued by the National Commission of Quality of Care (NCQA) are purposely vague so as to allow innovative approaches to integrated treatment. Avoiding over-regulation is important, of course; but it will also make it easy for organizations to pay lip service to the goal of integration while doing little in reality.

Both with regard to cooperation needed among governmental agencies and the degree of communication and coordination needed to achieve integration of physical and behavioral health care, the principle that "collaboration is an unnatural act carried out by non-consenting adults" will surely be at work here.

Beyond these inherent difficulties is the sad fact that health care reform has become the major symbol of the differences between the political parties. Democrats by and large support health care reform so as to provide access to decent health care to as many people as possible. Republicans by and large oppose health care reform as a symbol of government intruding into the private realm, of the federal government trampling the rights of the states, and of profligate spending.

Specifically, Republicans have proposed massive cuts to Medicaid and Medicare spending by reducing who and what they cover. Some have gone far beyond overturning the Affordable Care Act with proposals to turn Medicaid into a block grant program and to turn Medicare into a voucher program. Federal health coverage would no longer be an "entitlement". This would create substantial risk that federal health insurance coverage would not be inadequately funded. In fact, **it would no longer be insurance at all** because a person with Medicaid and/or Medicare who was in medical need would not be guaranteed coverage once the money allotted to their state or to them as individuals ran out.

Behavioral health services are particularly at risk in the conservative assault on federal health spending. Medicaid has become the single largest source of funding for mental health services, and over the past 30 years or so it has moved past the medical model of reimbursable services to include much more of what people with serious mental disabilities need—outreach, housing, rehabilitation, case management, etc. A return to using Medicaid to pay only for medical model services in medical settings would be a disaster for people with the greatest need of help in order to live in the community.

In addition, behavioral health services are technically "optional" services under Medicaid. Unfortunately, this makes them sound as if they are not really important to people and makes them a tempting target

see High Hopes from page 30

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LGBT Mental Health Conference Listens to Consumer Need and Provides Education

Staff Writer
Mental Health News

The E/Quality Care Conference is a one-day, free conference where over 250 New York City mental health/social service providers and consumers can learn about best practices, network with LGBT and mainstream service providers, and share ideas and information in order to help enhance the provision of effective services for LGBT consumers. The conference date is September 14, 2011. Pre-registration, which is required, may be made at www.equalitycare.org.

Thousands of lesbian, gay, bisexual and transgender (LGBT) adults are living with mental illness, substance abuse and developmental disability in New York City. Whether mental health professionals are aware of it or not, LGBT persons are part of the client population of every hospital, mental health clinic, residence, and day treatment program. Even so, their therapists and care providers often don't know how to provide affirming, supportive and culturally competent care, or aren't comfortable in doing so.

In its 2008 Local Governmental Plan for Mental Health Services, the New York City Department of Health and Mental Hygiene (DOHMH) reported that there is considerable evidence to suggest that the critical issue for the LGBT mental health consumer population may not be access to services, but rather, receipt of appropriate services and subsequent retention in care. The 2008 DOHMH service plan highlighted that LGBT consumers report that providers were often unresponsive to their concerns, and they felt many mental health providers' attitudes towards LGBT consumers was not always constructive or positive. This, according to DOHMH, resulted in many LGBT consumers entering treatment – but then leaving prematurely.

The disconnect between the needs of LGBT consumers and the quality of services available to them has had significant negative impact. In 2006 DOHMH's Community Health Survey demonstrated that approximately 23% of the LGBT community in NYC, approximately 79,000 people, or about one in four LGBT New Yorkers, reported having some kind of mental health disorder, as opposed to fewer than 14% of their heterosexual counterparts. The preponderance of the limited published data on the mental health of this population indicates that LGBT individuals are at increased risk for major depression, generalized anxiety disorder, eating disorders, panic disorders, alcohol dependency, drug dependency, poor self-esteem, and co-morbid diagnoses as compared to the general population.

When asked why LGBT people experience such significant mental health disparities, conference Co-Chair, Dr. Christian Huygen, (who has provided LGBT cultural competence trainings to dozens of agencies and hundreds of mental health professionals), indicated that "when providers lack solid information about issues,

Christian Huygen, PhD

challenges, and best practices when working with LGBT consumers, it raises a number of barriers to consumers receiving effective and affirming care. Fearing negative consequences, LGBT individuals may not disclose their sexual orientation or gender identity to their providers. Well meaning providers may not know how to fully support a client pursuing a gender transition, or how to maintain a strong therapeutic alliance with a client in the midst of a tumultuous break up with a same sex partner."

In 2009, to help address the need for provider education, the Citywide LGBT Committee of The NYC Federation for Mental Health, Developmental Disability and Alcoholism Services (an advisory committee to NYC DOHMH) planned and presented E/Quality Care, the first conference of its kind, to share information and resources, educate providers about best practices, and raise the profile of LGBT affirming agencies. The conference served as an educational, as well as networking opportunity for over 300 people. Mainstream agencies formed linkages with LGBT agencies. Those seeking to improve their skill-set for working with the LGBT population were connected with capacity building providers with the shared goal of ensuring all consumers can receive effective, sensitive and culturally competent care, regardless of their sexual orientation or gender identity.

As plans for the September, 2011 E/Quality Care Conference continue, Conference Co-Chair's Dr. Christian Huygen and Mr. Bert Coffman confirm that the event will once again present a format where consumers, providers and the government entities that fund services can come together and share best practices and communicate about unmet needs. Conference organizers are targeting a wide provider audience, including psychiatrists, psychologists, social workers, case managers, residential advisors, peer specialists, consumer/providers, and people in recovery engaged in mutual support networks.

"This is an opportunity for providers to learn how they can extend their skills and wisdom to benefit consumers of all sexual orientations and gender identities," says conference Co-Chair, Dr. Christian Huygen. "We know that affirming care reduces hospitalizations, which reduces costs and improves treatment outcomes. It's a win/win."

This year over 25 expert presenters will conduct workshops and sit on audience interactive panels and question and answer sessions. The conference is co-sponsored by the New York City Department of Health and Mental Hygiene; the New York State Department of Health; NYC DOHMH Office of Consumer Affairs and Rainbow Heights Club. Major funding for this year's event has been provided by the Queer Wellness Fund of the Stonewall Community Foundation, as well as the Johnson Family Foundation.

At the September 2011 conference, providers with little or no experience providing services to LGBT consumers will once again engage in discussions and presentations designed to enable them to provide more respectful and affirming care to their LGBT consumers. A simultaneous conference track will facilitate conversations between LGBT consumers, providers and the entities that fund services. Like its predecessor, the 2011 E/Quality Care Conference will be entirely free of charge for all participants, though registration is required.

Conference Co-Chair Bert Coffman, a longtime mental health consumer advocate, points out that although the conference brings together the efforts of dozens of providers and consumers, the original inspiration to plan and present this conference came from LGBT consumers themselves. "Year in and year out, mental health consumers have expressed their frustration that many care providers lack the information they need to provide affirming care. It was consumers themselves who first proposed that we present a conference to teach providers what they need to know to be more effective with LGBT people."

To help ensure that the focus of the conference remains on the consumer, LGBT mental health consumers will present the keynote address that launches the day-long conference. A short subject, documentary film, produced by Michael Posner, features LGBT mental health consumers describing, in their own words, a topic they are experts on: "What helps and what doesn't." Articulate, funny and often moving, the consumers in the video repeatedly touch on themes of stigmatization, acceptance, understanding, and belonging. "And that," says Mr. Coffman, "is what the day is all about."

The People We Serve from page 4

health communities everywhere must come together to safeguard the people we serve so that they are not lost in the shuffle and fall through the cracks. Throughout the United States we are fortunate to have coalitions and advocacy organizations that work tirelessly on behalf of the rights and services of the mental health community and our statewide population of people with mental illness and substance use disorders.

Much of the work to develop NYS's newly emerging system of behavioral health care lies in the recently formed Behavioral Health Reform Work Group (BHRWG), whose members were selected by the Co-chairs of NYS's Medicaid Redesign Team, Linda Gibbs, Deputy Mayor of New York City for Health and Human Services and Michael Hogan, Commissioner of NYS's Office of Mental Health. Members of the BHRWG include: Wendy Brennan, Executive Director, National Alliance on Mental Illness (NAMI)-NYC Metro; Pam Brier, President and CEO, Maimonides Medical Center; Alison Burke, Vice President, Regulatory and Professional Affairs, Greater New York Hospital Association; Lauri Cole, Executive Director, NYS Council for Community Behavioral Healthcare; Donna Colonna, Executive Director, Services for the Underserved; John Coppola, Executive Director, New York State Association of Alcoholism and Substance Abuse Providers; Betty Currier, Board Member, Friends of Recovery – New York; Philip Endress, Commissioner, Erie County Department of Mental Health, Arlene Gonzalez-Sanchez, Commissioner, New York State Office of Alcoholism and Substance Abuse Services; Kelly Hansen, Executive Director, New York State Conference of Local Mental Hygiene Directors; Ellen Healion, Executive Director, Hands Across Long Island; Tino Hernandez, President and CEO, Samaritan Village; Cindy Levernois, Senior Director, Behavioral Health and Workforce, Healthcare Association of New York State (HANYS); Ilene Margolin, Senior Vice President, Public Affairs and Communications, Emblem Health and Health Plan Association; Gail Nayowith, Executive Director, SCO Family of Services; Kathy Riddle, President, Outreach Development Corporation; Harvey Rosenthal, Executive Director, New York Association of Psychiatric Rehabilitation Services, Inc.(NYAPRS); Paul Samuels, Director and President, The Legal Action Center; Phil Saperia, Executive Director, The Coalition of Behavioral Health Agencies, Inc.; Sanjiv Shah, MD, Chief Medical Officer, Fidelis Care NY; Richard Sheola, Executive Vice President, Value Options; and Ann Sullivan, MD, Network Senior Vice President, Queens Hospital Network, NYC Health and Hospital Corporation.

Mental Health News salutes the efforts now underway in NYS and hopes that these guardians of our system of care get it right. Even in this climate of fiscal crisis, the bottom-line is that people's lives are at stake—a reality that cannot be overlooked—no matter what the cost.

Your comments and suggestions are always welcomed at *Mental Health News*, write to: iraminot@mhnews.org.

Good luck in your recovery.
Have a wonderful Fall season !

If you are experiencing a difficult time in your life, always remember that you are not alone. There is a caring and helpful mental health community nearby that can help you get through this difficulty. Don't feel embarrassed or afraid to ask for help, it is not a sign of weakness. Best Wishes from Mental Health News

Developmental Disabilities Nurses: Consultants in Mental Health Settings

By Joni Jones RNBC-CDDN
Certified Developmental Disabilities Nurse

There has been recent discussion about health reform and its potential impact in the community setting. With the implementation of a new or changed concept there comes a period of transition. Discussions that include exchanges of ideas to ease the transitional process may become very relevant if the outcome is projected as a positive one. The intent of this article is to foster an idea; promoting a new concept during this period of revision as it relates to the merging of two very important services. This includes services to the population affected by developmental disabilities and those that seek or require services in the mental health setting.

By profession I am a Registered Nurse. Although I am certified in psychiatric and mental health nursing and as a developmental disabilities nurse, nothing has prepared me more in the provision of services as being a parent to children affected by both. With that combined experience I found an enhanced ability to relate to others that are in fact impacted by similar challenges. The result is the engagement in *functional* solutions to help others reach their individual optimal potential in life.

Experience becomes our best teacher if we are aware of the presented opportunity. This submission will provide two real life situations that occurred in a mental health setting for the purpose of providing the education that captures the vision of the *benefit* that can be obtained by the creation of such a position. The details of these examples have been slightly modified for the purpose of confidentiality.

It's a gloomy day. The rain is pounding on the roof top accompanied by loud cracks of thunder, bolts of lightening and inside lights flickering. Word has been received that an 18 year old woman has found herself in a crisis situation with thoughts of taking her own life. Shortly she found herself in a mental health setting; very much confused with an overwhelming feeling of helplessness and hopelessness.

When I first set eyes on Mary, I did not encounter the stereotypical presentation one might expect from a depressed individual with suicidal ideation. I met a very well groomed individual with sophisticated language enhanced with an air of such mannerism and politeness. We engage in conversation that revealed her life had turned so upside down that she could not "take" not knowing what was "wrong" with her any longer. She sought such relief because the tortured thoughts in her mind progressed to those focused of ending her life altogether. This was truly a tragic situation.

With the process of gathering information I was able to inquire and obtain information about Mary's history that wasn't listed on the standardized computer generated questionnaire. My added experience in this particular specialty made this encounter a positive one. As we talked further and further Mary felt the weight lift right off her shoulders. She felt like a changed woman simply from someone *understanding* what she was going through.

Conversation revealed she had many signs of Asperger's Syndrome. She learned to read at a very young age and used sophisticated lan guage. She did not "hang out" with people her own age and to this day described herself as having a social phobia. She always had focusing challenges but was always exceptionally bright in her area of interests. She possessed literal translation and felt it was difficult to maintain eye contact when conversing. She became confused about emotions especially when two different emotions co-existed. She laughed about her peculiar traits as it related to obsessions and compulsions. It was terrific to

see Nurses on page 30

Mental Health Treatment in Westchester

The VNSW Mental Health Home Care Program provides:

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

Program Features

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

The Big Picture

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

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

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

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

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VNSW services are covered by Medicare, Medicaid and other health insurance plans.

"Hang On" - A Commentary On Mental Health Care for Children

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

Andrew Malekoff, LCSW, CASAC

About 20-years ago I was swimming in the ocean off Long Beach, Long Island, where I live, and someone pointed to a cluster of girls that had drifted towards the jetty, the rock formation that helps to protect the shoreline from erosion. The girls must have been pulled out by the undertow and were unnoticed by the lifeguards.

I swam to them. When I arrived, there were three little girls; one looked about nine-years-old. The others, who were crying and holding on to the older girl, appeared to be six or seven. The older girl was barely in control of her emotions. I wrapped my arms around the three of them and said, "Hang on." Swimming in with them as a group was not an option; neither was leaving any of them behind. All I could do was hold on, calm them, steer them away from the jetty and wait. Finally, the lifeguards arrived and took over. I swam to shore and went back to my beach chair. I never saw the three little girls again. Nevertheless, I think of them often.

When I recall this encounter, I realize that the four of us were strangers who spent maybe 90 seconds together. I said only two words to them: "Hang on." Ninety seconds, two words and 20-years and I still think about them often. We were so close that I could see their freckles. Afterwards someone told me that they were sisters.

Let's consider another scenario. Try to picture me swimming out to the three girls. Now, imagine if, instead of telling them to "Hang on," if I treaded water at a safe distance and asked them if they had Medicaid insurance. Imagine if they answered, "No mister." And, if I then said, "Sorry, girls," turned my back on them and swam to shore.

This is the situation that we now face as New York State is making a dramatic departure from its responsibility to make sure that our most vulnerable citizens – our children – get community-based mental health care, regardless of their family's economic status. They expect us to throw the underinsured middle class and working poor overboard with no life preserver. That's our government.

And, the health insurance industry is no better. Most private health insurers pay substandard rates that we can no longer afford to accept. To add insult to injury, as one journalist Amy Goodman, observed, "profit-driven insurance claim denials actually kill people." For example, in 2001 Timmy O'Clair, a 12-year-old from upstate New York, committed suicide after his parents were unable to obtain mental health treatment for him due to health-insurance coverage limits.

Although Timmy's death was the impetus for the passage of Timothy's Law, which extends insurance coverage for mental illness, profit-driven insurance companies still have a very long way to go.

For example, in spite of the deepest and most lasting recession in more than a half a century the five largest health-insurance companies in the U.S. revealed combined profits of $12.2 billion last year.

I invite you to jump into my Atlantic Ocean memory with me, because it is a story that is about more than me and three little girls. It is about all of us and the thousands of children that community-based mental health agencies like ours guide safely to shore every year and offer them the chance to see a brighter day.

New York State and the health-insurance industry need to understand that our children's lives are at stake and that their ongoing efforts to curtail universal mental health care cannot continue.

Andrew Malekoff is Executive Director and CEO for North Shore Child and Family Guidance Center in Roslyn Heights, New York. He is a former member of NYS Office of Mental Health's Children's Plan workgroup. This is a slightly adapted version of Mr. Malakoff's article that appeared in 18 Anton Community Newspapers in Nassau County, Long Island, NY.

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are able develop real relationships and synergies otherwise difficult to secure and maintain. These clinical relationships across medical and behavioral health disciplines, centered on individuals, break down traditional silos of care: medical "patients" and psychiatric "patients" cease to exist and a ***person*** with multi-faceted, complex needs emerges.

While for most individuals behavioral health services act as the "launch pad" for other Recovery Center offerings, irrespective of how an individual chooses to begin his or her journey at the Recovery Center, enrollees soon begin to experience a reinvigorated sense of hope for the future that permeates in the language, expressed beliefs and attitudes of staff and other enrollees. Coupled with nearly seamless access to the full cadre of Recovery Center services, the high risk enrollee is better able to transition into recovery and the services needed to support it in the community.

In the midst of the extensive healthcare reform strategy aimed at reducing healthcare costs and improving the health outcomes of the highest utilizers of Medicaid dollars now being realized in New York State, the SUS Recovery Center serves as an effective integrated service model for engaging and managing the complex healthcare needs of the "disconnected", emergency room and hospital dependent, Medicaid recipient living with a behavioral health condition. Fully cognizant of the need to actively address physical health concerns, we are engaged in efforts to incorporate medical services into our Recovery Center service array. This addition will afford Recovery Center enrollees access to *truly* integrated primary medical and behavioral healthcare services in a single practice setting.

The Recovery Center also serves to meet the healthcare needs of people with HIV-AIDS, many of whom also live with behavioral disorders ranging from Post-Traumatic Stress Disorder to serious mental illness with co-occurring substance abuse disorders. As a particularly medically complex subset of the Medicaid population, people with HIV-AIDS will be better served by the Recovery Center once primary medical services are established there. While our Recovery Center presents new opportunities to offer integrated care at SUS for people HIV positive individuals, since 2010, we have been providing care coordination for high risk individuals with AIDS and advanced HIV disease living in commercial SRO hotels who are not engaged in effective medical treatment and management of HIV-AIDS. The project is structured as a partnership with private primary medical practitioners who have agreed to serve as the "health homes" for this high-risk, high-need population, engaging participants in on-going health monitoring and treatment leading to improved health status.

Put simply, our SUS Recovery Center is positioned as an effective behavioral health setting poised to reach and engage people with complex healthcare needs, neglected by the health care system, living without the supports necessary to recover. As we know at SUS, once engaged in recovery-oriented system of care, emphasizing total wellness, the overall well-being of the people we serve improves. Our recovery mindset and associated services, informed by an organizational culture that values recovery, provides consumers with a thoughtful and organized environment conducive to wellness and personal fulfillment. With the RecoveryCenter's new addition of primary medical health services, SUS will have even greater capacity to engage and support the recovery of people who are at greatest risk for health crises that result in repeated and avoidable dependence on emergency rooms and hospitals.

The SUS Recovery Center is located at 1125 Fulton Street, 2nd and 3rd Floors, Brooklyn, N.Y. 11238. The phone number at the Center is, (347) 226-9025.

Mental Health News
2012 Theme and Deadline Calendar

Winter 2012 Issue:
"Housing for People with Mental Illness"
Deadline: October 24, 2011
Press Date: November 1, 2011

Spring 2012 Issue:
"Understanding and Treating Depression"
Deadline: January 23, 2012
Press Date: February 1, 2012

Summer 2012 Issue:
"Understanding and Coping with Suicide"
Deadline: April 23, 2012
Press Date: May 1, 2012

Fall 2012 Issue:
"The Medical Needs of People with Mental Illness and Substance Use Disorders"
Deadline: July 23, 2012
Press Date: August 1, 2012

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Parity for Consumers from page 10

annual half-day Workplace Wellness Think Tanks for employers, benefits consultants, mental health advocates and others. This series addressed topics such as mental health parity, the role of HR in workplace mental health and best practices in workplace mental health management.

Evaluating the Law

Timothy's Law was intended to provide employees with increased access to mental health benefits. Anticipating the need for an assessment of whether it was achieving this goal and to determine the financial impact of the law, lawmakers included in the legislation a requirement that the New York State Department of Insurance complete a study of the law's impact, in consultation with the Office of Mental Health.

The Superintendent of Insurance would assess "the numbers" associated with the law's implementation: costs, utilization rates, how many policyholders elected to purchase other mental health coverage pursuant to the law, and the type and number of illnesses for which coverage has been provided.

These are quantitative measures, which are effective in assessing any changes in the utilization rates of mental health services. A quantitative evaluation, however, cannot determine the reasons for the change in the utilization observed, or even if individuals are receiving appropriate care.

This omission risked leaving undiscovered barriers that may exist for a large proportion of the population. NAMI-NYC proposed to undertake a qualitative evaluation to complement the quantitative analysis, providing citizens and policymakers a more comprehensive picture of the impact of Timothy's Law.

Study Results

In April of this year, our study was published in *Psychiatric Services*. It finds that employees covered by Timothy's Law are largely unaware of their new benefits and are continuing to encounter significant barriers as they attempt to access mental health services.

Mental health consumers and their families report that health plans are not providing clear communication or complete information about extended mental health benefits to employees. Written notices are said to lack descriptions of full benefits, online information proves difficult to find, and in some cases, health plan representatives appear to be unfamiliar with the law and may be providing inaccurate information.

A major obstacle for employees seeking mental health care is locating high-quality, in-network providers. Provider lists are reported to contain providers no longer accepting members' insurance or with waiting times for appointments of weeks or months.

Beyond a lack of information and few provider options, some interviewees also perceived more aggressive use of managed care of their mental health benefits. In some cases, preauthorization requirements for mental health services were not found to be comparable to those for general medical care. Criteria for determining the medical necessity of inpatient care were hard to determine. In addition, insurance company denials of care on the grounds of medical necessity have been reported to be inconsistent with the assessments of providers.

Recommendations

Our study shows that comprehensive education programs and effective oversight could improve access to quality mental health treatment. Here are some key recommendations:

Education efforts by health plans are needed to ensure that Americans affected by parity laws know about their extended benefits and able to access them. Federal standards would be extremely useful, as would monitoring of these communications, which must be clear and accessible to anyone seeking care.

Mental health providers must educate clients about their extended benefits. Behavioral health agencies have a role to play, assisting this effort by making benefits information available online and in newsletters.

Human resources departments must develop education programs for their employees. This is, after all, employer-based insurance, and untreated mental illness in the workplace affects both lives and profits. These efforts would simultaneously address stigma, the most persistent barrier to care.

The provisions of the federal law that mandate parity in inclusion criteria for provider networks and managed care mechanisms need to be monitored. People seeking mental health services must be able to find providers close to their homes that accept their insurance and have appointments available in a reasonable period of time.

New York took a great step forward by extending benefits to employees and their family members with mental illness through Timothy's Law. With a little leadership from health plans and employers, and effective government oversight, we hope that access to and availability of quality care will improve.

Why Integration Works from page 8

more and more providers across the country are working toward integration. Although some have been integrated for quite some time, many have been spurred by the incentives provided in the Affordable Care Act to work in new service delivery models like Health Homes and Accountable Care Organizations (ACOs).

Although there are a variety of specific models that will take shape, consumers can generally expect to have more team-based care comprised of a number of different providers or more streamlined referral processes from primary care providers. For instance, if the practice in the beginning scenario had been fully integrated with behavioral health, the primary care physician would have likely screened you for depression and/or anxiety as part of standard practice, which could have led to your being seen by an in-house or referred to an affiliated behavioral health specialty practice.

Patients with mental health or substance use disorders are more likely to suffer from one or more co-occurring physical health conditions and are less likely than the general population to receive preventative services like immunizations, cancer screenings, and smoking cessation counseling. The Robert Wood Johnson Foundation's Synthesis Report recently found that integrated care interventions improve quality and treatment of major depressions and anxiety disorders, based on more than 30 random-control trials.

Behavioral and primary care integration can also help patients overcome another major obstacle in obtaining proper behavioral health treatment: stigma. Society's perception of mental illness and substance abuse, paired with industry biases against behavioral health, have negatively impacted patients' access to needed care. Integration of behavioral health and primary care has the potential to minimize the stigmatization of behavioral health disorders and those affected by them and also helps mitigate discriminatory treatment patients may have experienced from providers prior to integrated care models being adopted.

Stigma is a key component of discussions around integration. Stigma not only manifests itself in negative connotations, stereotypes, or explicit discriminatory treatment but may be the reason for the lack of behavioral health screening in primary care, the reluctance among patients to consider they need behavioral health treatment, and the remaining resistance to see that behavioral health is as important to general well-being and health status as physical health.

Structural and system reforms must occur in order for individuals living with behavioral health disorders to receive proper care, regardless of how complex the physical and behavioral health needs are. All over the country, organizations are successfully integrating healthcare for patients, by providing team-based, person-centered care.

By embracing this vision, the hope is that fewer patients fall through the cracks in the healthcare system and fewer behavioral conditions go undiagnosed and untreated. Our minds and bodies are both essential components of good health and well-being, which is why you and I should be able to sit down in waiting rooms assured that our primary care institutions can effectively treat them both.

For more information about the bi-directional integration of primary and behavioral health, please email integration@thenationalcouncil.org or go to www.centerforintegratedhealthsolutions.org for materials and resources.

In the Workplace from page 6

Mental health parity is expected to confer myriad benefits to not only employees and their families but to the overall health system as well. While it is still too early to tell how the federal parity law will affect the marketplace, past experience in states – the veritable laboratories of democracy – with parity laws on the books has been relatively positive. What has been shown is that parity policies can indeed be effective at controlling costs while also not inciting employers to drop health care coverage offers.

Parity isn't the only mechanism used to address mental illness in the workplace. Numerous other benefit design-related techniques are employed as well. These include enhancing the capabilities and scope of employee assistance programs (EAP), being innovative with absence management and disability programs, increasing health risk assessment completion rates, and being thoughtful about pharmacy benefits – e.g., incorporating a value-based insurance design. Integrating these services is essential to enhancing value for both the employer and employee.

The ultimate goal of this assemblage of mental health services is to keep employees healthy and productive; and employees should use these services. Evidence shows that employees who take advantage of behavioral health services are more productive, experience less disability leave and cost less. These outcomes benefit both employer and employee. Firms would have greater flexibility in their budgets to retain more employees – a much-needed dynamic in this current economic climate – and to perhaps even expand their business. Employees, on the other hand, would likely show higher levels of job satisfaction, be more upbeat both at work and home, and optimize their output. When employees' mental illness progresses or is exacerbated – because of lack of access or inadequate support – no one benefits.

Yet because of the stigma often associated with mental illness or seeking behavioral health services, employees often forego these important features of their benefits package. Employers should thus take an active role in communicating the availability of these tools to their workers. Numerous avenues exist to accomplish this. Company health fairs, intranet, management training, and even word of mouth are suitable and have been proven successful.

Skyrocketing health care costs and rapidly changing marketplace dynamics are causing employers to take a serious look at their health benefits programs. Employers would be wise to not lose sight of how effectively addressing mental illness in the workplace contributes considerably to improving their employees' clinical outcomes, reducing annual trend increases, and raising productivity and output. The synergism of federal health reform, innovative employer strategies and mental health parity will result in greater access to much-needed behavioral health services, a market trend that employers must embrace. Communicating these changes to employees and breaking down barriers attributed to stigma is a tactic fundamental to progress as well. Indeed, actively responding to the effects that mental illness has on a workforce can make a world of difference in a tight marketplace that is increasingly global and competitive.

Health Care Reform from page 1

representatives from the Legislature, health care industry, patient advocacy groups, and State executive staff including the Commissioners of the Office of Health, Office of Mental Health, Office of Persons with Developmental Disabilities and the Office of Alcoholism and Substance Abuse Services, and the New York State Medicaid Director. (3)

Behavioral Health Organizations

The MRT proposed various means of achieving the challenge to reduce Medicaid expenditures. Behavioral health services emerged as one of the central concerns due to the fact that the 300,000 behavioral health recipients were deemed "high cost". (4) The MRT, therefore, proposed creating Regional Behavioral Health Organizations (BHO) to monitor inpatient behavioral health services for Medicaid fee-for-services beneficiaries and SSI enrollees in managed care, for a two year period prior to moving all consumers into some type of managed care.

The Tasks of BHOs

- Monitoring behavioral health inpatient admissions, length of stay, and discharge planning
- Children's outpatient SED tracking
- Provider Profiling
- Facilitate cross-system linkage (5)

Utilization Threshold

To further control costs of health care, 30-Day amendments have been passed and implemented as of April 1, 2011. The amendment subjects outpatient clinics operated by agencies licensed by the Office of Mental Health (OMH), the Office of Persons with Developmental Disabilities (OPWDD), and the Office of Alcoholism and Substance Abuse Services (OASAS) to utilization thresholds. The thresholds were established by DOH, in consultation with these state agencies, on either a provider-specific or patient-specific basis. Provider-specific thresholds are based on average patient utilization compared to a peer-based standard and are to be applied prospectively based on the amount a provider's utilization exceeds the threshold.

Andrew Cleek, PsyD

Patient specific thresholds are based on annual thresholds determined for each service and reduce payments for visits over that threshold by a pre-determined amount. The base year for the thresholds is 2009 and is retroactive as of April 1st, 2011. OASAS has adopted a provider specific threshold and OMH has adopted a patient specific threshold.

The MRT proposed thresholds for OMH, OPWDD and OASAS. For OMH adult clinic providers, there will be a decreased in billable rate of 25% after 30 sessions; and a decrease of 50% in the billable rate after 50. For children's clinics there is no decrease after 30 sessions but the 50% reduction is in effect after 50 sessions. For OPWDD clinics, the reimbursement rate would be a 25% reduction after 90 visits and a 50% reduction after 120 visits. Lastly, for OASAS clinics, the 25% reduction occurs at visit 66 and the 50% reduction would occur at visit 86. (6) It is expected that the implementation of this utilization threshold will reduced costs by twenty-five percent if a lower threshold was exceeded, and a fifty-percent reduction in payment would occur if a higher threshold was crossed. This would translate into an annual total reduction in New York State Medicaid expenditures of at least $10.9 million in OMH's Article 31 clinics, at least $2.4 million in OPWDD Article 16 clinics, and at least $13.25 million in OASAS' Article 32 clinics. (3)

Nisha Beharie, MPH

Health Homes in New York State

The MRT's recommendation to create Health Homes to provide coordinated care for Medicaid enrollees with multiple chronic conditions was adopted into law effective April 1, 2011. Health Homes are required to provide the following services:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology (HIT) to link services, as feasible and appropriate. (7)

Under New York State's approach to health home implementation, a health home provider is the central point for coordinating patient-centered care. Health Homes will be responsible for coordinating care, and connecting people to services that meet their needs. Their ultimate goal is accountability for improving health outcomes and reducing avoidable health care costs (i.e. preventable hospital admissions/readmissions and avoidable emergency room visits). In addition, NYS health homes will provide timely post discharge follow-up, and attempt to improve patient outcomes by addressing primary medical, specialist and behavioral health care needs through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services.

What this Means
for Providers and Consumers

These policy changes will have potentially profound effects on both providers and consumers. First, utilization thresholds for outpatient providers will lead to decreased funding for high need clients who require more sessions than are covered under the full rate. Second, the BHO will impact inpatient utilization and maintain additional reporting requirements for inpatient and children's providers. In addition, providers of all types will receive profiles of their services based upon certain performance metrics. Lastly, the impact of health homes is more unpredictable but will likely lead to, at a minimum, a radical re-structuring of the behavioral health case management system. The creation of health homes will also require physicians and behavioral health clinicians to work more closely with one another to provide more efficient and holistic care.

The increase in Medicaid recipients as well as the parity measure with behavioral health will require that clinicians in both areas provide services more efficiently to meet the needs of a greater number of clients without sacrificing the quality of care or positive outcomes. This will be a particularly salient issue for behavioral health providers as they will see an even larger increase in consumers seeking services. Behavioral health and health providers will also be incentivized to provide services in the most efficient means possible as the state and country move from a traditional fee-for-service model and utilization thresholds are implemented. At this time, both the long and short-term outcome of health and behavioral healthcare payment reform is uncertain. What is clear is that this transition will present a number of challenges and opportunities. How consumers of services, policy makers, providers, and academic partners work together to

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see Timothy's Law on page 14

that already had mental health parity laws already in effect, concluded the total cost of implementing Timothy's Law in New York would be $1.26 per insured individual per month. As further evidence of this point, major insurance providers in western New York have indicated that only 1% of the rise in insurance premiums in 2011 is due to Timothy's Law as State funding for the law expires.

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

The Extension of Timothy's Law

Presently, there is a push to extend Timothy's Law's coverage to those who suffer from Post Traumatic Stress Disorder (PTSD). The amendment would include PTSD in the 20/30 base benefits. It would also include coverage during the acute phases of the illness including inpatient and out-patient treatment in order to bring the person to stability. Again, looking to the minimal cost and likely potential savings, it makes financial sense for this amendment to pass. Moreover, there is increased concern, and rightly so, for the mental health issues that many returning veterans must deal with after the impact of living in a war zone. Clearly, including PTSD within the ambit of coverage for Timothy's Law would be of great assistance to this population of individuals. Unfortunately, as of the writing of this article, the amendment has not become law.

Conclusion

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

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address these changes will have a significant impact on the outcome.

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High Hopes from page 20

for cutting. In fact, "optional" in this context simply means that—under current law—it is permissible for states to be in the federal Medicaid program without covering behavioral health services. Despite the legal option, all states currently use Medicaid to pay for mental health services. Eliminating the federal share of Medicaid for behavioral health would undoubtedly result in a vast reduction of behavioral health services throughout the United States.

So, we all have to be ready to fight to preserve both the provisions of health care reform and federal behavioral health benefits that were available prior to health care reform. The good news is that all of the mental health advocacy organizations are in the battle already, and they have been effective. (It may be that vouchers for Medicare are already off the table.) The bad news is that unless there is a political shift in Congress after the next election, the battle for decent behavioral health services in the United States has just begun.

Michael B. Friedman is Founder and former Director of the Center for Policy, Advocacy, and Education of the Mental Health Association of New York City. He currently teaches at Columbia University's schools of social work and public health. His writings are collected at www.michaelbfriedman.com, and he can be reached at mbfriedman@aol.com.

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see this modification in her mood as we continued to talk.

I inquired if she ever heard of the term Asperger's Syndrome. She became very excited and said yes. In fact an acquaintance several years ago; who actually had the syndrome, felt she too possessed similar characteristics. She said that her dad was actually going to look into this, but she has gone to Psychiatrists that have prescribed antipsychotic medications that were making her feel worse instead of better. She stated she was tired of all the medication changes. When asked if she ever was evaluated by a neurologist her response was "no." As a child she was never examined by a developmental pediatrician.

We connected. It was very simple and uncomplicated. I reinforced that I was not a Physician and had no authority to diagnose but could provide information that she can discuss with the Psychiatrist about the consideration of such a diagnosis. We discussed reading materials, support groups and organizations should she be interested.

In that moment I watched a beautiful young lady exclaim excitedly her interest and reverse those feelings of helplessness and hopelessness as the weight lifted so effortlessly off her shoulders. We were both happy we met.

Then there was David. David was a teenager diagnosed with a developmental disability with a coexisting cognitive impairment who suffered with feelings of depression, triggered from the rejection of a desired first sexual relationship. He heard voices that reminded him of the event; replaying in his head over and over throughout the day. Those voices emerged into command hallucinations. As one can imagine, life became tortuous for David.

David's mother was very supportive and quite educated about his disorder. Her love for her son was evident. She was quick to educate staff; covering feelings of her own helplessness. She came to us once before and was not pleased with the outcome so she dreaded his return. She felt like there was no choice though, for her son's life too, had spiraled out of control.

Staff complained of her overbearingness. Personally, I saw it quite differently. I saw a past part of me in her so relating came quite easily. I picked up the phone with a plan to anticipate her needs. Not only was she quite surprised, but her defensiveness became thin as the security rose in her voice. The conversion of helplessness and hopelessness to hopefulness came swiftly and naturally. The air seemed simply magical.

David was quite popular on the unit. His developmental challenges were evident in his looks and presentation. Although he had an auditory processing delay he answered questions and expressed himself quite appropriately.

Quite often I find that individuals fall prey to IQ testing that was performed many years ago. Unfortunately results sometimes attach to them like metal does to a magnet. His expressions certainly did not match those IQ conclusions.

As in any mental health setting there are rules and regulations based on existing policies. However, modification within interpretation can be sometimes necessary to individualize effective plans of care. Being certified or educated with the specialty of working with the developmental disability population gave me the credentials needed for persuasion related to such modification.

Orders were received that allowed this gentleman to have his security bedding. It also allowed him to listen to his music in an isolative room under camera surveillance. To my surprise was the response; inflexibility of surrounding staff and support from all the patients that didn't receive such privileges.

This was such a simple and reasonable accommodation for his disability, There were no explosive outbursts as disclosed in his history and he felt safe. With the mood stabilization, calm environment, and sense of security, therapeutic intervention soon followed.

A conference with both David and his mother became life altering. We discussed the use of classical music with headphones to manage the voices. We agreed that the lyrics in songs could trigger the reminder of the failed relationship. David was very excited. He shared that he really enjoyed classical music. We discussed referral to supported employment for David.

We discussed job coaching and opportunities for him to meet others in the community to aid in the development of healthy relationships and to help resolve the isolation, disturbing thoughts and depression that followed. We discussed IQ testing, cognitive behavioral therapy, self-talk and affirmations. David was equally excited and so was his mother. She could not believe the difference in her experience this time around. With permission, we all hugged.

David now had a sense of purpose and direction. If non experienced nurses cross paths I am confident such direction would not have been provided and the circle for this family would have continued. It is very important for professionals to *listen* and be *alert* to all presented disclosures that can provide the clues necessary to develop an *effective* plan of care.

Going through motions should not be in any repertoire when it comes to the preservation of life itself. Because of my experience and certification in developmental disabilities, the visit to our facility became life altering. I believe it is time for legislators and organizations to become more aware of the many specialized skills that Developmental Disability Nurses possess.

Yes, this is the time for health reform. Many people are now finding themselves with mental health challenges and many of those individuals have an existing developmental disability. The health management specialty of the Developmental Disability Nurse can help preserve life and should be viewed as a valuable asset to the healthcare system.

Joni Jones RNBC-CDDN, is a Registered Nurse, Board Certified in Psychiatric and Mental Health Nursing, is a Certified Developmental Disabilities Nurse, and is a member of the Developmental Disabilities Nurses Association (DDNA).

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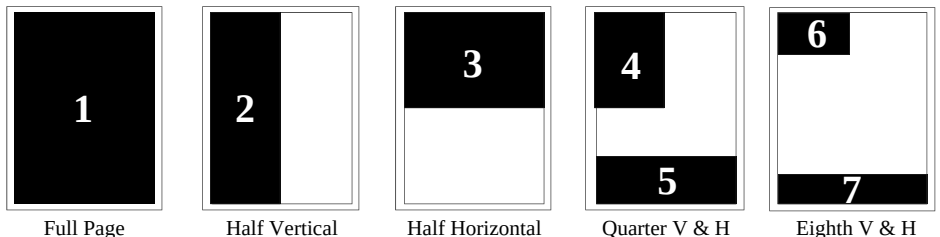

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Half Horizontal (3)	10.4	6.4
Quarter Vertical (4)	5.1	6.4
Quarter Horizontal (5)	10.4	3.1
Eighth Vertical (6)	5.1	3.1
Eighth Horizontal (7)	10.4	1.5
Business Card (not shown)	5.1	1.5

MENTAL HEALTH NEWS

Recovery from mental illness is possible but it takes a community of support.

Mental Health News provides news, information, education, advocacy, and resources in the community that adhere to our strict evidence-based standards and is a vital link to that community of support.

Learn how Mental Health News can help provide your organization or community group with an affordable and trusted source of mental health education.

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