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FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE

VOL. 13 NO. 2

The Medical Care and Psychosocial Needs of Older Adults

By James Spencer, MD
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More than half of the older adults who receive behavioral health care receive it from their primary care physician. There has been much recent interest in the medical or health home model that provides comprehensive care, and in which a primary care physician (PCP) leads a team, which may include nurse practitioners or physician assistants. The team is responsible for providing all the patient's health care and, when necessary, arranges for appropriate care with other physicians. This model integrates behavioral health and primary care.

The New York State Office of Mental Health is currently supporting a group of Geriatric Demonstration Projects that have shown the value of behavioral and primary health care integration for the elderly. Primary care physicians have found that



added assessment and treatment services provided by a mental health professional (MHP) are not only helpful in addressing varied behavioral health problems, but also may improve physical health and care delivery (e.g., better adherence to treatment

plans, reduced frequency of unnecessary phone calls and office visits to MD). The MHP in a primary care practice or health home provides a practice component for identifying behavior related issues and dealing with them.

Important behavioral conditions that have been identified and addressed in the primary care setting by these projects are symptoms of depression and anxiety, some of the psychiatric disorders described in DSM IV, and behavior related issues like smoking and obesity. These are all problems by themselves, but they can also have a significant impact on an individual's physical and mental health.

In addition to these symptoms, disorders and behavioral problems, certain types of psychosocial needs or stresses are often found; problems related to domestic conflict, care taking responsibilities, housing, financial management, home health support, safety, nutrition, social isolation, health insurance, and medication management appear with great frequency. They are elements in a complex set of needs of older adults who are "aging in place". These difficulties are particularly prevalent for the elderly who live alone without family or other support, and feel that they have nowhere to turn for help.

Primary care practitioners often struggle with these patient needs, because they

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Senior Peers Provide Companionship to Homebound: New York City Program Addresses Social Isolation in Older Adults

By Yoshita Pinnaduwa, MA, MPA
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The Bureau of Mental Health,
New York City Department of Health
and Mental Hygiene

Individuals of any age group benefit from being socially connected: having friends, outside activities and people to talk to. Older adults, especially those with a mental illness, potentially have more difficulty remaining connected because it is easier for them to gradually lose their social relationships as a result of their illness or as they retire from their jobs and physically challenging social activities. Many studies, old and new, have found that older adults who adjust to later life transitions by remaining socially active are happier and healthier than those who don't engage in social activities (Cavan et al. 1949; Lemon, Bengtson, and Peterson 1972). While it is

not easy for many seniors, especially those who are home bound to remain socially active, there are very few programs that address social isolation. This article highlights an exciting program in New York City that tries to address loneliness among homebound seniors.

Despite how aware we are about the importance of being socially connected, the truth is that most older adults eventually lose many of their relationships due to retirement, relocation, or a death of a loved one. Mullins and Dugan (1990) say that individuals who are 65 and over are at higher risk of becoming socially isolated with advancing age than younger adults. Compared to several decades ago, changing family structures and cultural shifts have compelled many seniors to live alone. A study on seniors living below the poverty line (Klinenberg, Pg. 32) concluded that of all seniors living alone, one out of three do not see friends or neighbors for as long as two weeks at a

time, and one out of five have no phone conversations with friends. The Baby Boomer generation, which will be the largest cohort of seniors ever, is expected to be at even more risk for social isolation than their parents.

Sadly, even in a place like New York City that has over eight million people (almost a million of whom are seniors age 65 and above), as many as thirty five percent of them live alone (United Neighborhood Houses, 2005). And even in densely populated areas like upper Manhattan, the South Bronx, central Brooklyn, and portions of lower Manhattan, many seniors live in isolation.

As mentioned earlier, older adults who suffer from a physical or mental disability are usually even further isolated from the rest of the community. Many are unable to travel or the nature of their illness prevents them from initiating and maintaining social relationships. Reports estimate that roughly forty

six percent of New York City's seniors live with a physical or mental disability. The New York City Community Health Survey (2009) showed that thirteen percent of the City's adults 65 and older reported a history of diagnosed depression. Many more seniors remain undiagnosed because they are reluctant to seek help or because they don't have access to screening and treatment.

To address the mental health needs of older adults, New York City currently has about 120 publicly funded mental health programs throughout its five boroughs. More than half of the programs provide treatment for mental illness and the rest provide a range of services from outreach and advocacy to case management and rehabilitation. A few of the latter group of programs try to address social isolation by providing outreach and recreational opportunities for their senior members.

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"Health Reform and Mental Health Parity
and their Impact on People and Service Providers"

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Deadline: November 1, 2011

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— From the Publisher —

Reflections On My Father's Golden Years

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

In recent years there has been an explosion of interest and research to discover the cause and ways to successfully treat Dementia and Alzheimer's Disease. There are new medications to stave off brain decline and if already in decline, to improve the brain's cognitive ability. There are also many recommendations for ways to exercise the mind to keep it sharp, including reading, playing board games, and even ballroom dancing (WebMD). Certainly, many seniors are now more computer savvy, surfing the Internet, social networking, and web-cam chatting with friends and family; all wonderful ways for older adults to keep their minds active and to avoid social isolation.

But what did older adults do years ago when there was no science working on ways to combat brain decline, and there were no computers, email, social networking, and so forth? It's shocking to realize that personal computers, email, and the internet only became popular around the mid 1990's. That's only 15 years ago, and about the time I got my first computer and started *Mental Health News*.



Ira H. Minot, LMSW

While thinking about this, I can't help but reflect on my father Herbert's life. My father was born in 1913, was a successful attorney, raised five children, and lived another 20 years in Florida after my Mother passed away. Dad was 89 years old when he died in 2002, and he remained sharp and lived on his own up until the very end of his life.

One thing my father was known for and had mastered into an exact science was his gregarious and out-spoken personality. He developed these skills in part because of his line of work as an attorney in private practice. What he would often do was recount past achievements, clients and cases over and over again to us (his kids) and to new people he would meet throughout his life. I used to cringe and often leave the room in embarrassment when he would go into one of his stories—partly because members of the family had obviously heard the same stories over and over again, and also because as a youngster, I didn't understand the genius behind what he was doing. I can laugh about it now and think of how many episodes of *Seinfeld* could have been written about someone like my father, his outgoing personality, and the endless stories he told.

But you know what? I think it was those very same stories that kept his mind sharp throughout his life and into his golden years. He didn't have a computer, the internet, or email. He was a master of the spoken (and hand-written) word. He always took an interest in people and would encourage them to speak about how they were doing, and loved to be consulted about a problem someone may be having.

He brought those same skills with him when he retired to Florida. He became a sought-after advisor to the local condominium scene, who often came to him to answer legal questions or to resolve a dispute between boards and their residents. He loved and thrived on the attention he received, and would always send me clippings about his appearance on a local radio talk-show or in the local newspaper about his condominium activities.

During my father's golden years I finally came to understand the many good qualities he had, that I did not appreciate when I was younger. He taught me many lessons during those years that I still cherish and hope I too may be remembered for as I now approach my own golden years.

I often think about my own experience overcoming mental illness, starting over again, and what it has taught me. It is that you need to find something you really love and are passionate about, and use it as much as you can in your day-to-day life. For me, it became starting this newspaper 20 years ago. It has not only helped a lot of people get connected to the mental health community, but it has given purpose to my life, was instrumental in my recovery, and keeps me going every day.

Good Luck in Your Recovery
 Have a Wonderful Spring Season!

— Letter to The Publisher —

The Arizona Killing: Let's Get the Facts Before We Act

By Michael Friedman, LMSW
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Work and Public Health

Horrifying, but rare events, like the recent killings in Tucson, Arizona, sometimes result in changes in public policy that calm the fears evoked by the events, but which may not actually reduce the risk that they will occur again. Of course, calming public fears can be useful, particularly to elected officials, who need to show their constituents that they are taking action to protect them from what everyone hopes are preventable events. Hopes, however, are not realities. Sadly, not all terrible events are preventable. And it is far easier to create emotionally satisfying changes in policy than to create changes that will work.

In response to the assumption (which may or may not be true) that the man who shot and killed so many people in Arizona is severely mentally ill, many people are questioning mental health policy in the United States. Some are calling for increased use of coercive interventions and for more use of inpatient treatment. Some decry these approaches and argue instead for increased availability of, access to, and engagement in mental health services in the community.

Those who call for increased coercion generally refer to research findings that

people with serious mental illness are somewhat more likely to commit acts of violence than those who do not have serious mental illness. Those who argue against increased coercion generally refer to research findings that people with serious mental illness are not more likely to commit acts of violence than others in the absence of other factors such as substance abuse and that they are more often victims than perpetrators of violence.

Before jumping to a conclusion, policy makers should look carefully at the available research. To do so they will need to ask the right question. The issue raised by the incident in Arizona is not about the possible link between mental illness and violence, which has been the center of most of the debate. Studies about violence in general include getting into fights, waving weapons to threaten people, and other relatively minor acts as well as acts that result in serious injuries or deaths. The question provoked by incidents like the one in Arizona should really be about the link between severe mental illness and homicide. To be more precise, the question should be about the link between mental illness and killing strangers. (Most homicides involve family or acquaintances).

Unfortunately, it appears that little is known about mental illness and "stranger homicides" in the United States. Researchers (Nielsen et al 2009: <http://schizophreniabulletin.oxfordjournals.org/content/>

[early/2009/10/12/schbul.sbp112.abstract](http://schizophreniabulletin.oxfordjournals.org/content/early/2009/10/12/schbul.sbp112.abstract)) recently reported the findings of an analysis of seven research studies in the developed world about psychosis and homicide. They noted that they were unable to find studies about the incidence of stranger homicide by people with psychotic illness in the United States.

However, what they report about stranger homicide in other parts of the world is important. First, it is extremely rare -- approximately 1 per 14 million population. If that is the rate in the United States, there would be about 21 stranger homicides by people with psychotic illness per year. Second, it is even rarer among people who have had treatment for mental illness than among those who commit homicide during their first episode of psychosis, prior to identification and treatment.

What do these findings suggest as sound public policy?

- As awful as it is when a person with a severe mental illness murders people, we should be careful not to over-react to these exceedingly rare events.
- Much more research is needed regarding the incidence of stranger homicide and murderous rampages by people with severe mental illness and about what distinguishes them from the vast, vast majority of people with mental illness, who do not commit such acts.

- Earlier identification of people experiencing their first episodes of psychosis and helping them get good treatment might reduce the already low rates of stranger homicide.

- Earlier identification of people who have dropped out of treatment for psychotic conditions and outreach to re-engage them in treatment might also be helpful. (New York City and New York State have started a joint project to do this. It will be important to see what the outcomes are. http://www.omh.ny.gov/omhweb/justice_panel_report/).

Should there be increased use of coercive interventions so as to prevent stranger homicide by people with psychotic illness? Should there be improved access to high quality mental health services? The recent research data suggest that what is important is early identification and engagement in treatment.

The aftermath of a tragedy is often the occasion for unreflective action to quell public fears. It can also be an opportunity for reflective policy change. Let's be careful to base responses to the horrifying shootings in Arizona on the facts and not on fears and futile hopes.

Reprinted from The Huffington Post, January 18, 2011.

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Geriatric Mental Health in New York State: A Reflection on Progress and Future Directions

By Kimberly Williams, LMSW
Director, The Center for Policy,
Advocacy, and Education, at the
Mental Health Association of NYC

The first wave of the baby boom generation turns 65 this year. In New York State, the number of older adults will grow 50% over the next twenty years from 2.7 million in 2011 to 3.9 million in 2030. 20% of these individuals have diagnosable mental and/or substance use disorders. As a result of this population growth, the number of older adults with mental disorders in New York State will grow from 540,000 to 780,000. Are we ready to confront the mental health challenges of this demographic shift?

Over the past few years, we have made some important strides in NYS to prepare for the mental health needs of the elder boom. We have the nation's first Geriatric Mental Health Act, landmark legislation that is leading the way in addressing the unmet mental health problems of older adults. The Act's Interagency Geriatric Mental Health and Chemical Dependence Planning Council, which is chaired by the Commissioners of the Office of Mental Health, Office for the Aging, Office of Alcohol and Substance Abuse Services and Division of Veterans Affairs with representation from six other state departments as well as six public appointments is conducting long-term planning regarding the mental health needs of older adults. NYS provides \$2 million per year for the Act's service demonstration programs -- innovative community based projects in two areas, (1) integrating mental health into primary care and (2) educating and training community gatekeepers to identify at-risk older adults and connect them with services. An effort is also underway to assist these projects to structure their services and billing systems to bring in entitlement funding, mostly Medicare, so they can become financially sustainable once the grant funding ends. Important regulatory changes, such as the lifting of Medicaid neutrality, have also paved the way for potential significant service expansion. In New York City, The City Council has recognized the critical need for more geriatric mental health services by providing over \$12 over the past six years to fund the expansion of community-based mental health services for older adults in non-traditional settings. A range of diverse supports have been mounted including mental health education; outreach and engagement; screening, assess-



Kimberly Williams, LMSW

ment and onsite treatment or referral; supports for family caregivers, and more.

Although we have had some significant accomplishments in New York State, for which we should be proud, the elder boom is here, and we are not yet ready. We still have, as the saying goes, "miles to go before we sleep." We need more meaningful planning and substantial expansion and restructuring of services to adequately prepare for the increase of geriatric mental health problems over the next several years. Our goals should be to:

- Enable older adults with mental health and/or substance use problems to age in the community
- Improve access to services through service expansion and by offering more services in the home and community-based settings where older adults congregate such as senior centers and NORCs (naturally occurring retirement communities)
- Enhance quality of care and treatment in the community and in long-term care facilities
- Integrate health, mental health, and aging services to provide comprehensive, coordinated care tailored to the needs of the individual
- Build a workforce of clinically and culturally competent mental health, health and aging service providers

emergency room visits, hospitalizations and other forms of intensive, intrusive and costly medical intervention can occur because of the psychosocial difficulty and the stress they cause.

Such problems may be well known to the patient's doctor, but he/she may have neither training nor time to deal with them. When effective professional intervention does occur it often takes the form of what is called case management, be-

and more extensively engage older adults in peer-to-peer service roles

- Provide support for family caregivers
- Provide public education and outreach to address ageism, stigma, and lack of knowledge of and fears about treatment and its effectiveness
- Improve research on effective prevention, intervention, and recovery support strategies
- Design finance models that support best and innovative practices, integrated service delivery, and incentives to enter, and remain in, the workforce
- Promote governmental and private sector readiness including dedicated leadership, interdepartmental planning, and program development

Given the current economic restraints, accomplishing these lofty but critically important goals will be exceedingly difficult. We have great challenges ahead, but, we also have reason for hope.

At the federal level, mental health parity in Medicare will be fully implemented in 2014, which will support expansion of geriatric mental health services. In addition, federal health care reform offers opportunities for better mental health care for older adults. It improves coverage of physical health care, which will benefit older adults with co-occurring mental and physical health disorders. There is also improved coverage of mental health services, expanded integration of health and mental health care, and enhanced long-term provisions. Ensuring the success of health care reform, however, will be difficult, to say the least.

In NYS, the health and mental health care systems are experiencing additional reform of their own. Out-patient mental health clinics are undergoing programmatic and fiscal restructuring, and a newer form of programming called Personalized Recovery Oriented Services (PROS), which focuses on recovery and rehabilitation, has been expanding in recent years. With this restructuring, we need to be sure that services effectively meet the clinical and programmatic needs of older adults and are fiscally sound so they can result in increased service capacity for the geriatric population.

Medicaid is also being re-conceptualized. In an effort to help close a \$10 billion budget gap, NYS Governor Cuomo has formed a Medicaid Redesign

Team to find ways to cut cost and improve efficiency in the program. Geriatric mental health initiatives can help. For example, long-term care services for older adults and individuals with disabilities are a major driver of Medicaid costs. What is rarely understood, however, is the high prevalence of mental illness among individuals with long-term care needs and the extent of unnecessary placements in expensive institutional settings due to the failure to address mental health issues of those who are disabled and of their families, who are at high risk for mental disorders that limit their ability to provide the care their family members need to remain in the community. In reforming Medicaid, we must see to it that mental health is effectively integrated into long-term care restructuring efforts so as to reduce cost and improve the quality of life of older adults both now and in the years ahead.

We should also optimize the use, and fight for the preservation, of the existing structure and leadership of the Geriatric Mental and Chemical Dependence Planning Council. With the Governor's Commission to reduce the size of government by 20%, the continuation of the Council, although established by law, is not at all certain. The Council's work is not yet done, and its efforts to foster interagency coordination and ensure effective service delivery for older adults are all the more vital as the population grows over the next several years. The geriatric mental health demonstration programs are also providing us with significant insight about successful organization and delivery of care. Their continuation and expansion will be important for the dissemination of state-of-the-art models that support older adults with mental disorders to age in the community across the state.

It's an uncertain time, but a critical time for us to be rethinking the structure and financing of health and human services. As we confront the challenges and seek opportunities for progress in the midst of crisis, all of us who care about the mental health of older adults will need to be vigilant and dedicated to assuring that geriatric mental health gets the attention, planning, and funding it deserves. And, time is of the essence. The elder boom has already begun.

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can complicate medical care and patient follow through, including proper adherence to care recommendations and because they often cause stress with consequent anxiety and depression. These needs can lead to serious deterioration of a patient's physical condition, unnecessary office visits, or time-consuming phone calls to the doctor. Sometimes

cause they are mainly psychosocial problems for which the patient needs help from family or social service agencies, or other sources that lie outside the usual range of medical services.

However, patients often do not know that help is available or how to obtain it. Or they may resist help for a variety of reasons. There is a need for intermediate flexible intervention by a physician or physician's representative. When success-

ful, this may be followed by more sustained support from an agency or other non-medical source, but the initial intervention (which may involve expertise in overcoming resistance and forming a supportive relationship, identifying problems and potential types of aid, knowledge of available services, and immediate practical help) must come from the people

see *Older Adults on page 16*



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Barriers to Accessing Mental Health Care for Older Persons with Depression

Jo Anne Sirey, PhD, Associate Professor of Clinical Psychology in Psychiatry, Weill Medical College of Cornell University

Early in my career, I took my oldest daughter to her first dentist appointment. Making small talk, the dentist asked me what I do. I told her about my research on barriers to care, the stigma surrounding mental illness and interventions to improve treatment participation for older adults. As she listened, I saw her eyes well up with tears. She told me about her father, who had been depressed in the final years of his life and had refused mental health care. Looking back, she remembered his fears about talking to a mental health provider. She told me that the family had difficulty untangling her father's medical illness from his aging-related functional losses and from the symptoms of major depression. They recognized later that their own biases were subtle and insidious. I have heard similar stories from family members, friends, providers and my own patients. As older adults are identified as needing mental health care or seek it out themselves, they often come face to face with barriers to care.

Much can be learned about the psychological perspectives of older adults who may need mental health care by conducting research out in community settings. When you speak with older adults in senior centers or apartment buildings, they openly talk about their reluctance to seek care. They do not perceive the need for treatment, either because they attribute their difficulties to normal aging or medical illness; or perceive the financial and social costs of treatment to be too high. In addition to the financial costs of care, it is the anticipated social costs of stigma and rejection by others that are often equally intimidating. For many of these older adults, mental illness is not like pneumonia where symptoms such as shortness of breath that cause distress are readily identifiable as abnormal and precipitate seeking care. Instead, many depressed older persons struggle to get moving, take care of themselves and their families, and manage their day to day affairs. They do not perceive themselves as suffering from a mental illness. As a



natural consequence, these older persons do not see that their difficulties could be ameliorated by seeking and participating in treatment. Many older adults perceive their distress as an intractable part of the aging process. If depression, medical illness and loss are a normal part of aging, why would one think to seek help?

Seeking care is a health behavior that emerges out of an often "non-conscious cost benefit analysis". It is only when we ask older adults the rationales for their choices and about their experience that these attitudes and beliefs become clear. To accept a referral and participate in mental health treatment reflects a balancing of barriers to care and the perceived need for care. Many providers are aware of the barriers older adults face due to transportation, expenses living on a fixed income, and the impact of medical illnesses. But often these factors obscure the attitudes and barriers that may be equal determinants. For older adults with depression, their low energy and resignation resulting from symptoms, cognitive deficits and associated difficulties in functioning each compound one another. In our work with community-dwelling clients of Westchester County aging services, we have found that half of elders who report symptoms of depression that would warrant attention do not perceive themselves as suffering from an emotional

illness. Many express concern about the social costs of being stigmatized for seeking depression treatment. Even among those older adults who do initiate mental health care, perceived stigma is a barrier to both participation in treatment and antidepressant adherence. When teased apart, beliefs about depression, preferring self-reliance and lack of knowledge about services can contribute to the lack of mental health service usage.

Additionally, barriers may reflect cultural assumptions about need and mental health care. Concerns about stigma, fear of involuntary hospitalization and reluctance to divulge personal information are common among older persons from culturally diverse and less economically advantaged communities. Based on resilience theory, at the individual level reluctance to seek care among minority older persons may reflect effective coping mechanisms and adaptations to having survived racism and discrimination. Over time, these coping mechanisms and adaptations can evolve into obstacles to health care in later years. Preferences for self-reliance, use of home remedies, faith-based interventions and care avoidance due to mistrust of care providers may be powerful remnants from earlier healthcare abuses. In these cases, the predisposing factors that once served to protect the individual have now become barriers to care.

In our recent work we found that older adults are aware of concerns about both public perceptions of stigma and personal social costs. When asked if "most people would willingly accept a person who has had depression as a close friend", 39% of older adults interviewed who endorse symptoms of depression did not agree. Similarly, 47% felt that most people did not believe that a person who has been hospitalized for depression is just as trustworthy as the average citizen. When reflecting on the reactions of their own family and friends, more than a third were concerned that others would treat them differently (40%), judge them (40%) or distrust them (40%). These reports confirm the continued concerns of older adults about societal stigma as well as personal stigma.

To combat stigma and other barriers to care we are working to develop interventions that promote engagement in mental health services among older adults identified in the community. Inquiries about what they expect when seeking mental health care, who in their lives has had similar difficulties or treatment, and who in their community knows about their illness can elicit information about stigma and other barriers. Prior experiences and concerns about what will happen in treatment can provide a way of openly discussing barriers to care. By understanding the concerns about accessing care, defining goals that could be achieved if care is effective and collaborating to address the barriers, our interventions hope to help older persons seek the care they can use, engagement in a collaborative treatment relationship with a provider and adhere to treatment agreed upon. Taking these steps may help address depressive symptoms that compromise the quality of life.

Jo Anne Sirey, PhD, is Associate Professor of Clinical Psychology in Psychiatry at the Weill Medical College of Cornell University and is associated with the Weill Cornell Institute for Geriatric Psychiatry, both in New York City. The Weill Cornell Institute located on the campus of New York Presbyterian Hospital in White Plains provides screening for depression to older adults. For more information, please call (914) 997-4331. Her research is supported by research funding from the National Institute of Mental Health (R01 MH079265, R01 MH087562).

Companionship from page 1

Among these few programs is a unique Peer Volunteer program called the Baruch Elders Services Team (BEST) run by Grand Street Settlement. Located in a primarily Hispanic, Asian and Jewish neighborhood in New York City's Lower East Side, Grand Street Settlement offers a continuum of innovative programs from early childhood and youth development to community support for adults and seniors. Established in 2003, BEST is one of the several recreational and socialization programs for seniors offered by the agency. It is located in the Bernard Baruch Houses' NORC (Naturally-Occurring Retirement Community) environment, the largest public housing complex in Manhattan, and has

senior Peer Volunteers serving homebound senior clients.

BEST, designed after the evidence-based Peer Support model, has an active 18-member Peer Volunteer Corps that live in the Bernard Baruch Houses. They serve around thirty homebound, frail, and socially isolated seniors, 95% of whom are Hispanic. The majority of Peer Volunteers themselves are of Hispanic origin and all are fluent in Spanish. The average age of a Peer Volunteer is 70-72 years and many are women. About half have a history of depression and most suffer from physical ailments like arthritis and diabetes. The Peers receive extensive training on mental health and other related issues when they are first hired and continue to receive refresher trainings throughout the year. They

do home visits, go to medical appointments, run small errands and make frequent phone calls to their clients who are in their 80s and 90s. The majority of the senior clients also have a history of depression and suffer from various physical ailments. In exchange for their small stipend of \$50 a month, the Peer Volunteers are expected to work only about 12 hours a month. Nevertheless, almost all of them voluntarily put in many more hours without any additional compensation. Case Managers and Clinicians at Grand Street Settlement refer clients to the BEST program and Lead Service Volunteers coordinate Peer activities. Peers have supervision with program staff twice a month and staff is also available to assist them with any challenges encountered during their meetings with clients.

Many of the Peer Volunteers have worked with the program for several years and say that their work is very rewarding. They tend to visit their clients in the evenings and nights when the seniors are less likely to have home attendants or other companionship. They also visit seniors while they are hospitalized. Most Peer Volunteers as well as the seniors they serve shared with us that they have few family members or friends in the city and feel somewhat isolated. Many are widowed. Peers and their clients have lived in the same community for several years and know each other so they find this companionship mutually rewarding. One senior said that her Peer Volunteer is her best

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Mental Health in The Elderly: Boomers Coming of Age

By Elizabeth H. Cymerman, MNH, BSN, RN-C, HNC, Assistant Manager, Mental Health Services, Visiting Nurse Service of Westchester

According to the National Institute for Mental Health in England (2005), "The presence of Mental Health problems [for the elderly], is a strong independent predictor of poor outcomes, such as increased mortality, length of stay, institutionalism, and resource use."

In North America an estimated 20% of seniors living on their own, and 80-90% of those living in institutions have Mental Health issues or illness. In addition, dementia cases are expected to double in the next 30 yrs. Over the next 25 yrs, the US will have a large growth in the population of older adults age 65 and over. This population will double, and the proportion of this sector of the American population will grow to 13-20%.

The mental disorders discussed are not a part of normal aging. Unrecognized and untreated Mental Health conditions can be severely impairing, even fatal. In the US, the rate of suicide, a consequence of Depression, is highest among older adults. The largest prevalence rate for people 55 and over of Mental Health disorders are the following: Depression and Anxiety, Dementia, Drug and Alcohol Abuse, and other Mental Health Disorders.

Mental Health problems can lead to or exacerbate other physical conditions, by decreasing the ability of older adults to care for themselves, by impairing their capacity to rally social support, and impairing physiological functions. Depression and anxiety can increase mortality from coronary disease and cancer.

Many older adults experience loss with aging: loss of social status and self-esteem, death of friends and loved ones. Loss of a spouse is common. Bereavement may increase the probability of, or cause/exacerbate mental disorders. Bereavement is a risk factor for depression. Ten to twenty percent of widows/widowers develop Major Depression during the first year of bereavement. Some succumb to Depression and suicidality, while others find new adaptive strategies. The reason for this is unknown, but one could speculate that it has to do with the person's previous coping strategies and attitudes toward living.

According to a study done by Texas A&M University, people 65 yrs and older are unlikely to receive mental health services. Data from a National Survey on Drug Use and Health found that older adults were three times less likely than younger adults (ages 16-64), to receive Outpatient Mental Health treatment. Only 2.5% of older adults, compared to 7% of younger adults utilized any Outpatient treatment. There may be several reasons for this which includes: The elderly may have difficulty with mobility and transportation, and the commonly held misconception that Depression, Dementia, and Anxiety is a normal response to aging.

Older people with Mental Health needs are at greater risk for abuse than other groups of older people. The risk is



greater for abuse under the following circumstances. When older people : (1) have cognitive impairment (2) people who are depressed (3) caregiver drinks alcohol heavily (4) poor relationships within the household (5) when the older person is physically or mentally abusive, or has behavior problems. Older people, especially those with mental illness, need to be examined periodically for suspicious bruises, scratches, and potential fractures induced by caregivers. General practitioners need to be more aware of elderly patient's mental status and mood, and inquiring about recent functioning and losses.

Cognitive impairment, which is loss of brain function, is seen in varying degrees in older patients, which is often memory loss. Memory complaints are reported in 50-80% of these patients. These complaints may not actually correspond to actual performance. Long and short term memory declines along with recall, slowing of information processing, selective attention, problem solving, and fluid intelligence.

Males and females have different risk factors for age-related cognitive impairment. Risk factors for females are more relationship focused. They lacked a strong social network and are dependent (3.5 times greater than those that are independent. Females with Depression are 2 times more likely to progress to dementia, than those who are not depressed. Males with mild cognitive impairment were likely to be overweight, have Diabetes and/or CVA (stroke), a 3 time increase in developing dementia. There is also a genetic factor (ApoE), which is seen frequently in patients with Dementia.

A French study also revealed that, in a 4 yr period, 42% of 7,000 people showed mild cognitive impairment initially. At the end of 4 yrs, 6.5% developed Dementia, while 37% returned to normal, implicating that people can drift in and out of mild impairment. Some suggestions from this study included: (1) maintain good relationships with friends and family (2) pre-

vent or treat Depression (3) maintain a healthy weight (4) prevent or manage Diabetes (5) prevent a CVA (stroke). These suggestions highlight the fact that cognitive decline may be prevented to some degree, through lifestyle changes.

In normal aging, there is a gradual decline of physical and mental functioning, but not as severe as negative stereotypes portray. Trends show that the prevalence of chronic disability is declining, and extreme disability, including mental disorders, is not an inevitable part of aging. There is much variability in individuals, that is dependent on lifestyle and psychosocial factors. According to research, again, lifestyle modifies genetic risk in influencing the outcomes of aging.

Another study postulates that successful aging is contingent upon 3 elements (1) avoiding disease and disability (2) sustaining high cognitive and physical function, (3) and engaging with life- i.e. maintaining interpersonal relationships and productive activities (paid or unpaid). All 3 elements must be included in order to affect aging. Aspects of Mental Health in normal aging include stable intellectual functioning, capacity for change and productive engagement with life.

Erik Erikson, a Developmental Theorist, characterizes the final stage of psychosocial development as "ego integrity versus despair," the final life crisis. The question a person asks is "Have I lived a full life?" There is a natural slowing of activity, thus allowing one the time to contemplate accomplishments. If one feels we have achieved our goals, one feels contentment and integrity, if one feels dissatisfied with life and in despair, this can lead to Depression.

This stage normally begins before retirement. In the recent years however, the age at retirement has gone steadily up, as well as life expectancy, leaving more years of being productive and more time to achieve life goals. In North America, female current life expectancy is 86, and male is 83 yrs old.

Relationships improve life expectancy

and bolster cognitive functioning, through social support when life is difficult, by assisting with concrete and emotional issues. Another theory is that the benefit from social support is due to actual biochemical changes in the body that produce chemicals when we are in relationships that protect our health.

Exercise is an important part of a healthy brain while aging. Studies have shown a lower risk of decline in elderly who exercise regularly. Exercise also assists in maintaining a healthy weight, blood pressure, and blood sugar goals as well, and reduces depressive symptoms.

A positive attitude toward aging may add additional years to your life. A study of 660 people revealed that those with a positive perception of aging lived an average of 7.5 yrs longer. This has implications for retraining society's image in middle age and senior yrs. Researchers also believe that positive thinking about aging can increase the will to live, and as a result, increase resiliency and proactive behaviors toward health. It is also thought that positiveness reduces mental stress of aging.

There has been much information in recent years regarding improving or maintaining brain fitness. As boomers have entered into this age group, they have clamored for more ways to save brain cells. Again, is biology or lifestyle responsible for the 20% of people over 85 having Dementia? Research has found that remaining engaged in cognitive activities will help maintain brain fitness. Basic principles include: (1) variety and curiosity. Suggestions include: Sudoku, crosswords, and electronic games for 15 minutes per day. (2) Meditation daily (3) Nutrition-include Brain foods: fish oils, nuts, seeds, olive oil, and antioxidant rich foods found in fruits and vegetables. (4) Turn off the TV and use your mind and body!(5) Exercise- vary your workout (6) Reading, but change genre for variety. (7) Learn a new skill- Chinese cooking, needlework etc. (8) Cultivate relationships-stay engaged (9) Live with meaning and purpose- find a passion.

Here, at the VNS of Westchester and Putnam, the average age of our patients is older than the national and state averages. As noted at the beginning of this article, Home Care will experience a doubling of patients over 65 in the coming years. As with other services of the Health Care Continuum, it is vital that we address the issues relevant to maintaining mental and cognitive health, and identifying/diagnosing and treatment of mental illness in the elderly. Education regarding steps one can take to maximize mental health in the golden years should be a part of the Mental Health Home Care visit, and at every point of entry in the Health Care Continuum.

Notes

Friedman, M. B., Williams, K. A. (Jan. 2010) Addressing the Mental Needs of Older Adults in "Age-Friendly communities." GMHA-NY, p.p. 1-2.

Surgeon General Report. Mental Health : A Report of the Surgeon General. Older Adults and Mental Health. Ch.5 pp.1-11.



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The Emotional Needs of Older Adults from the Former Soviet Union

By Alla Bazay, LCSW, Supervisor
FEGS Brooklyn Resource Center

Many people from the former Soviet Union seek and receive culturally sensitive services from the FEGS Brooklyn Resource Center on Kings Highway in Brooklyn. This outpatient OMH licensed clinic provides psychiatric and counseling services to many Russian speaking individuals of whom a majority are between the ages of 60-85. Certainly there are commonalities among older adults, but older adults who have immigrated to the United States as adults have a particular set of emotional issues that we are familiar with at the Resource Center Clinic, where I am a Supervisor.

The trauma of immigration is a primary stressor and can lead to emotional disorders in the older adults we serve. The transition into life in a new country often triggers frustration and stress. Some common stresses of immigration are: learning a new language, getting more education, finding employment, and dealing with the changes in family roles and family relationships.

Immigration also comes with many personal and significant losses including:



loss of loved ones or friends who were left behind, loss of property and possessions, and loss of social status.

One of the most profound losses, leading to tremendous stress, financially, socially and personally, is the loss of previous employment status. No matter how educated you were in the former Soviet

Union and what personal and professional accomplishments you had, once you immigrate, you have to start everything from the beginning. You are challenged to prove yourself professionally. There are many instances when people, who were scientists, teachers, lawyers, and doctors in the former USSR, could not attain their

professional status in the US and started working as car-service drivers or home-attendants. Such a tremendous change in one's social status could cause persistent frustration and contribute to emotional disorders including major depression.

Another major stressor leading to emotional problems for elderly Russian-speaking immigrants is isolation due to very limited English language skills and a poor social and community network.

Yet another is the pressure to meet citizenship requirements in a new language that is increasingly difficult to learn with age, for many immigrants).

How do Russian-speaking immigrants deal with their mental health issues? Once again a cultural perspective is vital to consider. In general, psychiatry in the former Soviet Union was associated with social oppression. It was used by government as a sentence to deal with many dissidents whose opposition was defined as only possible as a consequence of mental illness; at least this was the popular perception. People who needed mental health care were severely ostracized out of fear of association.

Russian-speaking immigrants may view visits to mental health specialists as

see Emotional on page 38

Aging with Optimism in F·E·G·S Behavioral Health Residential Programs

By Laura Williams, Regional Director,
Sara Smith, Residential Director,
and Alice Lundrigan, Clinical Supervisor
F·E·G·S Behavioral Health Residential Services

Growing old in America today carries a different connotation than it did in the past. The elderly are no longer settling for aging gracefully, rocking chairs, and permitting family members to decide how they will spend the remainder of their lives. Instead, striving for a youthful appearance and healthy body, meaningful relationships, financial stability and having a productive role in their life, is tantamount to overall wellbeing for adults as they age.

Adults with psychiatric conditions who are aging also want the same experience of wellbeing, activity and relationships. In persons challenged by mental illness and recovery, meeting their multiple needs requires added support from their family or care takers. Residential providers need to add supports that address their physical as well as their psychological needs if aging populations are to remain in and flourish in their communities. As new housing opportunities for the mentally ill open in the community, aging should not be viewed as an impediment to advancement and self-sufficiency.

Fifteen years ago, the F·E·G·S Community Residence/Single Room Occupancy (CR/SRO) in Harlem opened its doors as the agency's first SRO residential program. The 60-bed facility is now just one of many F·E·G·S sites meeting the needs of aging consumers. The residential pro-

gram's roster reflects 30% of its residents as part of the older population, all of whom have psychiatric conditions.

The CR/SROs are often stepping stones for persons moving towards greater independence in supportive housing. Learning to function in the least restrictive environment is the key to success, and the challenge for many older residents as they age. Too often, elders become accustomed to increased services as their day-to-day functioning decreases. As the probability of older residents becoming independent also diminishes, the expectation becomes discharge to more dependent care such as a nursing home or assisted living facility.

Conversely, by supporting the consumers' strengths and decision making abilities, through motivational interviewing, rehabilitation and recovery, and other supportive methods, additional loss of functional capacities have been prevented and/or minimized while they are residing in the supervised residence.

Across the various F·E·G·S residential programs, consumers that are ready for more independent lifestyles are given the opportunity to view available apartments. Apartment tours are arranged with specific consumer needs in mind.

As in the case of Eileen, (not her real name) a feisty, widowed African American female in her late 60's. Eileen was anxious to move from the CR/SRO where she resided for nine years but knew that the independent life she had once strived for was beyond her physical ability. After several housing application rejections, she attended an interview at a medical model facility whereby her multiple medical

needs would be met. Dejected, and discouraged, she returned stating "I ain't ready for that kind of place, they won't even let me go out by myself!" Eileen declined the offer to enroll deciding that she had too much of life left to live with restrictions.

Within the span of time she resided at the CR-SRO, Eileen's health had spiraled downward. Diabetes was taking its toll, and she suffered a diabetic coma. After her hospitalization, and difficult recovery, her days were plagued with the discomfort of neuropathy, arthritis, and overall weakness.

She relied on residential staff for her day to day living, from bed checks at night to escorts to and from appointments and program during the day.

No one could imagine a more unlikely companion for Eileen than Allen (not his real name). A single, African American male, diagnosed with paranoid schizophrenia, Allen had difficulty with socialization. Raised in foster care and later group homes when he was deemed unmanageable, Allen realized his own strengths in his intelligence, eagerness to learn and athletic capabilities. He became homeless after a lengthy hospitalization and developed the needed survival skills. His contact with a community outreach team directed him to F·E·G·S.

Allen gradually learned a lot about himself while residing at the CR/SRO. He had an excellent aptitude for electronics and computers and developed skill in repairing equipment. Allen also enjoyed sports, music and learned the art of DJ'ing and mixing music.

With staff support, Eileen and Allen

developed a lasting and complementary friendship that continued to grow at the residence. Eileen was able to provide a sense of comfort and nurturing that was lacking in Allen's life, while Allen offered the caring and security that Eileen needed to cope with her physical decline.

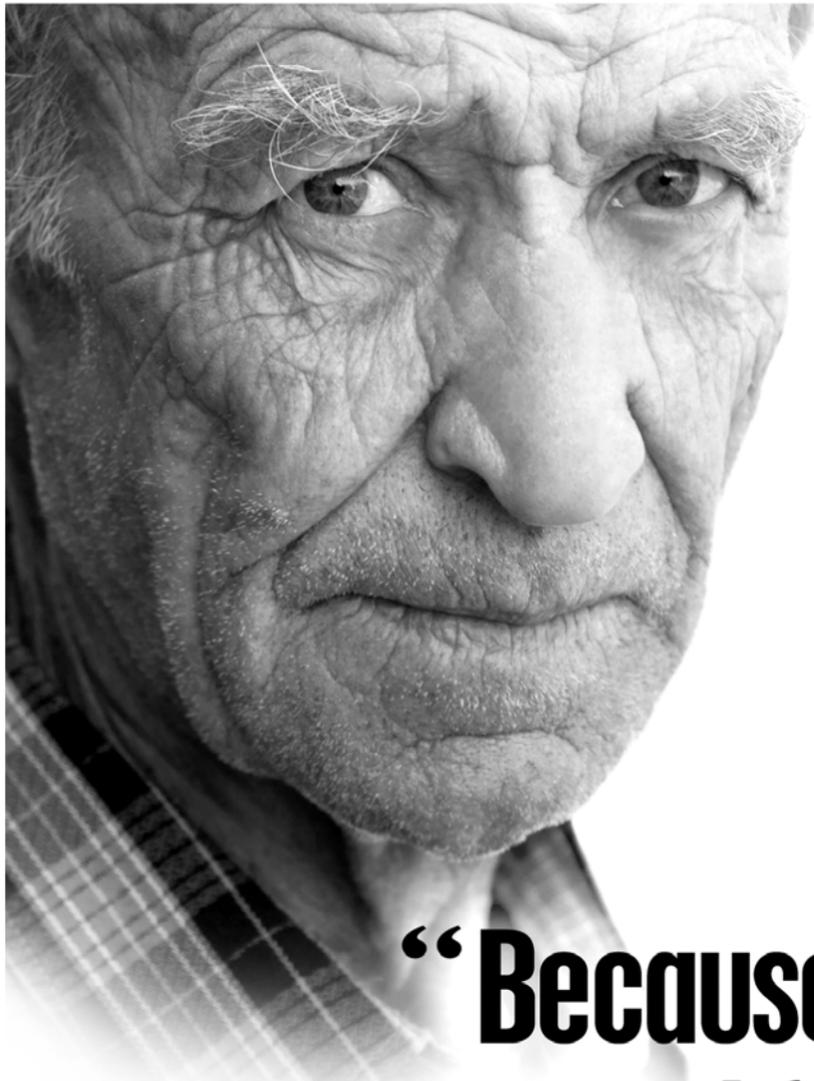
Individually, neither Eileen nor Allen was interested in moving to a new Bronx Supported Housing Program. Together, however, their mutually supportive role made them ideal candidates to share a two bedroom apartment. A ground floor, two-bedroom unit in the apartment house was secured and they moved into their home together.

Staff from both the CR/SRO and the Support Housing Program worked together to assure a smooth transition.

Eileen and Allen easily demonstrate that it's never too late to start over. They are flourishing in their new home and enjoy being host to visitors. They have attained the self confidence and reliance by having the opportunity to attain independence in a home of their own. As Allen says, "I never would have left if all of you didn't show me what was out there. . ."

For people with a mental illness who are aging in place in supported housing programs it is important for providers to recognize their changing needs but continue to support independence. As F·E·G·S population of aging consumers continues to grow, we will increase our efforts to improve services and seek out opportunities for residents to lead active, productive, lives as independently as possible.

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Upstate Providers Promote Awareness Of Mental Health Issues in Older Adults

By Nadia Allen, Executive Director, Mental Health Association of Orange County, and Susan K. Miller, Managing Director of the Orange/Sullivan Division of Rehabilitation Support Services

Three years ago, under the direction of the Orange County Department of Mental Health, the Geriatric Mental Wellness Alliance in Orange County (NY) was established. Comprised of representatives from Orange County government, private non-profit agencies, various health care agencies, and interested community members. The committee meets on a monthly basis. The mission of the committee is to promote, educate and advocate for the mental health needs of elderly persons so those needs can be addressed by government, social service, educational, health and community agencies in Orange County and neighboring areas.

The committee, which is co-chaired by staff from two of the mental health private not-for-profit agencies in Orange County, is also fortunate to have an advisor/liaison from the Orange County Department of Mental Health. The support and guidance from the Orange County Department of Mental Health has been instrumental in the success of the committee. Over twenty different community agencies participate in the meetings, which gives the committee a wide perspective of opinions and knowledge. Major issues are discussed and ways to address these issues are brought back to the agencies and community. Some of these issues are: (1) How to integrate mental health, health and aging services, (2) Increasing the capacity of the system to service cultural minorities through outreach and enhanced cultural competency/equity, and (3) Increasing public education to address issues of stigma, ageism and ignorance about mental illness.

Finally, for the past two years the Geriatric Mental Wellness Alliance and the Orange County Department of Mental



Nadia Allen

health have also sponsored eight two-hour lectures on a variety of topics, such as “Trying to Hold it Together – the Problem of Hoarding in Older Persons,” “Understanding Addictions Later in Life,” “Alzheimer’s, Dementia, Disease and Depression,” and “Practical Strategies for Addressing Medication Safety Issues Among Older Adults.” These lectures have been attended by 75-110 people from all areas of psychiatric and medical health care, such as clinicians, direct care staff, physicians and consumers. These lectures have been instrumental in increasing awareness and knowledge of the mental health needs of older adults in the community and have been well received. The Geriatric Mental Health Alliance of New York, which has consulted with the committee, provides the lecturers for this popular series.

In 2011 the committee looks forward to the continuation of the lecture series and its ongoing work in effecting positive change in the service delivery system for older adults with mental health issues.



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friend. Another said that she prefers spending time with her Peer Volunteer more than with her own children because she has more patience and understands how she feels. When asked why they chose to become Peer Volunteers, many replied, “this work helps me overcome my own

loneliness” and “it is very rewarding to be able to help someone else.”

V. Yoshita Pimmaduwa, MA, MPA, is a Policy Analyst in the Office of the Assistant Commissioner, and Pilar Pardon, MSW is a Program Specialist, in the Office of Treatment Programs at the Bureau of Mental Health, New York City Department of Health and Mental Hygiene (DOHMH).

The Growing Problem of Drug and Alcohol Use in Older Adults

By Barry T. Hawkins, PhD, Director
Chemical Dependency Services
Orange County Department
of Mental Health

I recall when I was doing a field placement in a geriatric care facility in Joliet, Illinois, I encountered a resident who kept a flask of whiskey in his robe pocket, and seemed to always have a ready replacement when one was empty. Often the patient was in a stupor, and had several incidents in which falls and other accidents had impacted his health. When discussing this with one of the administrators, I was surprised to find that instead of concern about the abusive pattern, or how the alcohol was being supplied, the staff person suggested that this behavior didn't hurt anyone. The patient had been a regular drinker his entire life, this staff person continued, and why should anyone begrudge him a little pleasure in his final years of life. This was forty years ago, and at the time I was a student, trying to learn about geriatric care, with little knowledge or self-confidence. I didn't realize either the gross misunderstanding this administrator's statement represented, or the shocking lack of appropriate care. Even people advanced in age can benefit from life changes that increase health and resilience. As the U.S. population ages, in-



Barry T. Hawkins, PhD

creasingly we are going to have to come to terms with problems of alcohol and substance use that were once the province of younger people. Trends reported to SAMHSA's Treatment Episode Data Set (TEDS) show an increase of 32% in the number of older adult admissions from 1995 to 2002 and that trend is accelerat-

ing. Primary drug admissions among older adults increased 106% for men and 119% for women in the same period.

Results of the National Household Survey on Drug Abuse suggest that more than two million people 65 and older had some sort of alcohol problem. Likewise, a study titled "Substance Use by Older Adults: Estimates of Future Impact" (Korper, 2002) estimated that by the year 2020, the number of problem substance abusers aged 50 or older will reach five million.

Changes in the aging body – lower tolerance, decreased water content, and less efficient metabolism – mean that an aging person may not be able to use alcohol or other drugs in the same quantity or frequency without increased consequences (Hawkins, 2008). These exaggerated reactions may not appear as typical "alcoholism" or "substance abuse" because of the smaller amounts involved, but may exacerbate problems that already are prevalent in older adults, such as hypertension, diabetes, gastrointestinal problems, lower bone density, sleep problems, as well as various mental health diagnoses. It has been many years since the clinical community recognized that children are not just "small adults" and need to be treated by professionals with special knowledge and skills. A similar realization is needed that elderly persons are not clinically equivalent to "young people with more wrinkles."

Overdose, medications errors, and such aside, there are a number of interesting modalities in incidence of actual dependency, but two important categories are early and late onset. Early onset describes the history of individuals who have abused substances for many years and now are joining the ranks of the elderly. Though this group is partially self-winnowed by the number who die from their addiction or develop such catastrophic medical consequences they are forced to abstain, there are increasing numbers entering the geriatric age set, whose baby-boomer lifestyle included regular use of illegal drugs or excessive alcohol use.

More problematic in some ways, is late onset dependency, because a life of responsible use makes both the individual and his/her support system hesitant to apply a label that never before fit. Seniors are less ready to admit a problem that had an even greater stigma during their youth than it does today.

Yet healthcare providers, themselves, sometimes maintain ageist attitudes. They may not be trained to recognize signs of substance abuse, may be unwilling to listen attentively to older patients, and often dismiss older patients' observations about their own attempts at diagnosis, while attributing all complaints or changes

see *Problem on page 42*

Study Ties Blood Protein to Alzheimer's Brain Abnormalities

By The National Institute
on Aging (NIA)

Scientists are seeking ways to detect the earliest stages of Alzheimer's disease, since harmful changes may be taking place in the brain years before symptoms appear. Now, researchers report that a blood test detecting a specific protein in blood samples from cognitively normal older people may reflect the levels of beta-amyloid protein in the brain—a hallmark of the disease. Supported in part by the National Institutes of Health, the findings may eventually lead to a blood test that helps predict risk for Alzheimer's disease and who may be a good candidate for participating in clinical trials.

Madhav Thambisetty, M.D., Ph.D., of the Intramural Research Program at the National Institute on Aging (NIA), part of the NIH, was the lead author on the study with collaborators from the Institute of Psychiatry at King's College, London, and the Department of Radiology at Johns Hopkins University, Baltimore. The study appears in the Dec. 20, 2010, issue of the *Journal of Alzheimer's Disease*.

"Recent advances in imaging and biomarkers that help track the onset and progression of Alzheimer's disease show promise for early detection of the disease process, and for tracking the effectiveness of early interventions," said NIA Director Richard J. Hodes, M.D. "This is critically important in



streamlining and conducting trials more efficiently so that we can find out about possible therapies that much sooner."

Using proteomics technology, a method of studying hundreds of proteins from a small blood sample, the researchers analyzed blood samples of 57 older and symptom-free volunteers to determine whether specific proteins were associated with amyloid burden in the brain. They measured brain amyloid using PET (positron emission tomography) scans

with Pittsburgh Compound B, a tracer that binds to amyloid plaques. The volunteers are participating in the NIA's Baltimore Longitudinal Study of Aging (BLSA), America's longest-running scientific study of human aging.

The researchers found the amount of a specific protein called apolipoprotein E, or ApoE, in the blood samples was strongly associated with the level of beta amyloid in the brain. Those with high blood levels of the protein had signifi-

cantly greater deposits of amyloid in the medial temporal lobe, the region of the brain important to memory function.

"These results are especially intriguing as this protein is made by the APOE gene, the most robust genetic risk factor for late-onset Alzheimer's," Thambisetty said. Late-onset Alzheimer's is the most common form of the disease and occurs around age 65 or later.

He now plans to test these findings in serial blood samples collected every year in BLSA volunteers to determine how changing blood levels of ApoE protein may relate to pathological changes in the brain over time.

"If the results are equally positive, we may be able to develop a blood test that provides a less invasive, inexpensive method that helps to detect the early pathological changes of Alzheimer's disease," he said.

The NIA leads the federal government effort conducting and supporting research on aging and the health and well being of older people. For more on health and on aging generally, go to www.nia.nih.gov. The NIA provides information on age-related cognitive change and neurodegenerative disease specifically at its Alzheimer's Disease Education and Referral (ADEAR) Center at www.nia.nih.gov/Alzheimers. To sign up for e-mail alerts about new findings or publications, please visit either website. To learn more about the BLSA, go to <http://www.grc.nia.nih.gov/branches/blsa/blsanew.htm>.

Sheridan Hill House: An Alternative Residential Model for Older Persons with Serious Mental Illness and Medical Conditions

By Peter D. Beitchman, DSW, LMSW
Executive Director of The Bridge
and Chairman of the Board,
Mental Health News Education, Inc.



Peter D. Beitchman, DSW, LMSW

In the context of recent national research findings that people with serious mental illness have a significantly shorter lifespan than the general population, the mental health community has directed much attention to addressing this disparity. Integrating mental health and health care has become an important theme of our work as we recognize the necessity to address the complex and comprehensive needs of our clients.

Several models have emerged to address this challenge, including: partnering/co-location of mental health and primary care services, the establishment of primary care programs by mental health agencies, and linkages with outside hospital - or community-based primary care providers. However, little attention has been focused on the housing needs of older persons who have serious mental illness with co-occurring serious medical conditions. This article describes one such model developed by The Bridge, a New York City-based non-profit mental health rehabilitation agency that provides services to 1,800 men and women annually.

Sheridan Hill House, located in The Bronx, is a newly constructed permanent housing building consisting of 24 studio apartments with community space and staff offices. Capital funding to develop the building was provided by the U.S. Department of Housing and Urban Development

(HUD), New York State Homeless Housing Assistance Program, NYC Department of Housing Preservation and Development, and the Federal Home Loan Bank of New York. Ongoing operating and services funding is provided by HUD, the NYS Office of Mental Health, NYC Department of Homeless Services, and a special geriatric mental health grant from the NYC Council.

Each of the 24 residents, who are single adults who have serious mental illness and are medically frail due to age and illness, lives in a conventional studio apartment. The program has 24-hour staffing to meet the special needs of the residents. In addition to case management and medication monitoring, the program includes an on-site nursing component and an established linkage with a home care providing agency.

Nursing services at Sheridan Hill House are provided by a part-time Bridge nurse care manager and a nurse practitioner contracted through the Lifecare System of the Jewish Home and Hospital (which also provides the home care services). In addition to providing basic primary care services, the nurses provide staff and resident education, monitor treatment adherence and serve a vital function in communicating with outside medical providers to coordinate and integrate care.

The age range of residents at Sheridan Hill House is 58 to 81 years old; the median age is 63. Fourteen residents are diagnosed with schizophrenia, four with schizoaffective disorder, six with bi-polar or uni-polar depressive disorder. Twenty of the 24 residents have hypertension, 17 have hyperlipidemia, nine have COPD, six have insulin-dependent diabetes, six non-insulin dependent diabetes, three have serious stroke histories, five have cancer histories (three receiving active treatment), two have Hepatitis C, three have neuropathy, two are legally blind, and six are wheelchair bound.

Funded for services by the NYS OMH as an SP-SRO with supplemental funding from the NYC Department of Homeless Services, regular staffing includes a Residence Director, round-the-clock residence counselor staff, part-time cook (a nutritious dinner meal is served daily), part-time peer worker, and weekend geriatric recreational specialist. Interns from the Bronx High School for Medical Science also participate in the program. Nursing staff is funded through the geriatric mental health initiative of the NYC Council.

The outcomes of the program have been truly gratifying. As a cost-containment model, the program has

see Residential on page 36

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I'm Still Here: Engagement as Treatment for Dementia

By Cameron J. Camp, PhD, Director
Research and Product Development
Hearthstone Alzheimer Care

A few years ago I was conducting training for staff in a long-term care facility in Australia. It was a two-day training program, focusing on the use of the Montessori-based Activities Programming (MAP). I have been conducting research on the use of Montessori educational methods as a means of developing engaging activities for persons with all levels of dementia for a number of years (Camp, 1999, 2006, 2010), and training care staff and family members on its application on an international basis, as well. It has been heartening to see this approach being replicated in a number of countries and settings (e.g., Lin et al., 2009; Giroux, Robichaud, & Paradis, 2010). The emphasis of MAP is to focus on the strengths and capabilities available to persons with dementia, to create activity materials and procedures which capitalize on those strengths and the person's interests, and to provide meaningful engagement with the person with dementia. The emphasis is on the person in the phrase "person with dementia," echoing John Zeisel's message in his book titled "I'm Still Here" (Zeisel, 2009).

On the afternoon of the second day of training, staff went out onto the units to apply their training. It was Christmas season, and a musical program was being held on the first floor while the training was taking place on the second floor -- which housed residents with moderate to advanced dementia. The nursing staff had sent down all of the residents judged to be "able to get something out of" the musical program. As a result, the residents available for my trainees work with were not the highest functioning persons with dementia available. However, all of the trainees were able to immediately engage these residents in activities. This was done in front of a company executive, who also had attended the training. In one instance, as a trainee began to approach a resident, a nurse on the unit said, "Don't waste your time with her. There's nothing there." My trainee's response was most heartening. She said, "Bite your tongue."

There was one exception (there always is). Three of the trainees came back to me and said "There is a woman we cannot reach. She just does not react to anything we do. Show us how to engage her." I



Cameron J. Camp, PhD

always tell persons I work with or supervise that "I'll never ask you to do something I would not or could not do myself, so may God have mercy on your soul." With the three trainees in attendance, standing off to one side at a distance, I approached the woman, who was in a wheelchair, and pulled up a chair so that I could address her face-to-face. I introduced myself, and asked her permission to show her some materials that I thought she might find interesting. She stared blankly ahead, giving no response. Next, I took out some sea shells that were of different tactile textures. I put one in her hand and gently moved her fingers over the smooth inner surface, saying "smooth" aloud. Then I replaced it with a shell that had a rough surface and let her fingers trace it, saying "rough" aloud. All the while I spoke in a calm, soothing voice making eye contact with her as much as I could. I repeated the smooth and rough demonstration, then thanked her for working with me. I said, "I enjoyed my time with you, and I hope that I can see you again. I will look forward to it." As I turned and started to walk away I heard the trainees gasp aloud. I approached them and said, "What happened?" They looked startled, and one said, "When you started to leave, she waved good-bye." I then approached the woman, and waved good-bye to her.

This may seem like a very small thing, a very small achievement. But in reality, it is huge, because it represents

the first step in a major shift in providing care and treatment to persons with dementia. As I said to my trainees on departing, "Your job is not simply to provide engaging activities to residents. It is to transform your organization, to become agents of positive change and a shift in how your residents are perceived." This is the true nature of the "I'm Still Here"™ method of working with persons with dementia, in which MAP now is embedded.

As I've written in the past (Camp & Nassar, 2003), and emphasize in training seminars, the biggest barrier to providing good care to persons with dementia is a belief, often called therapeutic nihilism, which assumes that because a person has dementia that the person no longer is there, and that attempts to do more than "keep them busy" are wasted. Therapeutic nihilism emphasizes that nothing can really be "done" for persons with dementia, and that because of their cognitive deficits anything other than palliative care is a waste of time and a frustration to the person with dementia. As a result, those who believe in therapeutic nihilism create environments and care systems that become self-fulfilling prophecies.

There is only one way to reverse therapeutic nihilism, and that is to work miracles. The good news is that it is very easy to do. If individuals believe in therapeutic nihilism, and that persons with the diagnosis of dementia will never improve, never show competence, and only get worse over time, then when those individuals see persons with dementia: "waking up," discussing why hydrogen was chosen as the gas to

inflate The Hindenburg, anticipating trips to a museum, lecturing to children on the process of metamorphosis, and engaging with family and staff while in hospice care on the day that they die, then beliefs in therapeutic nihilism change. Seeing truly is believing, and the examples I just gave are real and recent.

Those of you reading this article have a vested interest in changing the way we think about persons with dementia. Almost all of us are affected by dementia. We have family members or friends who have been given this diagnosis. We worry about our own chances of getting the diagnosis. The way in which we think about and provide care and treatment for persons with dementia now is very likely the system that will deliver care and treatment to us if we develop dementia. It is time to get serious about changing our attitudes and perceptions about dementia. It is time to create systems that emphasize the "living" in the phrase "living with dementia."

We are part of an international effort to emphasize that non-pharmacologic treatment of dementia is, indeed, treatment. This is a matter of providing basic human rights. When a person with dementia is engaged in meaningful activity, the person is truly present. My group of trainees in Australia decided to form a task force, and to become a support group for each other in their efforts to change the culture within their organization. They named themselves, "The Miracle Workers." I invite you learn more about the philosophy and methods involved in the "I'm Still Here"™ method and MAP. I invite you to become a miracle worker.



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Older Adults from page 6

responsible for the patient's medical or mental health care.

The following case examples are taken from one of the OMH Geriatric Demonstration Projects. In these projects an MHP was available in a primary care setting to identify and address the mental health needs of older adults. In a number of cases, however, the patient needs identified had largely involved psychosocial issues.

Case 1: Mrs. S is an 88-year-old widow whose present medical problems include

congestive heart failure, spinal stenosis with back pain and an unstable gait, and depression with periods of paranoia. The PCP contacted the MHP to request assessment because of concern over increased calls to the office during which she sounded somewhat confused and agitated. The family has also been calling the PCP not knowing what to do to help their mother.

Assessment: Phone contact was made with the patient who agreed to an initial home visit because it was recommended by her physician. It was evident that she was struggling to maintain her home and,

though she still had a car, recognized she should no longer be driving. She seemed to realize she needed help with transportation, her bank account, and other ADLs. During the initial visit the MHP provided support and assured her that she was not there to have her removed from her home.

Intervention: The MHP established a relationship with further home visits. She learned that the patient had four children who all lived a distance away. She had a paranoid belief that one of her daughters was coming into the house at night and stealing from her. Mrs. S at first became

very upset at the thought of her children having contact with the PCP or MHP and did not want people talking about her "behind her back". The MHP finally got permission to speak with her son. A dialogue was established with the family on how to deal with her paranoid ideas. She allowed her son to take over her bill paying. A caregiver was hired to assist with ADL's and transportation through a local home companion agency. The PCP was updated regularly on the status and needs of the patient so collaborative care could

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Serving the Mental Health Needs of Homebound Older Adults

By Nancy Harvey, LMSW
Executive Director, Service Program
for Older People, Inc. (SPOP)

As our population continues to age, it is not uncommon for many of us to have an older neighbor who has become homebound and disappeared from view. Maybe once they were an active part of the community, but now as a result of life changes associated with aging, such as declining health or the loss of loved ones, their world has shrunk rendering them homebound. In addition what if these homebound individuals are also suffering from depression, anxiety, substance abuse or other mental health illnesses? Many service providers or family members are unfamiliar with how to identify mental health or deal with these issues in regards to the frail elderly. They might call the client's doctor regarding a physical ailment, but would they know what to do if there is a psychological issue? Would they consider this just another inevitable factor of growing old? They probably would not know that with the right intervention and treatment these isolated older adults can improve and enjoy a much better quality of life.

Since our founding in 1972 Service Program for Older People, Inc. (SPOP) has been providing comprehensive mental



Nancy Harvey, LMSW

health services to older adults. Historically SPOP largest program has been our Clinic which offers individual and group counseling, psychiatric evaluation and supervision of medication, case management, and family/caregiver counseling. SPOP has always provided its services to older adults where they could best access the treatment. If a client was unable to come to our Clinic, we could provide services at select senior service sites throughout Manhattan. If a qualified client could not get to these sites,

SPOP would arrange for clinical staff, including bi-lingual Spanish-speaking or French-speaking clinicians, to come to their home.

There are a variety of factors that can make a client homebound. The most obvious reason is physical infirmity or lack of mobility. This can be a chronic physical condition, such as someone who is in a wheelchair or bedridden. Or it can be periodic, such as the client who regularly comes to the clinic except when the elevator in their building breaks down and the clinician must come to them. This allows the client to keep up with their treatment, while also conveying to the client that they and their treatment are valuable. Similarly a clinic client who was being treated for depression and became homebound after a knee replacement operation did not have to discontinue their treatment during this recovery period. Instead their clinician came to their home. This resulted in the client's mental health and physical health treatment both working to the common goal of helping the client resume normal activities, such as being able to return to the Clinic. Some clients are unable to leave their homes for psychiatric reasons. For an individual suffering from agoraphobia the mere act of going to a clinic could bring on panic or anxiety attacks. For these individuals the ability to receive treatment in their home including the prescribing of the anti-

anxiety medication can prove essential for maintaining them in the community.

The SPOP's homebound services replicate what is offered to our traditional Clinic clients. For each of the homebound clients, one of the program's social workers conducts a mental health assessment that consists of a psychosocial evaluation, a psychiatrist does a mental status examination, and together they develop a Comprehensive Treatment Plan. Based on each client's Comprehensive Treatment Plan, the assigned social worker provides individual counseling and the psychiatrist provides medication management, as needed. Clients typically receive treatment once a week. Additional program services include family/couples counseling and support which is provided by a social worker.

Though SPOP's Homebound program parallels services offered in our Clinic, the clinicians find significant differences in how they interact with their clients. For example when treating a client in a traditional clinic setting the clinician is able to close the door of the treatment room and block out all other distractions focusing exclusively on the treatment itself. However when a social worker enters a client's home they also are stepping directly into this client's world. The clinician gets to see firsthand the client's living environment and the family dynamics. Is the

see Homebound on page 36

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Older Consumers and the PROS Model: A Growing Challenge

By Lauren Hagemann, MA
Gathering Place PROS – Advisor,
Geriatric Specialist,
Mental Health Association
of Nassau County

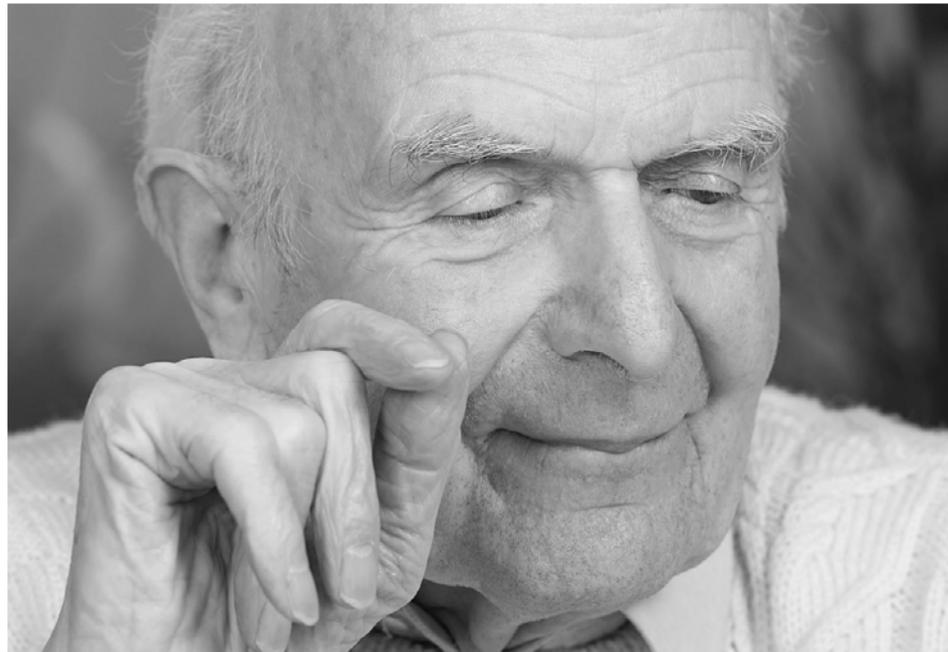
In 2011 the post-World War II “baby boom” generation starts turning 65. With this change it is expected that the census of elderly people diagnosed with a mental illness will also increase. It is projected that by the year 2030, the number of older adults diagnosed with a mental illness will rise significantly from 7 million to 14 million people. With the anticipation of this large growth in our nation’s geriatric cohort it becomes imperative to not only acknowledge the medical needs of this generation, but their psychiatric needs as well.

In a report published in 2006 by the National Association of State Mental Health Directors (NASMHPD) entitled “Morbidity and Mortality in People with Serious Mental Illness” it was found that individuals suffering from a severe and persistent mental illness die on average, 25 years prematurely than when compared to the general population. As the average U.S. citizen lives to age 78, this means that the average mental health consumer has an expected lifespan of 53 years. This statistic indicates that many mental health consumers will not even reach the traditional “geriatric” age of 65, making it an even more imperative task to clinically intervene as early as possible.

A major factor in the early mortality of older clients is the diagnosis of serious mental illness, combined with substance abuse and chronic health conditions. The types of mental disorders most commonly afflicting older adults include anxiety, depression, schizophrenia, and dementia. Individuals suffering from these diagnoses also experience greater rates of medical conditions such as diabetes, cardiovascular, respiratory and infectious diseases. Such conditions, combined with the prevalence of negative health habits such as poor diet and exercise routines, higher rates of smoking and the low utilization of medical services, in conjunction with medication side effects, all result in the tragic early death of mental health consumers. Another factor shortening the life span of consumers is the stress of years of institutional living in large state psychiatric hospitals, as well the psychosocial strain caused by homelessness and poverty.

With a lack of age appropriate psychiatric services available for older adults it is crucial that additional programs continue to develop in order to ensure adequate care for this unique group. Local senior and recreational centers may be an option, however, age requirements prove to be a limiting factor as these programs typically accept individuals 65 and older. Additionally, staff at Senior Centers may not be equipped to meet the needs of older mental health clients.

So, what options exist for older mental health consumers?



One program making strides to tackle this predicament is the PROS program operated by the Mental Health Association of Nassau County. To help offset such discouraging projections, the MHA has initiated an age specific geriatric track open to all members ages 50+, to educate consumers about age related issues relevant to both mental and physical health and well being.

What is the PROS Model?

PROS stands for Personalized Recovery Oriented Services and is defined by the Office of Mental Health as a short-term, comprehensive recovery program for individuals with severe and persistent mental illness. It is a model that intends to integrate treatment, support and rehabilitation in a manner that facilitates a consumer’s recovery. Such goals of the PROS model include: improving functioning, reducing the need for inpatient hospitalization, increasing employment and educational opportunities as well as securing housing. Structurally and conceptually the PROS model has proven to be successful for adult consumers; however there lies a major discrepancy for its use with geriatric clients.

Anecdotal evidence suggests that there is some confusion about the applicability of the PROS model for older adults. PROS and Medicaid require that the consumer demonstrate “progress.” If the consumer does not show progress, then the “medical necessity” of the services rendered can be called into question; a lack of medical necessity will result in the claim being denied, and the provider would undergo a “take back” of the funds. Some in the field would argue that it is much easier to show “progress” with younger consumers who would be better able to demonstrate the attainment of goals in regards to employment or educational pursuits.

Some of the early PROS programs reported that when they converted from a clubhouse or social club model that many older members left, and were replaced by a group of younger consumers. What then does recovery mean for our older clients?

Will the mental health system allow them to “retire” from the pursuit of employment and educational goals, and instead pursue other goals that can be deemed “medically necessary?”

To avoid the loss of members, and to help enhance the experience of our program’s older clientele, our geriatric track has maneuvered the PROS concept to include groups that integrate services specific to the health and wellness needs of our older adult population. Our schedule is constructed to include groups that focus specifically on medical and physical concerns, complete with weekly weight and blood pressure management and groups that teach age appropriate exercise, fitness and nutrition for clients to implement in their daily lives. Additional groups provide a review of the mental health concerns associated with aging, including depression, anxiety and long term conditions such as schizophrenia, in addition to reviewing effective coping strategies.

To help offset the development of such conditions as dementia and Alzheimer’s disease, members are encouraged to participate in our “Thinking Skills for seniors” group, which teaches simple and fun exercises to engage the brain and help prevent future cognitive decline. Our program also looks to enhance socialization and relationship building. Members participate in a socialization group that teaches social and communication skills pertinent to older adulthood and emphasizes the importance of maintaining interpersonal relationships across the lifespan.

Our program also provides the opportunity for members to revisit and process their own personal experiences. The PROS program addresses pertinent issues that are not oftentimes discussed, for example, the struggles with parenting mentally ill children and taking on the caregiver role for grandchildren, while at the same time managing their own aging and mental health needs.

Our geriatric track provides an age appropriate arena for older clients to share in their experiences and to learn from one another in a comfortable setting. Our goal

is to allow members to be responsible for their own health and wellbeing, teach warning signs and preventative measures to avoid the development of negative health conditions, and most importantly, increase longevity.

Within the year our program has witnessed the untimely passing of several members, both young and old. Such incidents serve as an eerie reminder of the reality that mental illness creates more challenges than originally thought. However despite such events, our program continues to service older clients effectively and help assist with important aspects of life including finding appropriate housing, securing benefits and providing socialization outlets to improve interpersonal relationships.

Specific cases exemplifying the benefits of the PROS model for older adults can be measured by the improvement seen in several members of our geriatric track. One consumer, a 62 year old male suffering from Schizophrenia, has led a life of isolation. With paranoid symptoms such as delusions and hallucinations believed to come from the television and newspaper, he was unable to accumulate a work history and develop interpersonal relationships. In his time at the Gathering Place PROS he has decreased his anxiety and the presence of symptoms. He has utilized the material at PROS to return to his long lost hobbies, and has organized several fishing trips and group outings to continue to improve his socialization and self esteem; a feat 30 years in the making. Gary has also conquered his fears of social interactions by participating in several public speaking engagements at the NYAPRS and Geriatric Mental Health Alliance of NYC conferences.

Another example of our PROS success is demonstrated by a 61 year old Vietnam veteran, diagnosed with schizophrenia and PTSD. This member served for 15 months in Vietnam and was honorably discharged. Upon his return home, he developed symptoms of PTSD and schizophrenia. For 40 years, he was institutionalized at various state hospitals and psychiatric programs. During that time, no one assisted him with the task to obtain the veterans benefits he deserved. The PROS program intervened and has since connected him with the VA; helping him file a claim for veterans benefits related to his PTSD.

The older adult client encompasses a distinctive history and psychiatric development and requires a specific approach to treatment. It is crucial that treatment be age appropriate and relevant. It is imperative that all health and medical providers strive to improve their geriatric services in order to create a united and cohesive approach to care. The PROS model, despite initial criticism, can be viewed as a useful treatment modality for older consumers. Its structure and mission for rehabilitation can prove beneficial for all age groups. However it is recommended that a stronger, more direct approach to geriatric mental health be put forth, starting today in order to prevent an epidemic of neglected consumers.

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— Point of View —

Generational Competence: A Conceptual Framework for Aging in America

By Michael B. Friedman, LMSW

Two major demographic trends will unfold in America during the first half of the 21st century. Minorities will grow from 29% to 47% of the American population, and older adults (65+) will increase from 13% to 20%, becoming roughly as large as the population of children and adolescents under 18 for the first time in history. The concept of cultural competence has emerged as a central organizing principle in response to the growing multi-cultural character of the American society. But there is no comparable organizing concept regarding the aging of America. It strikes me that “generational competence”¹ could serve as a useful counterpart to “cultural competence.”

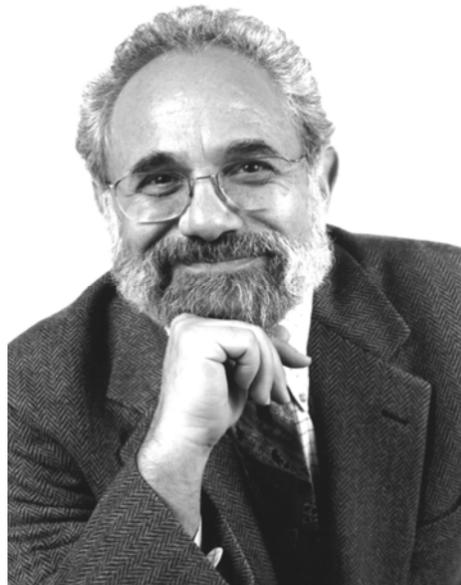
Of course, “generational competence” suggests not just competence serving older adults, but competence serving people in all stages of human life—from birth through working age—as well as older adults. Here I will focus only on generational competence regarding older adults, but it seems to me that much work could usefully be done to conceptualize and develop *systems* of health and mental health promotion and intervention for all ages.

By “generational competence” I have in mind not just the use of age-appropriate clinical practices. I am referring to generationally competent *systems*. The general idea is twofold—to bring (1) a developmental perspective and (2) knowledge of differences among age cohorts^{2,3} to the design of health, mental health, and human service systems.

I do not have nearly enough space in this column to explore each of the components of a generationally competent mental health system for older adults. Suffice it to say, as I frequently have before, that a sound geriatric mental health system would include efforts to overcome ageism and stigma; mental health promotion; outreach and engagement; better identification of mental and substance use disorders; improved access to treatment in the community, including treatment in the home and in natural community settings; an emphasis on aging in the community rather than in institutions; more housing alternatives; enhanced family support; improved quality of care, including better translation of research findings into practice; greater integration of aging, health, and mental health services; extensive efforts to develop a clinically and culturally competent workforce, including the use of older adults themselves in helping roles; restructured financing mechanisms that will support a generationally competent system; and equal attention to the mental health needs older adults as to those of younger people.

In this column, I will touch on just a few of the key themes of a generationally competent mental health system for older adults.

Overcoming Ageism: Just as overcoming racism and cultural stereotypes is a critical dimension of meaningful cultural competence, so overcoming ageism is a critical component of generational competence. In our culture, age is associated



Michael B. Friedman, LMSW

with decline, disability, and death. Commonly, calling someone “old” implies that they are decrepit, “over the hill,” or “done for.” So people evade the fact of old age. “You’re as old as you feel,” they say. Nonsense! You are as old as you are. But, if you are over 65, the chances are excellent that you can get great satisfaction out of life. You can be old and good. Strange thought? That’s because of ageist expectations. Think about this: major depressive disorder actually declines in old age. Hard to believe, perhaps, but that has been the finding of all epidemiological studies for more than a quarter of a century. Yes, mood and anxiety disorders are serious problems for some older adults. Yes, suicide rates are extremely high. Yes, cognitive impairment becomes more common as we age, and by 85 nearly half of older adults will have significant impairment. But that’s 20 years of potentially good, independent living for the majority of older adults and—hard as it is for younger people to believe—it is possible for people with cognitive impairment to continue to have satisfying lives. In the field of mental health, we use the term “recovery” to refer to the potential for people with severe, prolonged psychiatric disabilities to lead lives they find satisfying and meaningful. We need a similar concept for old people with cognitive impairment. (More below.)

Aging Well: Because there is so much opportunity to live well in old age despite the challenges of role changes, diminished physical and mental capacity, loss of family and friends, and the inevitability of death, a generationally competent mental health system would emphasize and facilitate successful aging. The key to aging well is remaining active and involved. Obviously, creating opportunities for satisfying and meaningful relationships and activities is not primarily the responsibility of a mental health system. But the mental health system can help. For example, the concept of “age-friendly” communities is catching on as a way to organize our cities and towns so that older people can have, and take advantage of, opportunities not to be isolated, to pursue personal interests, and to maintain or de-

velop significant, even sexually intimate, relationships. There are important mental health dimensions of age-friendly communities.⁴

In addition, outreach into the settings where older adults live or go—such as senior centers, houses of worship, senior housing, and naturally occurring retirement communities (NORCs) can help older adults (1) to learn about how to maintain their mental health (without which they cannot age well)⁵, (2) to identify mental and/or substance use disorders, and (3) to get access to good treatment (which, unfortunately, is difficult to find.) All of these mental health services and more are part of a generationally competent mental health system for older adults.

Boomers Will Be Different: Age groups from different periods of time are developmentally similar but have important differences in experiences, expectations, and values. There is little doubt that elder boomers will be different from the generation of people who are already old. The boomers are physically healthier than the generation before them and, generally, will be able to work and live independently longer. In addition, they are from the generation of “drugs, sex, and rock and roll” and have attitudes and expectations different from their parents, including greater expectations of happiness. What this means for the mental health system is not clear. For example, it is possible that the prevalence of depression will be greater among boomers. It is now. Will it decline as they age, as it did for their parents’ generation? We don’t know yet. Boomers may also experience less stigma about getting treatment. Indeed they may be more inclined to understand their fears and sorrows as mental disorders than just as unavoidable aspects of human life. A generationally competent mental health system would try to anticipate “cohort effects” like these and adjust accordingly.

Living With Disability - Recovery and Integrity: Obviously, older adults are more likely to experience disabilities than younger people. But this is far from the end of their potential to get satisfaction out of life. In the field of psychiatric rehabilitation, a concept of recovery has emerged that does not mean that people with long-term psychiatric disabilities eventually get over their mental illnesses fully. Some do; but many continue to experience the symptoms and psychological struggles of schizophrenia, bi-polar disorders, treatment refractory depressions, or disabling anxiety disorders such as obsessive-compulsive disorder. “Recovery” means that many can nevertheless discover ways of living that they find satisfying and meaningful.

We need, as I said before, a similar concept for people who develop cognitive impairments or continue to have psychiatric disabilities as they age. Here’s the twist. Virtually all of the most eloquent spokespersons for recovery—people who are in recovery themselves—note the importance of hope to their finding meaning and satisfaction in their lives. Hope, however, suggests a desire for future out-

comes that may not be open to very old adults. Erik Erikson, the originator of the idea that each stage of life has its pitfalls and potentials and that each has its own goal, maintains that the goal of very old age is not hope but integrity. In part this is a sense of a life well-lived—a challenge for anyone who had great disappointments along the way. But in part integrity refers to a sense of personal authenticity. Many older adults with cognitive impairment have much “to look backward to with pride,” to steal a phrase from Robert Frost, and many people with long-term psychiatric disabilities can take pride in the hard routes they traveled to reach a point of self-acceptance and peace with themselves. This state of being is different from the state of hope that is at the heart of recovery as it is usually conceived. A generationally competent mental health system would adjust its expectations accordingly.

Coming To Terms With Death: Integrity in very old age also means accepting the inevitability of death and coming to terms with it in one’s own way. This is extremely hard in a culture which assumes that we should fight death to the bitter end. “Do not go gentle into that good night. Old age should burn and rave at close of day. Rage, rage against the dying of the light.” This is what the poet Dylan Thomas said to his dying father. Cruel, it seems to me. Journalists assume much the same thing when they report about virtually everyone who dies after a protracted illness that they lost a long “battle” with their disease. Apparently, no one ever makes peace with death in our culture.

A generationally competent mental health system would help adults nearing death to make their peace with it, particularly by helping those who are believers to connect with spiritual communities. In addition, a generationally competent mental health system would not abandon and let die alone in hospitals and nursing homes those for whom mental health programs have become virtual family.

Conclusion: My goal in this column has been to suggest that because America is aging as well as becoming increasingly culturally diverse, we need an organizing concept such as “generational competence” as a counterpart to “cultural competence.” Here I have applied the concept in a very limited way to meeting the mental health needs of older adults. Far more needs to be done to flesh out a generationally competent mental health system for older adults as well as for other age groups. I want to emphasize again that the concept of generational competence is not the same as age-appropriate mental health treatment. The challenge is to describe a generationally competent *system*. It is, I think, a challenge worth taking on.

References

1. Mike Hogan, Commissioner of Mental Health in New York State, is the first person I heard use the expression “generational

see *Competence on page 34*



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DBT at Four Winds and Your Patient's Aftercare

**By Jonathan Bauman, MD
Chief Medical Officer
Four Winds Hospital**

For the past two years, Four Winds has been developing the application of *Dialectical Behavior Therapy* (DBT) in its Adult and Adolescent Inpatient and Partial Hospital programs. DBT is an evidence-based form of Cognitive Behavioral Therapy that integrates traditional CBT with dialectical philosophy and Eastern mindfulness practice. While originally developed to treat patients with Borderline Personality Disorder, DBT has been adapted to treat many forms of emotional distress.

With DBT, your patient learns about their problem *target behaviors* that may have precipitated the current episode of treatment, such as suicide attempts or threats, non-suicidal self-injurious behavior, risky or impulsive behavior that put self or others in harms way, drug or alcohol abuse, and behaviors that interfere with or destroy treatment. They learn to identify

prompting events (triggers) and *vulnerability* factors (hunger, fatigue, intoxication, not taking prescribed medication, etc.) that make them vulnerable to behaving in problematic ways. During the course of treatment at Four Winds, your patient is asked to complete one or more *Behavioral Chain Analyses* in order to identify behavioral and emotional links from prompting events to problem behaviors.

DBT is based on several principles, such as:

- Our patients' problem behaviors are the direct result of *emotion dysregulation* or are misguided attempts to regulate emotions
- Biological predisposition and an invalidating environment (the Biosocial Theory) result in problems with emotion regulation
- Patients want to get well and are doing the best that they can
- Although patients may not have

caused all their problems, they have to solve them anyway

- Patients need to do better, try harder and be motivated to change
- Change cannot be accomplished without an equal measure of validation and acceptance

In order to help patients better control behaviors that can lead to hospitalization, we teach *mindfulness* skills to help patients observe and describe their thoughts, feelings, and reactions non-judgmentally so they can better attend to the present moment. They receive coaching on *distress tolerance* (coping) skills to provide alternatives to destructive behaviors until the painful moment passes. In addition, they are introduced to principles of *emotion regulation* to enhance their emotional resilience and fortitude. Finally, they learn about ways to improve their *interpersonal effectiveness*.

Patients return to their outpatient providers with a *Relapse Prevention Plan* – an analysis of the chain of events and re-

lated behaviors that may lead to relapse or another hospitalization. To help break this chain, the plan includes skills and alternate behaviors the patient can utilize to avoid relapse and re-hospitalization.

DBT focuses on teaching patients specific skills to manage their symptoms and problem behaviors. These skills are presented in five modules:

1. Mindfulness – This is the bedrock on which all the other skills rest. Mindfulness is about developing the ability to focus on the present moment. Patients are taught to observe and describe objects and events without attaching judgments, so as to learn to be objective.

2. Emotion Regulation – This group of skills teaches patients to identify their feelings and manage them in appropriate ways. For example: it is okay to feel angry; it is how you express your anger that makes all the difference.

see DBT on page 24

Gangs, Crews, and Cliques in Schools: What to Look for and What to Do?

**By James Barrett, PhD
Professor of Psychology, Psychiatry
Department, Harvard Medical School
and Faculty, Department of Psychiatry,
Cambridge Hospital, Cambridge, MA**

This past October I had the opportunity to speak at Grand Rounds at Four Winds Hospital in Katonah, NY. When I talk about gangs I first give an overview of formal youth gangs in America as well as a hierarchy system to classify "types" of gangs from most organized to most diffuse. When many people hear the term "gang" they think of young people dressed in the same colored clothes or wearing bandanas and flashing hand signs. Indeed, this can be an accurate description of formal gangs, however the problem of group violence among youth runs much deeper than that. For example,

gangs can be highly organized through national chapters such as the Blood and Crips or gangs can be local and specific to a region such as neighborhood gangs. Across the country, young people are being seriously injured or in some cases killed over conflict among informal cliques, crews or groups of friends. The most effective way to prevent youth violence is to anticipate conflict before it arises. In order to do this successfully, one must know both the "players" and identifiers in their communities. Consequently, the challenge for parents, clinicians, teachers and school staff is to first be able to recognize identifiers of national gangs as well as local groups or cliques that are unique to a certain area. Here are two practical tips I offer to the audience to improve their gang awareness: first, be versed in the identifiers of the youth gangs and crews in your area. For example, if you know that a certain sports

team's colors or logo represent a local gang, you will be better able to recognize which students are at-risk for group violence. Second, it is important to stay abreast of technology such as YouTube, Facebook, and local message boards as students can be quite brazen in terms of posting threatening messages or gang-related content.

The Allure of Gangs

When I meet with audiences about youth violence I make it a point to remind them that we must not be dismissive of the incredible appeal that gangs and crews have to teens. It pains me to hear some adults make statements such as, 'why would they fight over something so stupid?' when discussing gang violence. We know that adolescents and pre-teens are at a developmental stage where they are predisposed to identify strongly with their

peers and act without thinking of the consequences when it comes to group violence. Young men in particular are socialized to believe that they are a punk or coward if they do not respond to perceived disrespect with violence. This problem is exacerbated when groups of young men become involved in a conflict or "beef." The mentality is often, "if you have a problem or beef with one of my people then I have no choice but to fight you." One of the ways that adults can be essential in preventing future violence after there has been a conflict is to help the parties mediate the beef in a manner that allows both to save face. One can be fairly certain that if there is a fight and one person walks away feeling that he looked like a "punk" he is likely to come back with his friends to settle it. This cycle of retaliation is often at the heart of

see Gangs on page 24

Four Winds Hospital is the leading provider of Child and Adolescent Mental Health Services in the Northeast. In addition to Child and Adolescent Services, Four Winds also provides Comprehensive Inpatient and Outpatient Mental Health Services for Adults, including Psychiatric and Dual Diagnosis Treatment.

FOUR WINDS HOSPITAL • SPRING 2011

APRIL

GRAND ROUNDS

Friday, April 15, 2011 • 9:30 – 11:00 am

Dialectical Behavioral Therapy for Individuals Diagnosed with Borderline Personality Disorder & Substance Dependence

Presenter: Kerry Pertchik, Ph.D.

Program Director of Adult Services and Director of DBT Training, Four Winds Saratoga

At the conclusion of this program participants will:

- Become familiar with the core foundations of DBT.
- Become familiar with dialectical formulation of BPD and Substance Dependence.
- Gain an understanding of staging treatment for co-occurring disorders.
- Become familiar with specialized treatment intervention strategies with co-occurring disorders.

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 hours pending*

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Register online at www.fourwindshospital.com

MAY

A COMMUNITY SERVICE

Wednesday, May 4, 2011 • 2:00 – 4:00 pm

National Anxiety Disorders Screening Day

A program for consumers designed to provide an anonymous screening and educational information about anxiety and depressive illness.

For information, or to schedule a confidential appointment, please call 1-800-546-1754 ext. 2413.

A Special Community Education Program

Friday, May 6, 2011 • 9:30 – 11:00 am

A Four Winds Foundation Presentation



Teenage as a Second Language: A Parent's Guide to Becoming Bilingual

Presenter: Jennifer Powell-Lunder, Psy.D.

Program Director, The Lodge Inpatient Adolescent Program, Four Winds Hospital-Westchester; Co-author of *Teenage as a Second Language*; Adjunct Professor, Pace University; Private Practice, Katonah, NY

You wake up one day and your cheerful, friendly kid has morphed into a sarcastic, sullen adolescent who can't - or won't talk to you. That's when you know it's time to learn to speak a second language - teen. With groundbreaking strategies, this presentation will outline how you can develop good communication, healthy interactions and a strong connection to your teen, no matter how rocky the road to puberty becomes.

At the conclusion of this program, you will learn how to:

- Let your teens help set the rules - and the consequences for breaking them.
- Put honesty above all else.
- Realize that "me, me, me!" is actually age appropriate.
- Try not to criticize, judge or become angry.

Fee: \$20, payable to the Four Winds Foundation, a not-for-profit organization

1.5 CME Credits Pending

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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.

Community and Professional Education Programs

MAY

SPECIAL TRAINING

Thursday, May 12, 2011 • 9:30 am – 12:00 pm

Child Abuse Identification & Reporting



Presenter: Valerie Saltz, LCSW
Four Winds Hospital-Westchester

New York State recognizes certain professionals to be specially equipped to hold the important role of mandated reporter of child abuse or maltreatment. These include Mental Health Counselors, Marriage and Family Therapists, Creative Arts Therapists, Psychoanalysts, Licensed Social Workers, Physicians, Dentists, Dental Hygienists, Chiropractors, Psychologists, RN's, School Administrators, Teachers, etc. A State Education Department Certificate of Completion will be given at the end of the class.

Fee: \$45, payable to the Four Winds Foundation, a not-for-profit organization

JUNE

GRAND ROUNDS

Friday, June 3, 2011 • 9:30 – 11:00 am

CUTTING THE BULL: The What, Who & How of Bullying

Presenter: Lisa Pasch, Psy.D.

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

Columbine, Virginia Poly Tech, Rutgers. We all know those names and what happened there, but what else do we really know? The violence that occurred in all those places has added to the growing national attention about bullying and its potentially horrific consequences. However, less often discussed are the roles that we all play (or have played) within it and what we can do to stop it. This talk will address what bullying actually is, how we are all involved and how we all need to help stop bullying in all its forms.

At the conclusion of this program, participants will:

- Learn what bullying is and the different forms it takes on.
- Learn the potential negative outcomes for those who bully, those who stand by and those who are the victims.
- Learn how to intervene.

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 hours pending*

* 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.



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- **14-17 years old:** focuses on empowering adolescents through peer support and feedback

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3. Distress Tolerance – This group of skills focuses on how to tolerate and manage distress. The focus is on developing coping skills so that when things are bad, you do not make the situation worse.

4. Interpersonal Effectiveness – This

group of skills teaches patients how to get their needs met, preserve a relationship, or not lose self-respect by advocating for themselves in effective and positive ways.

5. Walking the Middle Path – The focus of this module is on helping patients understand what is valid in the other per-

son's point of view. The basic concept is that being right is less important than being effective. This is also the essence of dialectical thinking.

During a patient's hospital stay, Four Winds therapists discuss the patient's treatment plan with their outpatient therapist, as well as the patient's pro-

gress toward effectively managing their problem behaviors as they approach discharge. For outpatient therapists unfamiliar with DBT, our treatment teams will discuss how DBT can be integrated with the work already occurring in the outpatient setting so that generalization of adaptive skills in the real world is facilitated.

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flare-ups in gang and group violence. The better we as supportive adults can be in anticipating fallout from previous violent encounters and intervening with the affected parties the better we can be at preventing future violence.

Collaborative Practice and the Safety Net Program in Cambridge, MA

The Office for Juvenile Justice and Delinquency Prevention stresses that collaborative practice is essential for the effective prevention of gang violence. We as professionals must move outside of our "silos" so that schools, clinicians, and law enforcement can collaborate to effectively and efficiently prevent youth violence. I am part of one such effort to establish and sustain partnerships across youth-serving agencies to support at-risk youth and prevent group violence: *The Safety Net Collaborative* in Cambridge, Massachusetts.

The Safety Net Collaborative is a partnership among the police department,

Cambridge Health Alliance, the public schools, and the Department of Human Services in Cambridge, Massachusetts. The planning committee for *Safety Net* also utilized the National Center for Mental Health and Juvenile Justice's blueprint for addressing the needs of youth with mental health needs in contact with the juvenile justice system to develop the programmatic structure and activities. The NCMHJJ believes that any effective intervention program with at-risk youth will include at least the following: (a) collaboration among juvenile justice and mental health professionals; (b) identification of the mental health needs of youth in contact with police or juvenile justice; (c) diversion whenever possible of youth with identified mental health needs away from incarceration and (d) access to effective mental health treatment.

Over the past 3 years *Safety Net* has incorporated the principles outlined above into a working structure for the program. The primary goal of *Safety Net* is to identify those children and teens in Cambridge who may be at risk for problematic or unsafe behavior and link them to the sup-

port and services they need. Every other week a group of police officers, clinicians, and youth workers meet to review current cases and initiate discussion on possible new cases. A course of action is developed for each case and examples of services and interventions include: home and school visits, screening for mental health problems, linkage to formal mental health services and supports, linkage to mentoring, linkage to youth development activities, and increased support in the schools. If the child has committed a formal offense a determination is made as to whether he or she is eligible for the juvenile diversion program.

In closing, if you are interested in gang and violence prevention in youth, I invite you to visit my website: www.jamesbarrettphd.com. On my site I have a blog that focuses on making mental health more relevant for hard-to-reach boys and young men. I also have resources and tips for parents, teachers and clinicians who work with at-risk youth and boys in particular. You can also sign up for my e-newsletter: "Beyond Boys Will Be Boys." Finally, I share articles

and relevant research on boys and mental health on my Twitter account: @JBarrettPhD.

Web-Based Resources:

OJJDP: Gangs and Schools

<http://www.ncjrs.gov/pdffiles1/ojjdp/183015.pdf>

Gang prevention

<http://www.safeyouth.org/scripts/topics/gangs.asp>

FBI and gangs

http://www.fbi.gov/hq/cid/ngic/violent_gangs.htm

Operation Ceasefire

<http://www.hks.harvard.edu/criminaljustice/research/bgp.htm>

National Center for Mental Health and Juvenile Justice:

<http://www.ncmhjj.com/>

— The NYSPA Report —

New York State Psychiatric Association's 2011 Legislative Agenda

By Barry B. Perlman, MD
Legislative Chair and Past President
New York State Psychiatric Association

Presenting the New York State Psychiatric Association's legislative agenda for the 2011 session in Albany represents more of a challenge than usual because the governor's budget proposal will be presented after the writing of this report and the printing of this issue of *Mental Health News*. This is later than usual due to a grace period afforded to a new governor. No matter the lack of budget specifics, we know that NYS faces a projected budget deficit in the range of \$10 billion which is likely to result in severe budget cuts to those sectors of the state's budget for which the largest amounts of money are appropriated. For advocates for persons with mental illness, especially those with serious and persistent mental illness, cuts to the Medicaid program present the greatest concern.

As a consequence of our state's fiscal crisis, NYSPA's most important efforts this year will be aimed at preserving the many important accomplishments of recent years, minimizing the adverse impact on what are certain to be targeted service areas, and identifying areas in which savings can be affected while simultaneously improving the mental health system.

Newspaper articles have raised the prospect of an intense focus on the high cost of mental health care, especially the burden of inpatient care for what are often referred to as the "high user" population. It is estimated that NYS Medicaid expends \$18 billion on 700 thousand individuals with two or more chronic illnesses; for a large proportion of these persons, mental illness is one of their chronic illnesses. As a result, the state will be looking to "managed care" approaches to lessen the cost. Unfortunately, "managed care" approaches have proven highly problematic in many states when applied to those with "serious and persistent mental illness" ("spm"). While NYSPA cannot endorse any particular approach to "managing" this group, we do ask that creative approaches such as that being pursued by the New York Care Coordination Program be considered as a clinically better alternative than commercial "managed care" as we have experienced it. As effort is exerted to shift the locus of care from the inpatient to the clinic setting, we suggest that even if clinic services are to be globally ratcheted down that the focus of services in state licensed clinics be those with "spm". Furthermore, as clinic restructuring proceeds we suggest that the state make an effort to maximize reimbursement to clinics while simultaneously leveraging a maximum federal share. Accomplishing this would shore up financially stressed clinics while providing a measure of budget relief for the state. Realizing this goal would require revisiting the coding scheme incorporated in the recent clinic restructuring regulations. Advocacy organizations should also be wary of possible attempts to merge the state's so called "O" agencies, that is OMH, OASAS, and OPWDD or to invest all rate setting power for Medicaid in DOH while leaving the



Barry B. Perlman, MD

"O" agencies solely as regulators and providers of direct care. It should be remembered that each of the "O" agencies was established to address the particular needs of vulnerable populations. That laudatory goal should not be lightly undone.

With respect to initiatives which could potentially save money without damaging the mental health system, NYSPA endorses the following:

First, NYSPA asserts that significant savings can be affected in relation to the purchase of psychotropic medications by refining the state's Medicaid formulary. NYSPA's endorsement of such an approach in 2005 was predicated on the physician retaining the final say in choosing medications for their patients and NYSPA continues to hold this position. (See the NYSPA Report in the Summer, 2005 edition of *Mental Health News*.) The goal of negotiating lower cost to the Medicaid system also might be used to strengthen the NYS OMH PSYCKES quality initiative. That program utilizes the state's Medicaid data base to flag individuals receiving antipsychotics that are considered to be an increased risk for "cardiometabolic" syndrome, an important health concern. Perhaps lower cost to the state's Medicaid formulary could be negotiated for those antipsychotics least likely to cause adverse health consequences if they were designated as the medications to be used as first line medications when antipsychotic drug therapy is initiated.

Second, NYSPA has long advocated against the program of civil confinement for sexually violent predators both because of its expedient use of the mental health system to solve a problem of the criminal justice system and because of its potential for ballooning cost growth. This year's budget crisis should prompt a review of a program which costs the state over \$175,000 per year per individual versus \$56,000 per year if they remained in prison. Currently about 6 new individuals are civilly confined monthly or more than 70 per year while over the 4 years of the program none of those confined have been released. Thus the cost to the state is increasing by almost \$13 million per year

with no upper limit in sight. Nor do these costs include the substantial legal costs of the process of litigating the cases which are also borne by the state. NYSPA suggests consideration of alternate approaches such as indefinite sentencing, treatment in prison, and increased reliance on outpatient models used in other states.

Timothy's Law, the NYS mental health parity legislation, was passed in 2006 and the federal mental health parity legislation was passed in 2008. Together these laws compliment each other to provide powerful protections for persons requiring treatment for mental illness including those who may be required to enroll in managed care plans including Medicaid HMOs. The American Psychiatric Association, along with coalition partners, advocated for and was pleased that there was no diminution of the federal parity law in the Affordable Care Act, the national healthcare legislation passed in 2010. However those protections have yet to be fully realized. Medicaid managed care organizations in NYS have yet to take concrete steps towards implementation, despite existing statute and a guidance document issued by DOH in September, 2010. Given the expectation that more New Yorkers, including those with "spm", will soon be moved into managed care it is critical that managed care organizations be made to abide by the federal law and the DOH guidance, both its quantitative and non quantitative requirements. If necessary, NYSPA suggests that the legislature hold hearings to draw attention to the failure of Medicaid managed care organizations to become compliant.

Finally, I should like to draw attention to an arcane issue but one of importance to all New Yorkers. As readers may be aware, many NYS hospitals have been forced to shutter their doors in recent years and additional closings are likely. Many hospitals depend on fulltime medical staff and those with large psychiatric departments utilize salaried psychiatrists. Salaried staff are usually insured by their institutions. When bankruptcy is declared, the salaried medical staff often are left without medical liability coverage. This situation presents a concern both for physicians as well as for patients who may not receive payment of existing liability awards or be left without appropriate avenues for redress of possible malpractice claims. NYSPA believes that NYS should require that hospitals and agencies, which insure their medical staff, including psychiatrists, create vehicles which would come into play in the event of bankruptcy to protect the employed physicians and the patients they have cared for.

The matters discussed above represent some of the concerns which NYSPA will be addressing during this year's legislative session. We hope readers will consider these concerns from their own perspective and, if you agree with the issues we have identified, will join with NYSPA's members in advocating for them.

Barry B. Perlman, MD, is the Legislative Chair and Past President, New York State Psychiatric Association and is the Director, Dept. of Psychiatry, Saint Joseph's Medical Center, Yonkers, N.Y.



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THE MENTAL HEALTH LAWYER



Planning Ahead for Difficult Health Care Decisions

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

During recent debates over healthcare legislation the term “death panels” was thrown around at a regular interval, conjuring up ideas of bureaucrats meeting in secret to decide who would live and who would die. Despite the ominous title and political imagery it provoked, “death panels” simply referred to a rather mundane piece of end-of-life planning. This small portion of the otherwise large healthcare legislation allowed physicians to receive compensation through Medicare for discussing documents such as health care proxies and living wills; essentially, what decisions will be made for you at the end of your life and whom you want to make those decisions for you.

Often times these very important decisions are neglected when we are of sound mind and body because they are too difficult to think about or because we do not wish to burden friends and family with the thought of our eventual death. While this topic may be uncomfortable to discuss, the burden is increased many fold when we are of failing health and unable to express our wishes because ultimately these decisions do fall upon family and friends. If one does not make their wishes known to the people you hoped to protect from discomfort by having a conversation they are left to guess as to what you really wanted. Even worse, if no family or friend is available the decision is left to strangers who did not know you at all.

This article will discuss the many options available to people to ensure that their wishes are met when it comes to many of the most important decisions of our lives. Specifically, it will give a brief overview of many of the tools available for “advanced planning” such as a Living Will, Health Care Proxy, Power of Attorney, Guardianship, and the new Family Health Care Decisions Act. This article will also discuss the relative limitations of these options.

Living Will

A Living Will is a fairly simple document that details what sort of life sustaining treatment you do or do not want performed if you lose the capacity to make that decision for yourself. For instance, if you are suffering from an incurable illness that will surely take your life, you can decide, in advance, while you are still of sound mind, that you do not wish to be resuscitated if that is necessary, or that you do not wish to have breathing or feeding tubes inserted to prolong your life. This provides health care providers with an unmistakable account of your wishes if you are to befall such a situation.



Carolyn R. Wolf, Esq.

Health Care Proxy

A Health Care Proxy allows you to appoint a Health Care Agent, someone to make decisions for you, if you become incapacitated. This allows you to choose exactly whom you trust most to carry out your wishes. It becomes particularly important if you are not married, or if the person you wish to make decisions for you is a friend and not immediate family.

Important to note, however, a Health Care Agent cannot make decisions regarding involuntary psychiatric care and treatment. In other words, if an individual with a mental illness suffers a deterioration of his condition their agent cannot commit them to a psychiatric hospital or consent to psychiatric medication in a psychiatric hospital setting. In addition, even if an individual lacks the capacity to make a decision on their own, but is still conscious and expresses wishes for treatment that are contrary to the Health Care Proxy, the proxy becomes void. Hence, if a mentally ill person loses capacity and begins to refuse medical treatment of a non-psychiatric nature an agent cannot make the decision for the person. In this situation, only a Court can override someone's active refusal to receive treatment.

Power of Attorney

A Durable Power of Attorney allows an individual to make financial decisions on your behalf. Unlike the Health Care Proxy, which only goes into affect when you lose capacity to make decisions for yourself, a Durable Power of Attorney authorizes your agent, called an “attorney-in-fact”, to make decisions while you are capacitated and also when you lose capacity, unless you specify otherwise. A Power of Attorney can be as broad or limited as you would like, authorizing your

agent to make all or only specific financial decisions on your behalf. Under a recent amendment to New York's law a separate form must be filled out if you wish your agent to have the ability to make gifts in excess of \$500.

Guardianship

A Living Will, Health Care Proxy, and Power of Attorney can only be executed when someone is of sound mind to make these decisions. Once someone has lost the capacity to make decisions, however, whether it is due to mental illness or any other infirmity, these instruments cannot be created. In these situations the law allows for a guardianship proceeding. A guardianship allows the Court to appoint an individual to make financial and personal decisions for an individual who has lost capacity to make a decision for themselves. A guardianship proceeding can be initiated by family, friends, the director of a facility where an individual resides, or certain governmental agencies charged with the welfare of the population. Although a guardianship can be tailored to be as limited as necessary, a guardian can also be granted the authority to make essentially all decisions for the incapacitated person. In addition to financial decisions and health care decisions a guardian can make decisions about whether the incapacitated person can drive, travel, where

they can live, etc. Also, unlike a Health Care Proxy, a guardian can make decisions for an individual even if that person verbally disagrees with the decision.

Like the Health Care Proxy, however, a guardian cannot make decisions regarding involuntary psychiatric treatment. The Courts have been clear that these decisions can only be made by a Court. So while a guardian can make a decision regarding major or routine medical procedures, a guardian cannot involuntarily commit or make decisions about whether or what psychiatric medication an incapacitated person should receive. Only a Court can make that decision.

Family Health Care Decision Act

Recently New York State passed the Family Health Care Decisions Act (“FHCDA”). The FHCDA fills a huge gap in the law where a person had not completed an advanced directive such as a Living Will or Health Care Proxy, and there was no “clear and convincing” evidence of their prior expressed wishes so therefore no one could make decisions if the person lost capacity. This often required cumbersome and time consuming petitions to a court even if family was available to make decisions. This law now provides a hierarchy of decision makers

see Decisions on page 37

Carolyn Reinach Wolf, Esq. and Douglas K. Stern, Esq. of

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The Economics of Recovery: What's In a Name?

By Donald M. Fitch, MS
Executive Director
Center for Career Freedom

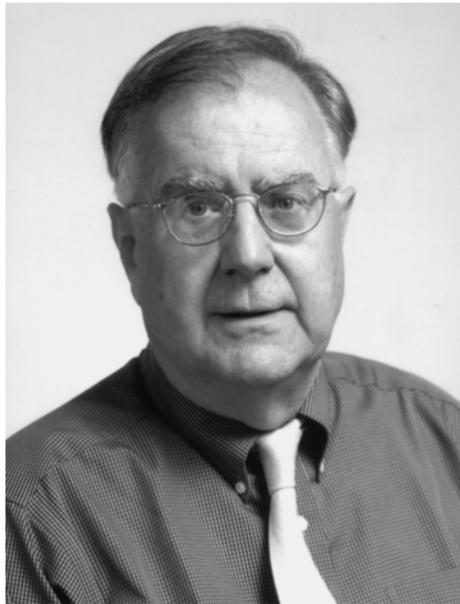
The Daily Show's Jon Stewart recently stated, "You hear about crazy – but it's rarer than you think." The tidal wave of media coverage over the tragic shooting of Rep. Giffords in Tucson, Arizona, a shooting that wounded thirteen and killed six people including a nine year old girl, produced a plethora of terms to describe and explain why Jared Loughner had committed these atrocities.

The Bazelon Center for Mental Health Law suggested "untreated mental illness," combined with "today's vitriolic political climate," may be the cause and called for increased services and system reforms. Many advocates and providers in the trenches of direct care spoke out against disability profiling, discrimination or pursuing laws that try to use the courts to compensate for gaps in basic services. Even President Obama questioned "the adequacy of our mental health system."

The terminology used to describe Loughner in the media by public officials, law enforcement, professionals, and pundits ranged from biblical to clinical; "A blood tide of massacres perpetrated by crazy people;" "Unmedicated loons with hatchets;" "Possessed by the devil;" "A pot-smoking loner;" "Mentally unstable;" "Paranoid schizophrenic."

Past tragedies were brought up: Virginia Tech, Columbine, and Kendra Webdale.

"Solutions" ranged from developing a national data base to keep guns out of the hands of "crazy people," to lifelong incarceration, more court-ordered treatment, one-way bus tickets, easier access to prescription drugs, more laws and a lot more money. A Professor at Rutgers said that even if Loughner had been treated sooner, "treatment alone is not necessarily going to stop someone with a mental illness from engaging in criminal behavior" (TIME Magazine). What seemed to



Donald M. Fitch, MS

be coming through all this "noise" was that we are surrounded by "crazies" and there was little we could do about it. Gun sales soared.

Estimates of the incidence of "adults with mental illness" range from 5% to 25%. In a press release, The Substance Abuse and Mental Health Services Administration (SAMHSA) reported that "20% of American adults (45 million) have experienced mental illness over the past year," and "4.4 million Americans with a serious mental illness are walking around untreated" (11/18/10).

The confusion over the incidence of "mentally ill" may arise from at least three official government sources: 1) The Social Security Administrations' 2) SAMHSA's National Survey on Drug Use and Health and, 3) The U.S. Census Bureau/ACS.

The Social Security Administration defines adults with serious mental illness (SMI) as having a diagnosable mental, behavioral or emotional disorder (DSM-IV) "that has resulted in functional impairment which substantially interferes with or limits one or more major life activities" (SSA.GOV).

The SSAs' definition differs from the

other two in three important ways: 1) The person rendering the SMI opinion is a medical professional – usually a psychiatrist and after a thorough medical history review and several diagnostic assessment sessions, 2) The impairment "substantially interferes with a major life activity" e.g. employment, and 3) The diagnosis is contained within the latest version of the DSM.

SAMHSAs' definition is not based on an objective medical professional's opinion, functional impairment, or on the DSM. It is based on the responses to questions (K6 scale) about "psychological distress" during the past year, "when they were at their worst emotionally" (Kessler et al., 2003). The six questions asked how often they felt: nervous, hopeless, restless, sad/depressed, worthless, and that "everything was an effort." SAMHSA acknowledges "the K6 scale does not directly measure the presence of a diagnosable mental illness," so they created a new definition of mental illness, called Serious Psychological Distress (SPD) (SAMHSA NSDUH, Appendix "B", 2009). SAMHSAs' new definition and the self-report survey methodology could explain the four-fold increase in the number of Americans who are "mentally ill" from 5% to 20%.

The Census Bureau's ACS definition of "mental disability" is even broader than SAMHSAs. "Because of a physical, mental or emotional condition lasting six months or more, does this person have any difficulty in doing any of the following activities; learning, remembering, or concentrating?" (Q. 17a). One must wonder why the U.S. Census Bureau and a prestigious University would issue and support data generated by such an obviously vague question, and then go on to classify the answers as accurately describing the incidence of persons with a "mental disability" (www.census.gov/acs/www/methodology, 2011) (www.ilr.cornell.edu/edi/nymakesworkpay/, 2010).

As a former Marketing Consultant, which included several Big Pharma clients, I believe the purpose of using SAMHSA's and the Census Bureau's data is to expand the definition of Mentally Ill (MI),

thereby creating four times the number of potential consumers of prescription drugs. Further, if one could incorporate these self-reported symptoms into DSM-5, this would establish a basis for reimbursement which would expand the dollar value of this market by several billions of dollars. Now that's strategic marketing! (Just a theory)

Stretching the definition of MI four-fold wouldn't just be a windfall for Big Pharma. Imagine what it could do for our own budgets, head counts and salaries! Though, main streaming the definition of MI raises the question of how to define "normal." Would having a bad hair day be a billable event? (Why is it always about the money?)

With all these definitions of mental illness flying around we wondered what terms our students would prefer (next to their own names). So we asked our folks to rate sixty-five items on how well they thought the term described them; perfectly, very well, fairly well, poorly, or not at all. "Survivor" was the overall favorite.

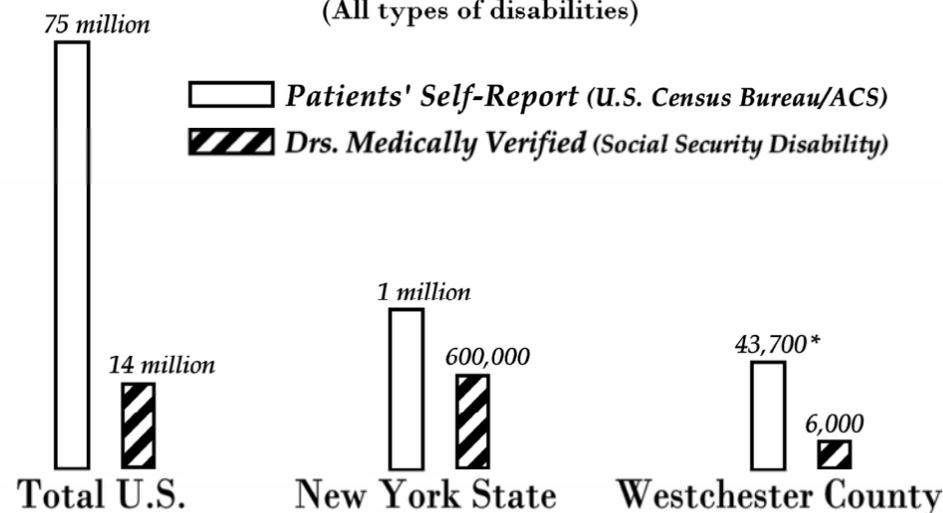
Some pointed out that the terms were situational. They felt the terms described phases of their recovery, e.g. they were called patients when they were inpatients, clients when they were in Program, and survivors when they were resettled in the community. Further, the terms "consumer" and "recipient" were felt to be commercial and passive, and did not reflect their struggles and victories. Perhaps OMH's Office of Recipient Affairs should change their name to the Office of Survivor's Affairs?

According to Wikipedia, "stigma" is a Greek word that referred to a kind of tattoo that was cut or burned into the skin of criminals, slaves and traitors in order to identify them as "morally polluted persons to be shunned." For our population, stigmatization is an issue of disempowerment and social injustice. Time will tell if we have suffered a serious setback. It is complicated.

To quote part of President Obama's eulogy for Tucson's victims; "Let us use this occasion to expand our moral imaginations, to listen to each other more carefully, to sharpen our instincts for empathy."

Definitions of Disability; Patients vs. Doctors

(All types of disabilities)



Sources: *ILR/Cornell University, 2010
SSA.GOV/Statistical Abstract, 2010

"How well do you think these terms describe your disability?"

"Perfectly / Very Well"

- #1: Survivor
- #2: Client
- #3: A Person With a Disability
- #4: Recipient
- #5: Patient
- #6: Consumer

"Poorly / Not at All"

- #60: Shell-Shocked
- #61: Differently Abled
- #62: Hysterical
- #63: Postal
- #64: Mentally Retarded
- #65: Demented

On The Precipice of Living a Full Life in the Community:

Institute for Community Living Awarded Contract to Provide Supported Housing For Almost 1,200 New Yorkers With Mental Illness

By Adrienne Johnson
Freelance Writer
Institute for Community Living (ICL)

The first time the Institute for Community Living received a court-monitored receivership, it not only succeeded—it spent the next 25 years growing into an agency now capable of helping 9,000 individuals struggling with mental illness, developmental disabilities, substance abuse and homelessness. Now in its 25th year, Institute for Community Living (ICL) has come full circle with a court-monitored, three-year and \$20 million contract. Through the award, ICL will assist close to 1,200 individuals with psychiatric disabilities presently living in Brooklyn, Queens and Staten Island Adult Homes move to their own community apartment. This marks ICL's first foray into Staten Island and the first time that the nonprofit will have programs in all five boroughs.

The project is part of an \$80-million program launched by the New York State Office of Mental Health. Seven different providers will develop 4,500 units of supported housing so that individuals with mental illness, now living in adult homes, can transition into the community. The program is a direct response to last year's District Court judgment in the case of Disability Advocates, Inc. v. Paterson, et al. The court declared that adult homes amounted to warehousing individuals with serious mental illness, and it ordered that these individuals be transitioned out of group homes into supported housing in a community setting.

Beginning February 1, 2011, ICL will initiate the process to engage, assess and provide support services to assist these individuals to transition from adult homes into scatter site apartments within the community.

"These folks will be embarking on a journey filled with pride, adventure, workable challenges and immense personal growth," says Dr. Peter C. Campanelli, President and CEO, ICL. He continues, "We are delighted to be working with the New York Association of Psychiatric Rehabilitation Services and the Coalition of Institutionalized and Disabled; their experience, especially with training, brings another depth to our own. This project is an opportunity and a challenge to transform lives, and we are eager to embrace it."

Collaboration of Three Agencies to Improve Lives in the Community

The individuals moving into supported housing will be coming from adults homes, which by their very nature, cannot and do not promote community integration. Supported housing is the best opportunity for residents to integrate with the community, but without the proper supports, services and considerations, they will not thrive any better liv-



Dr. Peter C. Campanelli

ing in their own apartments than they did in the group homes from which they came.

ICL's services and approach are rooted in the belief that community integration is vital to recovery, wellness and independence, and that with proper supports—psychiatric, medical, vocational and social—an individual with mental illness can lead a full life in the community. ICL will be collaborating with the New York Association of Psychiatric Rehabilitation Services (NYAPRS) and the Coalition of Institutionalized and Disabled (CIAD) to train staff and to provide evidence-based treatment, best practices and comprehensive services for the individuals transitioning into supported housing.

Harvey Rosenthal, NYAPRS, Executive Director, says, "This project builds upon our long history advocating for group home residents with psychiatric disabilities, and it brings so many of those efforts to fruition. The combined effort of ICL, NYAPRS and CIAD, who will work together to support these individuals every step of the way, will ensure that these men and women can look forward to a meaningful recovery and a full life in the community—a chance that until now, has passed them by."

What is remarkable about this collaboration is what it means for the client. Dr. Campanelli explains, "At the heart of this endeavor, are the three agencies that are bringing vastly different expertise to the table – all of which will surround each client with the right support services to live in the community successfully. ICL's proficiency at housing and integrating medical and physical health, NYAPRS's advocacy and pioneering skills in developing peer support and CIAD's know-how on working effectively with consumers is an incredibly powerful three-way combination."

Not Without Precedent

Beginning with the assumption of a court-monitored receivership 25 years ago, ICL has come full circle with this new project, ICL's largest to date. The \$20-million contract will allow ICL to create scattered site apartments in Brooklyn, Queens and Staten Island, meaning ICL's impact will now reach into all five boroughs.

ICL has reached the quarter-century mark, and with the advent and promise of this new project, ICL has even more to celebrate. Founded by ICL CEO and President Dr. Peter C. Campanelli in 1986, ICL began in Brooklyn with the ICL Stepping Stone Residence, a court-monitored receivership and supported housing program for individuals with mental illness. Under Peter's leadership, ICL expanded to provide housing and services to individuals in Queens, Manhattan and the Bronx; in the community, in schools and in shelters. ICL now provides recovery and rehabilitation services, supported housing, integrated medical and psychiatric care, and vocational support to adults, families and children with mental illness.

A Share of the Responsibility

In October of last year, the New York State Office of Mental Health requested proposals to develop and operate up to 4,500 units of supported housing to serve the current residents of 28 adult homes in New York City. The supported housing needs were broken down into eight geographic groupings, and seven different agencies were chosen to provide services. The total units, listed below, will be rolled out in three phases, over the course of three years:

- F.E.G.S: Bronx, 455 units
- Services for the UnderServed: Brooklyn, 571 units
- Postgraduate Center for Mental Health: Brooklyn, 468 units
- Institute for Community Living: Brooklyn and Queens, 621 units
- Pathways to Housing, Inc: Queens, 516 units
- Transitional Services for New York, Inc.: Queens, 660 units
- Catholic Charities Neighborhood Services: Queens, 640 units
- Institute for Community Living: Staten Island, 569 units

By the third year of the program, it is estimated that these contracts will provide a total of \$65.9 million in annual rental stipends and \$13.5 million to support staff, putting the total value of the project close to \$80 million. ICL's proposal was ranked

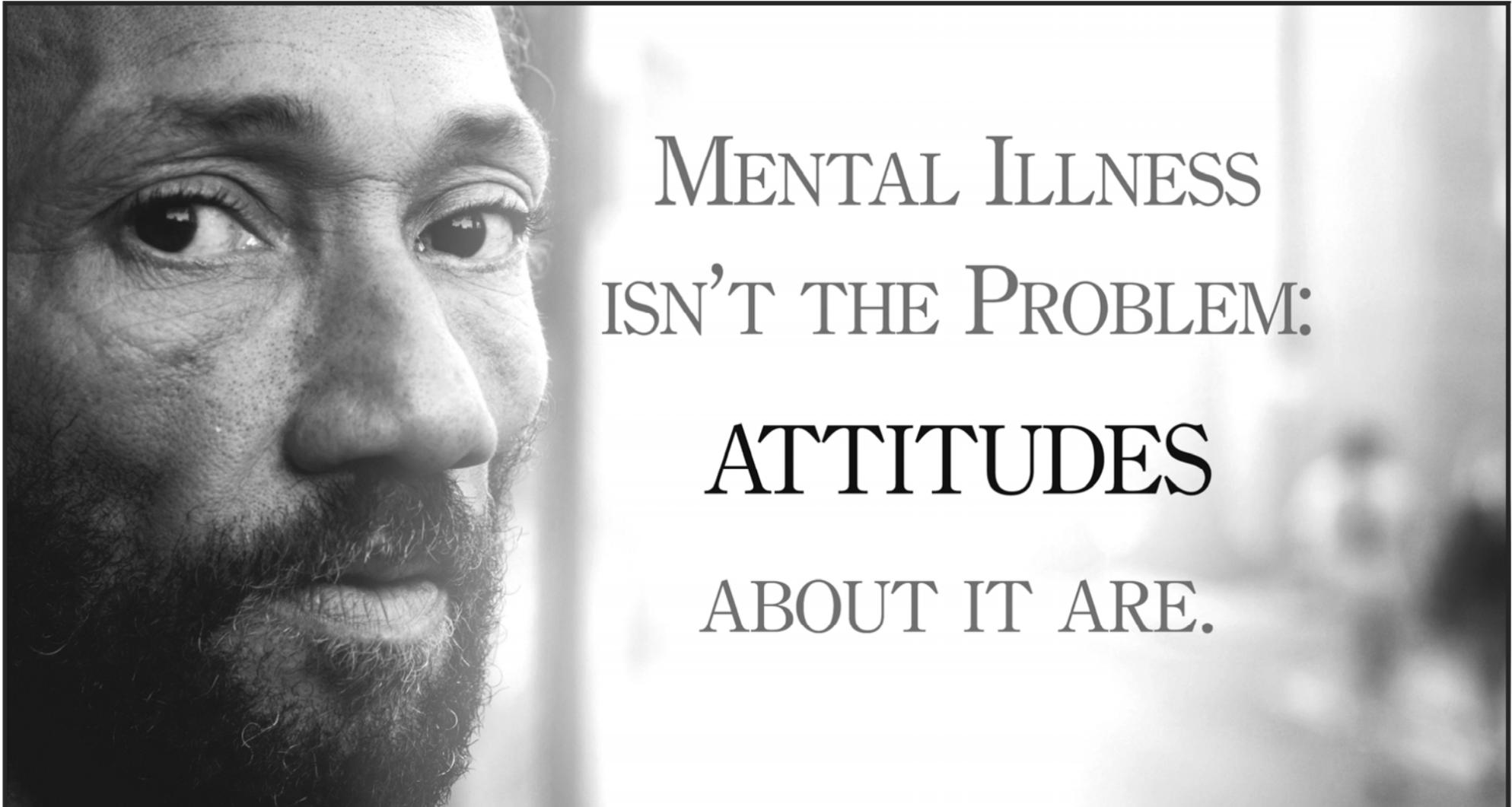
#1 among the providers, and it was the only agency awarded two groupings, giving ICL a quarter of the responsibility for transitioning the residents of group homes into a community setting. With this contract, ICL anticipates adding 100 new staff members, some of whom will be peer specialists who share similar histories and experiences to those they will be helping.

Background

Institute for Community Living: The Institute for Community Living, Inc. (ICL), founded in 1986, is a not-for-profit corporation that assists individuals with psychiatric disabilities, intellectual disabilities and/or developmental disabilities. At the heart of ICL are the people that are served and the communities in which they live. The agency provides 100+ evidence-based and best practice innovative treatments, rehabilitation programs and support services to over 9,000 adults, children and families in Brooklyn, Manhattan, Queens, the Bronx and Montgomery County, Pennsylvania; offers over 1,400 housing units and a comprehensive system of clinical treatment options; and operates a transitional residence in Queens for 243 veterans and a Brooklyn shelter for women with mental illness.

New York Association of Psychiatric Rehabilitation Services: The New York Association of Psychiatric Rehabilitation Services, Inc. (NYAPRS), founded in 1981, is a statewide coalition of people who use and/or provide recovery oriented community based mental services. Its membership includes over 100 community mental health service agencies that support the efforts of tens of thousands of New Yorkers by providing a wide range of services that share a fundamental belief in the capacity for recovery, healing and independence for every individual with a psychiatric disability. Through its individual and organizational memberships, it reaches over 20,000 individuals who currently receive recovery, rehabilitation and peer supported services. For more information, visit www.nyaprs.org.

Coalition of Institutionalized and Disabled: The Coalition of Institutionalized Aged and Disabled (CIAD) is a non-profit, consumer-led advocacy organization of adult home and nursing home residents and residents' councils. CIAD was established in 1973 to bring pride, purpose and self-determination to residents. Our mission is to provide residents with the information and skills they need to advocate for themselves, to protect and promote the rights of residents, and to improve the quality of their lives and their care. CIAD organizes residents into resident councils, training and nurturing resident leaders, educating residents about their rights, and promoting their participation in the affairs of their own residences as well as broader public policy issues.



MENTAL ILLNESS
 ISN'T THE PROBLEM:
 ATTITUDES
 ABOUT IT ARE.

Respect. Realize. Reconsider. Ignorance is not bliss. 1 in 4 adults suffers from a diagnosable mental disorder each year.

As a mental health advocate, you know the importance of compassion and understanding. To be effective in empowering those with serious psychiatric illness, mental retardation and/or developmental disabilities, we must work together. With over 20 years in the mental health field, the Institute for Community Living is here when you need us, with:

- *85+ programs in Brooklyn, Manhattan, the Bronx, Queens and Montgomery County, PA*
- *Specialized housing options for adults, families and teens*
- *Mental health clinics*
- *Evidence-based treatment and best practice approaches*
- *HealthCare Choices, a clinic integrating medical and mental health care*
- *National and state recognition*
- *CARF 2007-2010 accreditation for community housing, therapeutic community and outpatient treatment programs*

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Improving Lives, Building Hope, Empowering People

Saint Joseph's Medical Center Purchases St. Vincent's Hospital Westchester

Purchase Preserves Large Mental Health and Addiction Programs Serving the Region

Staff Writer
Mental Health News

Saint Joseph's Medical Center (Saint Joseph's) of Yonkers, New York has purchased St. Vincent's Hospital Westchester (St. Vincent's) of Harrison, New York. The sale included St. Vincent's main hospital campus in Harrison, which includes 138 inpatient beds and large ambulatory mental health and chemical dependency programs throughout the region, with more than 600,000 annual visits. In Westchester County, the Bronx, Brooklyn, Queens, and Staten Island, St. Vincent's also operates 600 residential beds for people with mental illness.

"We are very pleased to have St. Vincent's join the Saint Joseph's family and remain under the sponsorship of the Sisters of Charity," said Michael J. Spicer, Saint Joseph's President and Chief Executive Officer. "Our acquisition of St. Vincent's, combined with Saint Joseph's extensive behavioral health services, will mean we are one of the largest providers of mental health and chemical dependency services in the region."



Barry B. Perlman, MD, Director, Dept. of Psychiatry, Saint Joseph's Medical Center; Mr. Michael J. Spicer, President & CEO, Saint Joseph's Medical Center; Ms. Bernadette Kingham-Bez, Senior V.P. Saint Joseph's Medical Center and Executive Director, St. Vincent's Hospital - Westchester, A Division of SJMC

The Department of Psychiatry at Saint Joseph's Medical Center serves Yonkers and surrounding communities with a wide

array of outpatient and inpatient mental health services as well as substance use disorder treatment programs. Dr. Barry

Perlman, Director of Psychiatry for Saint Joseph's, said, "We are delighted to have our St. Vincent's colleagues, with whom we have worked for many years, become part of Saint Joseph's."

James J. Landy, Chairman of the Saint Joseph's Board of Trustees said, "By becoming a division of Saint Joseph's, with its commitment to behavioral health and other community-based programs, St. Vincent's can continue its long history of providing mental health and addiction treatment services. We look forward to this new chapter in our history."

Founded by the Sisters of Charity, Saint Joseph's is a not-for profit health-care facility that has been serving the community from the same location on South Broadway in Yonkers since 1888. Saint Joseph's provides a vast array of services for all ages, ranging from a children's dental clinic and Family Health Center to a state-of-the-art Emergency Room, one of the busiest in Westchester County, and an Ambulatory Surgery Center. In addition, Saint Joseph's offers the only family medicine residency program in Westchester and is a leader in providing geriatric services.

Support for Older Adult Peers

By Jeffrey Perry, CPRP (MSM) and Vera Popko
Baltic Street, A.E.H., Inc.

The Baltic Street, Advocacy, Employment, and Housing, incorporated, Geriatric Peer Advocacy Program may be the only peer to peer program in New York City that offers services to seniors that have psychiatric disabilities. The program has been in existence since 1998 and although it is a small program, over the course of its lifetime, its mission has been and continues to be to provide support to seniors, based on their needs for a successful life in their communities. We have been able to provide support and services for the older peers at locations like, adult homes, nursing homes, psychosocial clubhouses, etc. Our purpose is to help them sustain a well-balanced standard of living.

The Geriatric Peer Advocacy Program began under the guidance of the New York City Department of Mental Health and was approved as a result of a Request for Proposal (RFP) that Baltic Street, AEH, Inc., had submitted to the City of New York DOHMH to provide advocacy and support services to seniors, with an Axis I mental health diagnosis. We assist consumers who are at least sixty years of age or older. They may need help with housing (Senior Apartments, in particular), referral services to outpatient clinics, doctors' offices, benefits and entitlements, financial matters, and any other supports or resources that are applicable to the adult services and programs. In addition,



Jeffrey Perry, CPRP (MSM)

the program also helps advocate for legal advice and services. All of our services are delivered in an atmosphere that is friendly and trusting. This attitude of support is crucial to seniors and demonstrates that we sympathize with their situations and that they are not alone and not forgotten. As peer advocates we maintain contact and often give a supportive call just to inquire if there are any immediate needs or to just say "How are you doing?" As Peers, we provide a number of other services through collaboration with other programs and resources and we continually help coordinate essential services for



Vera Popko

older adults. We also do escorts or go-along-services with persons to appointments when necessary. Some of our clients may only need help with specific questions or just reminders of when they have an appointment.

In some of the Brooklyn adult homes, we facilitate groups where we meet a number of new consumers who may be dealing with mental health issues for the first time or the onset of mild dementia or who may have aged out of the mental health system. There is a need of a special relationship for older adults that are not the same for those younger in age and in

spirit. Some of the needs remain the same, like housing, financial support, and even alcohol and substance abuse, but these often are new and unique problems that arise. We always treat our clients in a respectful and caring manner. We understand that our elders need to be recognized as valuable members of our society, although they may not seem to be as attentive to what we feel is important in our society today. They could probably tell us all, a few things or two, about how to better our lives and we never minimize or underestimate their wisdom.

In the groups we facilitate, we discuss self-esteem issues, overall wellness, and recovery tools. We speak about health issues; from stress management, diabetes, better diets, exercising, and anything that is related to good health, in particular. Some seniors ask about information on traveling, employment, and personal needs, all of which we try to assist them with individually. We use a self-help approach, where seniors are shown that they can still do many things on their own with just a little coaching and encouragement. At this time in their lives, many find just our presence to be helpful. They are happy, sometimes, just to know that someone cares and is concerned.

A Case Study: George (not his real name) a senior came to Baltic Street, AEH, Inc. Geriatric Program some time ago, seeking support with financial issues and was given referrals and a listening ear to help him through the process. He came back to us on several occasions with

see Peer on page 36



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Bob – The Beginning: A Family Member's Journey Into the Depths of Bipolar Disorder

By Susan Lesco

Only a few short years before leaving his cat and clothes in the covered alleyway, next to the dumpster behind the deli on 2nd Avenue, Bob was an accomplished plastics engineer. His parents, brother and sister were living back east, and his favorite aunts, an uncle and cousin lived a couple of hours north of Los Angeles. He had a home with a pool and a spa, three beautiful little boys and a wife who could no longer live in denial.

It's not that his family didn't care; they just didn't know that the severe mood swings, violent outbursts and overly enthusiastic reactions to mundane events that Bob experienced in his younger years, had a name. They didn't know that the similarities between their mom and her oldest son weren't simply a result of being so close. It wasn't just that Bob was a genius with quirky habits, or that he was the oldest of three who often stayed home to help his mom take care of the kids: Bob had bipolar disorder.

It's not that his family didn't care; they just didn't know that bipolar disorder can't be ignored. If left untreated, Bob's enthusiastic happy moods would eventually turn into uncontrolled fits of violent rage. They had all heard about the fights

between Bob and his wife. She said he spent money like water, was collecting and storing things she called garbage, and he just wouldn't help around the house, which incidentally was now in foreclosure. And to top it off, he lost his job. His bad luck would turn around.

All couples argue over finances and chores, particularly when the breadwinner of the household loses his job, most certainly due to no fault of his own. His wife was just cranky because she had to cut down on the luxurious lifestyle she was living. It had nothing to do with Bob's increasingly bizarre behavior. There was no reason for her to call the police to have him removed from the house just because he broke a few things in the den. After all, he was the one who paid for that stereo and the window he threw it through, in the first place. Look what she did to the kids.

Bob had never imagined that feeling elated could be a problem, even if he had to deal with a few days of crushing depression every now and then. There was no need to take medication or talk to a therapist like his ex-wife had been nagging him to do. He had gotten over the divorce and was looking for another job. The studio apartment he rented would work perfectly as his main office and he would soon buy a new house for his three growing boys to visit. Besides, his family would help him out in a pinch.

The only thing Bob couldn't understand was why the landlord kept threatening to evict him. Bob had told him that he would pay the rent as soon as he got a job and the small fire in the bathroom didn't really cause a lot of damage. The landlord knew that he had to buy more office supplies to keep up with the work he was doing and it was none of his business how much stuff he stored in the apartment.

The shelter was getting a bit crowded and everyone was nagging Bob to take medication and see the therapist at the hospital. Since his cousin had been so helpful to him in the past, he thought it best to move there. His cousin would understand; he's family. Bob knew that his cousin would realize why he had to set up a tent in his backyard while he was at work. His cousin's kids would be happy to see him there in his new main office when they returned home from school. Bob wouldn't be disturbing anyone since he slept outside and would only use the house when everyone was out. In fact, he could babysit for the kids to give his cousin and wife a break. Bob couldn't understand why his cousin made him move out. He was just playing around with his youngest child in the swimming pool. He didn't mean to hold him underwater for so long. His cousin really overreacted by diving in the pool with his clothes on to grab his child away from

Bob. After all, the child started breathing again in a few minutes. No one got hurt.

Money was tight and Bob needed a new suit for the many job interviews he was expecting to get. It was tough getting around without a car and using the local Kinko's as his main office. He didn't mind living in state park since the weather was warm and he always loved camping anyway. However, even California gets cold in the winter.

Bob was ready for a place to stay with a phone and indoor plumbing. Luckily, his elderly single aunt wanted nothing more than to help her first nephew get back on his feet, so she told Bob he could stay with her for a couple of months. She had a one bedroom apartment and a pull out couch in Ventura County. However, when she made that offer, no one would have predicted that a few adolescent moods swings in his past would lead Bob through an interminable path of self-destruction.

It seemed like decades, but it was only a couple of years that Bob stayed with his aunt. Even though her own health was failing, she tried hard to help him by giving him her debit card to buy food and proper clothing to wear at a job interview. Bob knew that he was really the one helping his aunt since he was convinced that she had Alzheimer's disease. Unfortunately, Bob's

see Bob on page 34

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Disparity Without Despair: How Mental Health Nurses Deal with Racial or Ethnic Inequality - One Visit at a Time

By Elizabeth H. Cymerman, MNH, BSN, RN-C, HNC, Assistant Manager, Mental Health Services, Visiting Nurse Service of Westchester, White Plains, New York

The 1999 Report of the Surgeon General, entitled *Mental Health: Culture, Race, and Ethnicity*, highlighted the uncomfortable fact that not all Americans share equally in accessing and receiving treatment for mental illness. Many disparities exist, making it a critical public health concern. The report stated, "Even more than other areas of health and medicine, the Mental Health field is plagued by disparities in the availability of and access to its Mental Health Services. These disparities are viewed readily through the lenses of racial and cultural diversity."

In this report, the disparities for minorities noted were: (1) Less access and availability of Mental Health Services; (2) Less likely to receive mental Health Services; (3) Poor quality of care; and (4) Underrepresentation in research.

Usual barriers to care include: cost, fragmentation, lack of availability, and the stigma of mental illness. In addition, minorities experience mistrust, fear of treatment, racism, and discrimination, and differences in language and communication, which is essential for treatment of mental health disorders.

All of the above disparities in mental health care causes a greater disability burden for minorities. This influences the degree of disability in terms of activities of daily living and lost employment. This, in consequence, leads to less economic prosperity, more poverty and violence, and ultimately more mental health issues, increasing rates of mental illness by two to three times that of the non minority population.

Culture's Influence

Culture is important when considering treatment and access to care. It determines the differences in how symptoms are communicated and reported, societal culture-bound syndromes, who or what help is sought, coping skills, social support and degree of stigma felt attached to mental illness. Culture's influence is underestimated, and must be included in the delivery of care.

Culture also influences the professionals who treat their clients - within the professional group and as a result of their ethnic/cultural group. This governs the societal response to the patient, and influences the delivery of care. This can make the professional ill-equipped and occasionally biased in how the care is delivered.

Western Medicine as it is practiced in the U.S. emphasizes disease rather than Holistic or Eastern methodology, which

may be in conflict with clients, creating barriers to care.

The environment of the mental health system may deter clients and provoke mistrust when it does not respect or are incompatible with the cultures they serve.

Cultural Competency

Many mental health agencies and professionals are aware of the national standards developed by the Federal Office of Minority Health (Dec 2000) for culturally sensitive practice. Some are recommendations and others mandated by the Office for Civil Rights. The areas included are: clinical, organizational, and linguistic standards.

Dr. Campinha-Bacote, President and Founder of Transcultural C.A.R.E. Associates, defines cultural competence as "a process in which the nurse strives to achieve the ability and availability to effectively work within the cultural context of the client (patient, family, or community)." This process is on going, and consists of five constructs: cultural desire, awareness, knowledge, skill and actual encounters with clients of differing cultures.

At Visiting Nurse Service of Westchester (VNSW), mental health nurses are on the front line of racial and cultural diversity. As one of those nurses, it is my job to prepare and understand how clients

from different cultures express their need for nursing care and treatment. Cultural sensitivity is of great importance in dealing with clients in their own community. Cultural competence should be in the forefront of Home Care and Community based agencies.

Racial and Ethnic Differences of Minorities in the U.S.

African Americans are 12 % of the US population. Approximately 25 % are poor, with income lower than whites. African Americans tend to have greater health problems, and a higher mortality from disease. Discrimination and racism influences all areas of life.

American Indians and Alaska Natives are the most impoverished with greater than 25% living in poverty. They are five times more likely to die from alcohol related causes than whites, 50% higher suicide rates, and more likely to live in high need areas being homeless, or incarcerated, and a disproportionately higher rates of mental health disorders.

Asian Americans and Pacific Islanders are a very diverse group, with 43 different ethnic groups, and are increasing rapidly among the U.S. population. Income is equal to whites, but with great variability.

see *Disparity on page 38*

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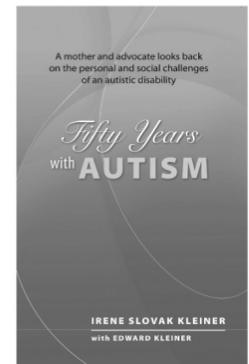
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Bob from page 32

aunt did have dementia. She never realized that her nephew had filled her house with his stuff. She didn't know that the \$300,000 she had saved over the years was spent on rubber bands, cameras, a knife collection and other important materials for Bob's main office.

When the police arrived after a particularly loud conversation between them, she couldn't remember how she wound up on the floor with a broken arm. Bob couldn't explain it either and he certainly couldn't understand why he was taken back to the emergency room yet again. His aunt was the problem, not him.

Bob's brother had tried to help. He went to California more than once to track Bob down and bring him home. But, Bob was fine and didn't need more nagging from his younger brother about taking medication and seeing a therapist. Bob's ex-wife got remarried and moved out of state and his aunt was in a nursing home; supplemented by his cousin, brother and sister. Bob couldn't understand why there was an order of protection to prevent him from visiting her since he had just spent a couple of years caring for her. Back east,

Bob's mother was diagnosed with cancer and dementia and had to move to a nursing home. Bob's dad was hit by a car and needed his children's assistance to live.

It's not that his family didn't care; they just didn't know how to make Bob accept help. His three sons loved their father and were now old enough to let him stay with them until he got back on his feet. The boys were ready, willing and able to do anything possible to help their dad. His oldest was planning to get married soon and Bob got to see his younger sons become college graduates. Bob set up his new main office in his sons' apartment. He knew that he'd get a new job soon and he was on top of the world. He simply couldn't understand why even they were nagging him to take the medication that the doctor prescribed during his last emergency room visit.

The new apartment that his sons rented for him would be a perfect main office, even if it wasn't in the neighborhood of his choice. As soon as he got a new job, Bob would be out of there. He wouldn't have to hear nagging words from any one. He had it all under control, until the day his oldest son was killed at work.

Bob didn't seem to have anymore

elated feelings. The crushing depression he used to put up with once in a while was there to stay. He didn't care that his job prospects were fading or that he was evicted from another apartment. It didn't matter that his aunt died in the nursing home or that his brother and sister-in law came to visit again: nothing would ever be the same. His youngest sons moved out of state to be with their mother. They still kept in touch with him, but were trying to start again themselves. They were the only reason Bob procrastinated about killing himself.

The people at the new shelter were very nice, but they wouldn't let him move into transition housing until he agreed to go to the program they offered, at their clinic. In the meantime, the guy at the deli on 2nd Avenue let him stay there during the day when he had nowhere to go. The cat that lived in the parking lot was Bob's best friend. Even though he wanted nothing more than to end the pain, he couldn't put his sons through another loss. Bob joined the program and began taking medication.

It's not that his family didn't care; they were afraid that he would simply give up. He seemed to be doing a little bit better with medication and therapy, but he was living in

transitional housing and had nowhere to go once he stabilized. Bob's father passed away and he didn't get to say goodbye in person. He wanted the chance to be with his mother before her time came. Bob's sons called his brother back east to tell him that they just couldn't take him in again, no matter how much they loved him. Bob was finally ready to accept help.

This time, Bob was happy to see his brother. He finally reached the turning point: acceptance. Bob could no longer manage his ups, downs and delusions with herbal supplements and denial. He returned to New York with a few re-established rules in place. He would take medication. He would allow his brother to handle his finances. He would see the doctor and attend a bipolar support group on a regular basis. He'd allow a community action team to help him really get back on his feet.

He'd let his family love him. He'd begin again.

Reference: Goodwin, F.K., and Jami-son, K.R. (2007). Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression, 2nd edition, New York Oxford University Press.

Competence from page 20

competence." At a meeting regarding the geriatric mental health needs of Latinos, he suggested that there was a need for both generational and cultural competence.

2. The Ceridian Corporation uses the concept of 'generational competence' to refer to different age groups of working people - "matures," "baby boomers," "generation

x," and "generation y," each of which has different characteristics both as workers and as markets. See "Changing The World of Work," 2005.

3. Peggy Gleeson has used the concept of "generational competence" to suggest that an effective professional workplace needs to take into account the "values, work characteristics, and customs" of different age groups. See "Understanding Genera-

tional Competence Related to Professionalism," *Journal of Physical Therapy Education*, Winter 2007.

4. Williams, K and Friedman, M. Addressing the Mental Health Needs of Older Adults in Age-Friendly Communities. The Geriatric Mental Health Alliance of New York. 2010. <http://www.mhany.org/media/1251/agefriendly.pdf>

5. Friedman, M and Williams K., "You Cannot Age Well Without Mental Health," *Huffington Post*, December 23, 2010.

Michael Friedman is an Adjunct Associate Professor at Columbia University's schools of social work and public health. He can be reached at mbfriedman@aol.com.

Principles for Promoting Inter-Group Relations Among Adolescents Through Group Work

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

Group work is a wonderful way of reducing prejudice and bigotry, promoting inter-group relations and enhancing ethnic group identity in adolescence. With its emphasis on mutual exploration and discovery, group work is very well suited to address these issues. The following are seven principles for addressing diversity in group work with adolescents. The principles may also be easily adapted for confronting other forms of diversity in groups (e.g., religion, gender, sexual orientation, age, disability).

1. *Address diversity as a normative adolescent issue in the group.* Encourage interaction about group identity, prejudice and inter-group relations as a normal part of adolescent development and not only in reaction to emergent conflicts or crises.

2. *Help the group to tune in to ethnically and racially-charged events impacting on youth.* This includes an awareness of local, national and international events with racial-ethnic overtones (e.g., September 11th terrorist attack on America; defacing of synagogues, churches and



Andrew Malekoff, LCSW, CASAC

other religious institutions; 2008 attack and murder of Ecuadorian immigrant Marcello Lucero in Suffolk County, N.Y. by a seven teenagers). When such stories dominate the media and youth's consciousness, stereotyping and polarization are often reinforced. A healthy and spirited exchange of ideas and opinions

about controversial subjects in a safe environment enables young people to test their beliefs and attitudes, to practice listening to others' views, to respectfully express differences and to discover common ground.

3. *Confront prejudice, stereotyping and oppression in the here-and-now of the group and workplace.* Confront issues such as stereotyping and the use of racial/ethnic slurs as they arise in the here-and-now of the group. Facilitative confrontation involves addressing issues and problems in a direct, caring and forthright manner. When the group or workplace replicates the oppressive or prejudicial behavior of society, the practitioner must skillfully intervene to raise consciousness, stimulate interaction, foster understanding and motivate change.

4. *Use cultural self awareness to model effective cross-cultural relationships.* Tune in to personal feelings, experiences, attitudes and values related to one's own group identity and views about different groups. Model respectful and effective cross-cultural relationships in the group and workplace. This is essential in post-9/11 America when profiling people of middle-eastern descent as terrorists or as sympathetic to terrorists has been expressed more openly among youths and adults.

5. *Promote understanding and respect for the world view and values of culturally different members.* Help group members to develop, if not an emotional affinity with different ethnic and racial groups, a cognitive empathy and cultural sensitivity that can lead to a deeper understanding of culturally different group members. This may be developed through a combination of self-awareness, eradication of stereotypes and unsubstantiated views and attainment of objective information about and real interaction with members of a particular cultural group.

6. *Tune in to the differential experiences of ethnic group members within their own particular cultures.* Help group members to understand the different experiences of members of ethnic groups that may customarily be perceived through an undifferentiated lens (i.e., "They're all the same"). In post-9/11 America, youths of middle-eastern descent are more likely to be taunted with the label "terrorist." So fearful was one Muslim mother, that she dyed her children's hair a lighter color to prevent them from being profiled as "kin of terrorists."

7. *Open pathways for intercultural communication and socialization.* In addition

see Group on page 36



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Dr. Kenneth Popler Reappointed Chair of Community Services Board

Staff Writer
Mental Health News

Mayor Michael R. Bloomberg has reappointed Dr. Kenneth Popler as chair of the New York City Department of Health and Mental Hygiene's Community Services Board (CSB), for a four-year term through December 2011.

The CSB is empowered by New York State Mental Hygiene Law and the New York City Charter to advise the department's commissioner and executive deputy commissioner - currently Drs. Thomas Farley and Adam Karpati, respectively - in all areas of the city's responsibility for services and programs relating to community mental health, developmental disabilities, and substance abuse prevention, treatment, and harm reduction.

As the CSB's chair, Dr. Popler continues to serve as a member of the New York City Board of Health, a post that he has held since 2004.

Now in his seventh term, Dr. Popler is the CSB's longest-serving member. First appointed to the board in 1984 by Mayor Edward I. Koch, Popler has been reappointed by each successive mayor.

Dr. Popler is the president and chief executive officer of the Staten Island Mental Health Society (SIMHS), West Brighton, which he has led since 1981. The SIMHS is a children's services agency that provides mental health and related services to over 6,000 Staten Island children and their families each year, with a budget of \$22 million, a staff of 300, and a volunteer corps of 500.

An officer or member of numerous Boards of Directors and advisory committees throughout New York, Dr. Popler is the founding president of the Staten



Dr. Kenneth Popler

Island Behavioral Network, Inc., a provider-owned care-coordination company. He is also a senior active member of the Rotary Club of Staten Island.

Dr. Popler earned his Master's and Doctoral degrees in Psychology from the New School for Social Research, Manhattan, and is board-certified in Clinical Psychology from the American Board of Professional Psychology. He is licensed as a psychologist in New York and New Jersey, and is certified as a school psychologist in New York State. He holds a Master's degree in Business Administration from Wagner College, Staten Island.

Dr. Popler and his wife Lois, a clinical social worker employed by the Archdiocese of New York, reside in Westerleigh, Staten Island.

Group from page 35

to advancing an understanding of cultural differences, reach for commonalities experienced among adolescents across cultures to encourage inter-group pathways for relating. For example, it is not uncommon for groups of culturally-different adolescent group members to discover some common ground in their experiences of negotiating with parents or other authority figures for greater freedom and more privileges.

In conclusion, a good group experience can provide adolescents with a good opportunity to explore the typically taboo areas of race and ethnicity, exposing

deeply ingrained or loosely-formed beliefs and attitudes. The mature group, through the development of its own history and culture, becomes a special frame of reference for its members, influencing their perceptions and behavior in the world outside of the group.

Group work is a special arena in which the problems of diversity may be confronted openly, honestly and safely where the richness of diversity can be celebrated.

Andrew Malekoff, LCSW, CASAC, is Executive Director of North Shore Child and Family Guidance Center in Roslyn Heights, New York and author of the popular textbook *Group Work with Adolescents: Principles and Practice* (New York: Guilford Press).

Homebound from page 17

client being mistreated or exploited? Are there visible signs of alcohol or substance abuse (i.e., empty bottles)? As one clinician stated "You see so much when you walk into someone's home." Though our homebound program does not focus on case management services, it is important to help clients to advocate for themselves and to get the services they need. This is another step in the process to help the clients regain their independence. For example the *New York Times* recently ran a story about a chronically depressed woman who had become a virtual recluse. When her apartment was hit with an infestation of bed bugs, her SPOP therapist helped the client to apply for funding to replace her discarded household goods.

For an isolated homebound older adult, the routine of having someone come to their home to just focus on them, is important to their own self-esteem and gives them a sense that they have some control over their lives. As a result of this treatment some patients make very dramatic progress. For example, there is an 81 year old single, woman who came to SPOP with a long history of major depressive episodes, including two suicide attempts and several psychiatric hospitalizations. Two years ago, upon her release from a local hospital the client was referred to SPOP's Homebound program for mental health services. This client began receiving weekly home visits from SPOP's clinical staff, due in part to her depression which left her socially isolated and unable to leave her apartment. In addition the client suffered from neuropathy of the spine, making ambulation difficult

and painful. As a result of the home visits, this client was encouraged to see the SPOP psychiatrist, who managed the client's psychotropic medications, stabilizing the client for the first time in years. Since then, the client has not been re-hospitalized, is attending physical therapy sessions twice a week, is re-engaged with friends, and has returned to her great love, attending the opera.

There are many challenges in running a homebound program. It requires a highly skilled staff, greater flexibility in terms of scheduling appointments than in a traditional clinic setting, and clinicians have to spend more time traveling, which means they can see fewer clients. All of this contributes to higher operating costs for the program. However over the long run it is actually cheaper to provide timely intervention to a homebound client, thus avoiding the more costly alternative of long term hospitalization.

Timely intervention by mental health professionals helps to deter the emergence of more severe mental health problems with all their potentially disastrous consequences, including displacement through institutionalization, loss of funds, and additional isolation.

As our frail elderly population continues to grow, so too will the demand for homebound mental health services. As SPOP has shown, this is a group that can be effectively treated with such positive outcomes as increasing socialization; reducing isolation; and preventing and reducing hospitalizations for both physical and mental health disorders, with the ultimate benefit of improving the quality of life for participants and allowing them to age in place in their community.

Peer from page 30

various needs, including housing assistance. Then we submitted the required paperwork for the housing application. He attended the housing interviews and was quickly accepted, without having to go onto a waiting list. Today he enjoys freedom in sharing an apartment which he

has personal responsibilities for, that is in a safe and warm environment.

This is just one of many success stories that are borne out of the work of Geriatric Peer Program.

Jeffrey Perry, CPRP (MSM) is the Bridger Program Manager, and Vera Popko is Program Manager for Geriatric Peers at Baltic Street, A.E.H., Inc.

Residential from page 15

documented a sharp decrease in the number of emergency room visits and inpatient hospitalizations by residents. The rate of missed medical appointments is now close to zero and there is a very high rate of medication and treatment compliance. Many residents whose health was previously highly unstable have been maintained in the residence without significant medical emergencies.

Housing for older people with serious mental illness will become an even greater need and challenge as the mental health population ages and as the recent adult home relocation order is implemented. The Sheridan Hill House model

is appropriate for those who have serious medical conditions but who, with appropriate supports and services that an enriched congregate care setting can provide, are able to remain in the community to protect their quality of life and avoid costly nursing homes. As such, Sheridan Hill House is a model nursing home diversion program. Its \$23,000 per resident annual cost is a small fraction of the \$130,000 average annual cost of a nursing home in New York City.

For further information on Sheridan Hill House or to arrange a visit contact Olga Brito, CSW, Assistant Residential Director for Supported Housing at The Bridge, at 718-328-1490, or email her at obrito@thebridgeny.org.

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Decisions from page 26

beginning with a spouse and proceeding to adult children, parents, siblings all the way to a close adult friend. This person must make decisions in accordance with the incapacitated person's moral and religious views.

In the instance where there is no family or friend available to act as a surrogate, the FHCDA allows a hospital where the individual is being treated to make these medical decisions. A treating physician alone can make minor medical decisions. For major medical decisions two physicians must agree on a particular course of treatment and that the treatment

is medically necessary. In the event that an individual does not have a potential surrogate a hospital may also make end of life decisions, such as withholding life sustaining treatment where it would provide no medical benefit because the patient will imminently die and to provide such treatment would violate medical standards.

Conclusion

As this article illustrates, there are many options that allow for whom and how decisions can be made for individuals once they lose capacity to make decisions for themselves. All of these options

can be tailored to be as broad or narrow as is needed in the particular situation. There is a great deal of debate in the instance of mental illness as to whether or not a surrogate is allowed to make psychiatric decisions. On the one hand, unlike other areas where one loses capacity as a result of a loss of consciousness, an individual's bodily autonomy should only be overridden by a Court. Others feel that mental illness, at times of extreme deterioration, robs an individual of the capacity to make rationale decisions and therefore those who have cared for the individual and know his/her wishes best should have the authority to make these decisions. This, the argument goes, would save a great

deal of time and expense allowing for greater treatment options, potentially a quicker recovery period. The recently passed Family Health Care Decisions Act continues to require interpretation and clarification in the area of persons with mental illness, developmental disability or mental retardation. There is much work being done with the hope of a timely resolution as to what a surrogate can and cannot consent to in these instances, as well as those who require treatment, sometimes life sustaining treatment, but have no surrogate. As the law in this area becomes more defined we will inform our readers of these updates and hopefully full clarification and direction will come soon.



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Emotional from page 12

threatening because of ideologically based stigmas in their native country. The Russian-speaking immigrants often experience "psychophobia" – a strong denial of psychological problems and mask their depression by multiple somatic complaints.

During an intake interview with a Russian-speaking client, when he is asked about his presenting problem, you will often hear "My back hurts, I have terrible headaches" rather than "I feel sad" or "I feel lonely." Fear of coming to a mental health clinic and denial of psychological problems in the Russian-speaking population often makes doctors and medical facilities the primary mental health resource for this population.

However, when seeing a Russian-speaking patient a medical doctor may easily miss the depression behind somatic complaints and may refer the patient for an inappropriate treatment for a physical illness. Untreated depression not only limits a person's daily functioning and places a difficult burden on their family, but also dramatically increases the risk of suicide. The timely treatment of depression is important to prevent an exacerbation of the symptoms and escalation of suicidal behaviors.

Education about depression and other mental health disorders for Russian-speaking immigrants may help reduce the cultural stigma about getting help for mental health problems.

Since Russian-speaking immigrants don't often refer themselves to mental health professionals for the treatment of psychological problems, it's ex-

tremely important that the community members; educators, clergy, doctors, and family members, recognize the signs of emotional disorders in this population and make referrals that might save lives.

At the FEGS Brooklyn Resource Center Clinic we have helped many older adults overcome depression through medication and counseling, with sensitivity to their individual cultural perspective. As a result, clients forged better relationships with family members and found connections in the community that lessened their social isolation. This then made their lives fuller and helped alleviate their depressive symptoms. Many psychological problems could be prevented and the treatment of depression would be more effective if a person has a reliable support network that is attuned to a contemporary approach to mental illness. Thus, more family involvement and community education are still important tools in treating clients as members of communities, especially immigrant communities.

More about the F.E.G.S Brooklyn Resource Center: In addition to the OMH licensed mental health clinic, with a fully bi-lingual clinic staff, the Center also houses a computer resource center, employment preparation and job placement services and the agency's long standing citizenship program where thousands of refugees have received tutoring for the written test and interview to become a U.S. citizen.

For information about FEGS programs please call 212-366-8038 or visit our website www.fegs.org.

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Disparity from page 33

Southeast Asians and Pacific Islanders have increased poverty rates.

Hispanic Americans are the fastest growing and largest minority in the US. Income is the lowest, and the group is very diverse in regard to education, generation, and country of origin. Mexican Americans have a 27% poverty rate, while Cuban Americans have a 14% poverty rate. Overall rates of mental illness are the same as whites, but varies, with the lowest rating among Hispanics born in Mexico or living in Puerto Rico. Those born in the US have higher rates of mental illness.

Availability and Access to Treatment

Due to less government financing and a limited number of African American specialists (2-4% of all MSWs and MDs), African Americans are more apt to go to Emergency Rooms and Psychiatric Hospitals for care. This is in response to delayed treatment and acuity of symptoms. Asian and Pacific Islander Americans have a 50% rate of problems with language, a 21% lack of health insurance and do not avail themselves of Medicaid enrollment as do other groups. Of Hispanic Americans, 40% did not speak English well, and have limited access to Spanish speaking providers. They are least likely to have health insurance (37%, two times

that of whites). American Indians and Alaskan Natives have severely limited access to treatment. Clinics are located on the reservations, yet most Indians do not live on the reservation. Of this group, 20% do not have health insurance.

VNSW is an equal opportunity employer, which is very helpful in recruitment of nurses and social workers to meet the demands of clients with diverse ethnic and cultural origins. On the mental health team, we have 2 nurses and 3 social workers who speak and understand fluent Spanish, and have a variety of other professionals who are representative of the community we serve. Our social work department is available to assist patients in applying for Medicaid funding with Spanish speaking social workers available to those clients who require assistance.

Mental Health Home Care nurses assist patients in their home in maintaining compliance with meds, monitoring mood, behavior, and thought processes. We are in frequent contact with psychiatrists, case workers, medical doctors, outpatient treatment centers and day programs. Mental Health nurses encourage compliance in maintaining appointments in these areas as well. Significant caregivers and family members are included in the treatment plan whenever possible. We are there to work with clients who may have reservations about a particular treatment, to dis-

cuss potential barriers to care, within the context of culture and the home environment, where the client feels more secure and in control of their life and surroundings.

The People We Serve

Westchester County has less white people and more minorities than the average US population. VNSW provides care for more minorities, specifically Blacks and Hispanics, and less whites than the average Home Care agency in New York.

The median income in Westchester is \$77,856. The median income is highest among whites, middle for Asians, and lowest for Blacks and Hispanics. Income of less than \$15,000 is highest among Blacks (15.6%), Hispanics 12.1%, whites 6.6%, and Asians 4.1%. Unemployment is highest among Blacks (9.8%), Hispanics 8%, whites 5.8%, and Asians 3.8%. Poverty rates are highest in Hispanics 15%, Blacks 13.2%, Asians 5.5% and Whites 4.1%.

Blacks and Hispanics are a higher percentage of the population in Westchester, and have the most problem with economic issues, which puts them at risk for poor mental health outcomes. VNSW sees a higher percentage of these disadvantaged than the average New York Home Care Agency.

It is also known that in Westchester County, greater than 50% of Spanish speaking people spoke English less than

very well, and 30% spoke not well or not at all. Again, VNSW utilizes staff with Spanish fluency to serve these clients.

The Future

Funding for the most vulnerable clients is in question. Recently Medicaid funding has been cut by over 1 % for Home Care. Due to economic insecurity, many employers are limiting or eliminating medical insurance, making access to mental and medical services less financially feasible for many. This may change when the economy returns to baseline, but when cannot be predicted. Many people who would benefit from early intervention will not receive the same, resulting in more disability and rising use of acute Emergency Room visits and Hospitalizations.

Higher education for minorities must continue in order to encourage college students to enter the mental Health field as nurses, social workers, and psychiatrists, and serve the people within their community. Improving language and mental health access in each individual minority community would make mental health services more visible and "user friendly" for potential clients.

In the future VNSW and mental health home care nurses will be there, on the front lines, serving the minority community, one visit at a time!

Older Adults: The Hidden “Sandwich” Generation

By Tobi A. Abramson, PhD
Assistant Professor, Mental Health Counseling, and Director of the Center of Gerontology and Geriatrics at New York Institute of Technology in Old Westbury, New York



Tobi A. Abramson, PhD

No one signs up ahead of time to become a caregiver, yet millions of Americans today are caregivers. The Family Caregiver Alliance’s definition of caregiving states that the group of caregivers is composed of, “Anyone who provides assistance to someone else who is, in some degree, incapacitated and needs help” (www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=439). Typically, when one considers the statistics and the definition of caregiving the image one conjures up is of an older adult receiving care provided by either an informal caregiver (spouse, adult child, sibling, friend or relative) or a formal caregiver (home care professional). This perspective is prevalent in both the professional and consumer literature where the caregiver is often typified as the adult child, usually the adult daughter, who is the one caring for their older parent. These adult children have been labeled as being the “sandwiched” generation, caught between caring for their older parents and their own families. Yet, caregiving roles are much broader than this narrow conceptualization. Older adults do find themselves in caregiving roles, most often caring for their spouses or siblings. What is less obvious, are those older adults who have assumed the role of caregiver for their adult children. They constitute a hidden sandwich generation of caregivers.

This sandwiched cohort is caught between caring for their own adult children and their own physical and mental health needs. There are various reasons underlying why this cohort finds themselves in this position, ranging from having a child born with a developmental disability, to having a child who suffers from a long term disability or having an adult child

who has been diagnosed with a psychological disorder. Parents of those with long term disabilities have spent many years as caregivers, a role many of them have successfully managed with the aid of both informal and formal supports. However, as these children age and become adults their parents are confronting aging issues as well.

Families are the primary providers of care for adult children who have a developmental or psychological disability. Mothers, whether young or old, continue to be the primary caregiver, with fathers generally accepting this role only once the mother has died (Factor, 2004). According to Factor (2004), parents who had learned to embrace, negotiate, and manage the role of caregiver, even seeing it as a legitimatizing and important social role, which has provided them with a purpose, may begin to face challenges as a result of their own aging process. As older adults experience age related changes they may become less able to provide care for their children, many of whom are now beginning to experience their own aging related issues.

Older adults are plagued by many of the same physical and emotional struggles and challenges as their younger caregiver counterparts. Research has found that caring for a mentally ill child has a long-term impact on the caregiver’s well-being, both physically and psychologically (Ghosh & Greenberg, 2009). In general, caregivers are less likely to practice preventative healthcare, develop poor eating habits, fail to exercise or to stay in bed when they are ill, and postpone medical appointments. These caregivers, not only suffer from medical problems, but are also likely to suffer from mental health problems. It has been well documented that caregivers are more likely than their non-caregiving counterparts to suffer from symptoms of depression and anxiety as well as suffering from burnout (Cannuscio, Jones, Kawachi, Colditz, Berkman, & Rimm, 2002). Ghosh and Greenberg (2009) found that aging fathers caring for schizophrenic children reported experiencing higher levels of depression, poorer perceived health, lower levels of psychological well-being, and decreased marital satisfaction as compared to non-caregiving aging parents. In addition, these men were unlikely to seek out or utilize formal support services despite their distress.

Mental health professionals must help older adults cope with the numerous stressors and strains resulting from being sandwiched between caregiving roles and their own aging. On one side of the sandwich are the stressors arising from the financial impact that caregiving has on them, the emotional strain from caring for another person, frustrations when the person being cared for does not respond to one’s efforts to help them, worries about who can be relied on within one’s family to assist with the caregiving role, and feelings of anger towards family members who do not offer assistance. On the other side of the sandwich are the issues relating to facing one’s own fears about growing older, facing one’s own health issues, mortality, and worries over who will advocate for them as well as their adult child

if they should ever face a health crisis. Many older adults experience symptoms of anxiety related to numerous concerns about the long range needs of their adult children, particularly what will happen to this adult child when they are no longer physically capable of providing for this child’s care. For some older adults who are caring for an adult child who is suffering from psychological problems, emotions may center on feelings of failure, responsibility for their child’s emotional state, self-doubt, and despair.

Older adults benefit from mental health treatment when experiencing stressors and strains related to caregiving, whether it is caring for a spouse or an adult child. Strategies to improve caregiver mental health are similar to those for any caregiver. It is important for caregivers to take care of themselves first if they are going to provide care to anyone else. This includes, maintaining a healthy diet, regular exercise, getting sufficient sleep, not abusing drugs or alcohol, making time to find an activity that they enjoy to participate in, even if it is just for a few minutes a day, recognizing the signs and symptoms of stress, burnout, and overload, recognizing and seeking treatment for depression and anxiety, maintaining supportive relationships and support networks, embracing one’s limits, asking for help with caregiving tasks, utilizing respite services when needed, and engaging in long range planning for themselves as well as for their adult children.

Mental health professionals must acknowledge that adult children are not the only caregivers caught in this “sandwich” role. Older adults are often the hidden generation of sandwiched caregivers. Attention needs to be provided to the struggles that they face when caught between caring for their adult children and their own aging. With proper mental health care and support older adults can continue to provide care for their children.

Dr. Abramson is also the Co-Chair of the Nassau County Geriatric Mental Health Alliance.

Mental Health News 2011 - 2012 Theme and Deadline Calendar

Summer 2011 Issue:

“Women’s Issues in Mental Health”

Deadline: May 1, 2011

Fall 2011 Issue:

“Health Reform and Mental Health Parity”

Deadline: August 1, 2011

Winter 2012 Issue:

“Housing for People with Mental Illness”

Deadline: November 1, 2011

Spring 2012 Issue:

“Understanding and Treating Depression”

Deadline: February 1, 2012

Anti-Racism Resources: A Follow-up to Our Winter Anti-Racism Issue

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be provided and so the patient would recognize that the changes made had the support of her doctor.

Outcome: The relationship with her children improved and she began to speak with the daughter she was estranged from due to her delusion. She is now comfortable with her caregiver and reports feeling better both physically and emotionally. Her agitation and the number of unnecessary, time-consuming calls from the patient and family to the PCP have been greatly reduced. No psychiatric medications or conventional psychiatric treatments were necessary.

Comment: The initial assessment suggested that much of her anxiety and some of the paranoid tendency derived not from medical or psychiatric symptoms, but from her fear that she was losing her independence and control of her daily life. Time was necessary to establish a working relationship with patient and family, and the backing of the patient's physician was critical in order to get her to accept the practical advice and help she needed. The main interventions with patient and family were primarily case management. The psychosocial improvements yielded a considerable reduction in her agitation and in the family's worry.

Case 2: Mr. N is a 68 year old single male with a medical history including severe heart disease and significant weight loss. His PCP requested assessment because of concern about medication non-compliance and possible psychosocial stressors, and the stability of his medical condition. He had recently lost his job of 23 years.

Assessment: The MHP completed assessment and found that the patient was struggling with his recent job loss and loss of prescription drug coverage. He was illiter-

ate which made navigating "the system" very difficult. He was also eating very poorly which increased his risk factors.

Intervention: The MHP helped the patient apply for assistance for high cost meds and assisted in securing prescription coverage through Medicare Part D. Mr. N was referred to a senior center for meals, and new opportunities for activity and socialization were identified. His financial resources were very limited, but a plan was developed which allowed for retirement. The MHP was able to provide counseling to assist with adjustment of losing his job and transitioning his concept of unemployment to one of retirement. Information was shared with the PCP during weekly case review to plan psychosocial interventions.

Outcome: There were positive changes in Mr. N's physical state and care, including better medication compliance and stabilization of medical conditions. He has engaged in the congregate dining program at the local senior center which provides socialization and additional support.

Comment: The working relationship with the patient was satisfactory at the onset in part because he viewed the MHP as representing his physician. Again, it appeared that his worsening medical condition and difficulties with treatment planning and compliance derived from his anxiety about several realistic concerns regarding his life situation. He needed help with high cost medication and practical assistance with retirement planning. The interventions were mostly case management, although the MHP also provided counseling to alleviate the stress and shame of feeling "unemployed" and viewing himself as "retired".

The psychosocial problems illustrated by these cases:

- Come to the attention of the patients'

doctor or someone in his/her office, through observation, patient request or family concern expressed to the doctor.

- Are not "medical" problems, but do significantly affect patient health and medical care.
- Had not been resolved because the patients lacked information or lacked the cognitive or financial capacity to resolve them, or because they resisted the decisions or actions needed.

The interventions made by the MHP:

- Do not fit the usual categories of medical care, but benefit from the patients' recognition that their physician is involved and supports the intervention
- Are flexible and aim to do whatever necessary to support better health and better care
- Are sometimes resisted by the patient at first, but can be overcome with psychological expertise.
- Cannot initially be referred for conventional services because of patient resistance.

In a Health Home or integrated primary care practice, an MHP can:

1. Screen and assess for symptoms such as depression, anxiety, and specific psychiatric disorders, and then provide
 - a. Short-term counseling or therapy, sometimes with medication from the PCP
 - b. Referral to more extended care when necessary
2. Screen and assess for other behavioral issues such as dietary habits, smoking,

aims to build or rebuild self-esteem.

There is plenty of good news along with the alarms. Increasing resources are available to train clinicians in the specific needs of the aging. Furthermore, seniors tend to respond well to intervention, with those needing treatment completing at a higher rate than younger people. Also, those who may not have crossed the line into addiction often benefit from interventions that may change patterns or frequency of use. (Promoting Older Adult Health, SAMHSA, 2002).

The following features are recommended for incorporation into the treatment of older persons:

- Age-specific group treatment that is supportive and non-confrontational, which

- A focus on coping with depression, loneliness, and loss.
- A focus on rebuilding the client's social network.
- A pace and content appropriate to the older person (noting potential sensory and cognitive losses).
- Staff who are interested and experienced working with older adults.
- Linkages with medical services, services for the aging, and institutional settings for referral in and out of

and alcohol use that affect health and medical care, and then provide

- a. Short-term counseling and other brief interventions aimed at behavior change or preparation for referral
 - b. Referral to longer term intervention aimed at behavior change
3. Screen and assess for psychosocial problems that affect health and care, and then provide
 - a. Short term brief case management
 - b. Referral to more extended case management care and assistance

Brief Case Management

Brief case management as discussed above can include any or all of the following:

1. Evaluating the need for help and services
2. Establishing a working relationship
3. Getting family support and involvement
4. Overcoming resistance when necessary
5. Providing information
6. Providing assistance
7. Arranging for a sustainable case management plan, with help and services from family or other professional sources

Reflections

Case management interventions like the above prove clinically valuable; they result in better care and increased patient satisfaction. They can also decrease the overall cost of care because they obviate later more expensive medical interventions or placement in a nursing home.

treatment, including case management. (Schonfeld and Dupree, 1996)

Elements of specialized treatment elements, including modality specific strategies and phase appropriate interventions for older adults are described and organized in an excellent guide available from the Center For Substance Abuse Treatment, including the valuable Treatment Improvement Protocol (TIP) #26.

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in health status merely to the aging process. (Walker, 2004)

With over 30% of seniors taking eight or more prescriptions medications, as well as over-the-counter drugs and supplements, many seniors are not only in danger of over-medication, but may fit the definition of abuse, because they use more than their health conditions require and become victims of dependency. The potential for harmful interactions and overmedication are so wide reaching that one researcher stated, "Any symptom in an elderly patient should be considered to be a drug side effect until proven otherwise." (Gurwitz, et. al, 1997)

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

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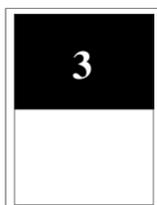
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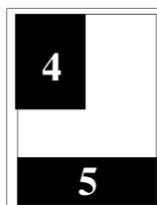
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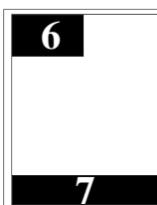
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