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SUMMER 2011 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 13 NO. 3

Women's Issues in Mental Health

Women and Depression: Discovering Hope

By The National Institute of Mental Health (NIMH)

Everyone occasionally feels blue or sad, but these feelings are usually fleeting and pass within a couple of days. When a woman has a depressive disorder, it interferes with daily life and normal functioning, and causes pain for both the woman with the disorder and those who care about her. Depression is a common but serious illness, and most who have it need treatment to get better.

Depression affects both men and women, but more women than men are likely to be diagnosed with depression in any given year.[1] Efforts to explain this difference are ongoing, as researchers explore certain factors (biological, social, etc.) that are unique to women.

Many women with a depressive illness never seek treatment. But the vast majority, even those with the most severe depression, can get better with treatment.

What are the different forms of depression?

There are several forms of depressive disorders that occur in both women and men. The most common are major depressive disorder and dysthymic disorder. Minor depression is also common.

Major depressive disorder, also called major depression, is characterized by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. An episode of major depression may occur only once in a person's lifetime, but more often, it recurs throughout a person's life.

Dysthymic disorder, also called dysthymia, is characterized by depressive symptoms that are long-term (e.g., two years or longer) but less severe than those of major depression. Dysthymia may not disable a person, but it prevents one from functioning normally or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes.

Minor depression may also occur. Symptoms of minor depression are similar to major depression and dysthymia, but they are less severe and/or are usually shorter term.

Some forms of depressive disorder have slightly different characteristics than those described above, or they may develop under unique circumstances. However, not all scientists agree on how to characterize and define these forms of depression. They include the following:

Psychotic depression occurs when a severe depressive illness is accompanied by some form of psychosis, such as a break with reality; seeing, hearing, smelling or feeling things that others can't detect (hallucinations); and having strong beliefs that are false, such as believing you are the president (delusions).

Seasonal affective disorder (SAD) is characterized by a depressive illness during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not respond to light therapy alone. Antidepressant medication and psychotherapy also can reduce SAD symptoms, either alone or in combination with light therapy.[2]

Bipolar disorder, also called manic-depressive illness, is not as common as major depression or dysthymia. Bipolar disorder is characterized by cycling mood changes – from extreme highs (e.g., mania) to extreme lows (e.g., depression).

What are the basic signs and symptoms of depression?

Women with depressive illnesses do not all experience the same symptoms. In addition, the severity and frequency of symptoms, and how long they last, will vary depending on the individual and her particular illness. Signs and symptoms of depression include: persistent sad, anxious or "empty" feelings; feelings of hopelessness and/or pessimism; irritability, restlessness, anxiety; feelings of guilt, worthlessness and/or helplessness; loss of interest in activities or hobbies once pleasurable, including sex; fatigue and decreased energy; difficulty concentrating, remembering details and making decisions; insomnia, waking up during the night, or excessive sleeping; overeating, or appetite loss; thoughts of suicide, suicide attempts; and persistent aches or pains, headaches, cramps or digestive problems that do not ease even with treatment.

What causes depression in women?

Scientists are examining many potential causes for and contributing factors to women's increased risk for depression. It is likely that genetic, biological, chemical, hormonal, environmental, psychological, and social factors all intersect to contribute to depression.

Genetics

If a woman has a family history of depression, she may be more at risk of developing the illness. However, this is not a hard and fast rule. Depression can occur in women without family histories of depression, and women from families with a history of depression may not develop depression themselves. Genetics research indicates that the risk for developing depression likely involves the combination of multiple genes with environmental or other factors.[3]

Chemicals and Hormones

Brain chemistry appears to be a significant factor in depressive disorders. Modern brain-imaging technologies, such as magnetic resonance imaging (MRI), have shown that the brains of people suffering from depression look different than those of people without depression. The parts of the brain responsible for regulating mood, thinking, sleep, appetite and behavior don't appear to be functioning normally. In addition, important neurotransmitters-chemicals that brain cells use to communicate-appear to be out of balance. But these images do not reveal WHY the depression has occurred.

Scientists are also studying the influence of female hormones, which change throughout life. Researchers have shown that hormones directly affect the brain chemistry that controls emotions and mood. Specific times during a woman's life are of particular interest, including puberty; the times before menstrual periods; before, during, and just after pregnancy (postpartum); and just prior to and during menopause (perimenopause).

Premenstrual Dysphoric Disorder

Some women may be susceptible to a severe form of premenstrual syndrome called premenstrual dysphoric disorder (PMDD). Women affected by PMDD typically experience depression, anxiety, irritability and mood swings the week before menstruation, in such a way that interferes with their normal functioning. Women with debilitating PMDD do not necessarily have unusual hormone changes, but they do have different

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Deadline: February 1, 2012

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Editorial: New York's Medicaid Reform Portends Major Changes in Behavioral Health Service Delivery

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

The 27-member Medicaid Redesign Team (MRT) appointed by Governor Andrew Cuomo in January made a series of far-reaching recommendation pertaining to the delivery of mental health and substance abuse services (taken together, *behavioral health services*). The MRT, comprised of stakeholders from provider and consumer organizations, elected officials, unions, and government officials, was charged with the task of making recommendations to both reduce Medicaid costs while maintaining access and improving quality of the system. The group was asked to find $3 billion of savings in the state's $58 billion Medicaid program.

Behavioral health services emerged as one of the MRT's central concerns. The state's 300,000 behavioral health recipients were singled out as being a "high cost" Medicaid population, whose care is "unmanaged" and whose behavioral and health care services "lack coordination." For weeks, the MRT considered whether to fold high-need behavioral health recipients into general managed care (currently, Medicaid-funded behavioral health services are paid for on a fee-for service basis in which recipients obtain services without having to go through a managed care company) or to maintain the current

Peter D. Beitchman, DSW

"carve out" of behavioral health services, at least temporarily, while at the same time beginning to move toward a managed care system. This "carve out" approach was strongly supported by a broad coalition of provider and recipient advocacy organizations and was championed on the MRT by OMH Commissioner Dr. Michael Hogan and OASAS Commissioner Arlene Gonzalez-Sanchez.

The MRT's ultimate recommendation was a hybrid of the two plans, which was then adopted in the State budget process. For a two-year period, beginning in October of 2011, regional Behavioral Health Organizations (BHOs) will be established (a total of 5 or 6 statewide). Although behavioral health services will continue to be paid on a fee-for-service basis during this period, BHOs will have a significant role in promoting continuity of care by monitoring both inpatient behavioral health hospitalizations and recipient transitions between hospitalization and community agency services. In three years, BHOs will be replaced by a full managed care system for both *behavioral and health care* services. It is expected that this permanent system will include all of the typical features of managed care: provider payments will be on a capitated or case rate basis; the managed care entities will implement a system of "prior approval" of services; they will be at financial risk in contracting with the State and will have financial incentives to achieve quality standards and benchmarks.

Both the recipient and provider communities are very concerned about how this major restructuring of the system will unfold. While specialized behavioral health managed care has been implemented in a number of states nationally, in some cases quite creatively to the benefit of recipients, the inclusion of both behavioral and health care services in a single managed care system for high need recipients will be an enormous financial, management and programmatic challenge.

There are many critical questions to be answered as the New York plan moves forward. In mental health, a key question is which services will be folded into the system? Child and Adult Mental health Clinics and PROS programs may be obvious, together with psychiatric emergency and inpatient services, but what about ACT Teams, case management programs, clubhouses and residential services? How will access to services be assured? How will quality standards be developed and implemented? Will payments to service providers be sufficient to assure the maintenance of and future investment in the behavioral health system? Will there be sufficient flexibility in the system to promote the kind of innovation that is needed to achieve the dual goals of having a high quality system while reducing costs?

Finally, there is the question of how the emerging fully managed care system for high need behavioral health clients will fit into Federal health reform. With the development of health homes, accountable care organizations and other significant reforms under the Federal legislation, these will add another dimension to our challenge in New York State.

Mental Health News will monitor developments closely and update our readers as the process unfolds. We also encourage readers to share your concerns and perspectives on the restructuring of the system at this critical time.

The Mental Health News - Autism Spectrum News Readership Survey: Help Us Learn About Ourselves and Win a $100 Amazon.com Gift Certificate

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

The first step in any effort to chart a course for the future is knowing where you are starting from. To accomplish this we are now actively involved in looking at ourselves like never before. We believe that the end result of our efforts will enhance our educational mission and enable us to better serve the readers of *Mental Health News* and *Autism Spectrum News*.

To help us in this endeavor, we are asking all of our readers to please take a few minutes to fill out and send in our 2011 Readership Survey found on the next page. To say thank your participation, we will have a drawing at the close of the survey process and award a $100 Amazon.com gift certificate to the winner, who will be chosen at random. If you wish to enter into our $100 Amazon.com Gift Certificate Drawing, please give us your contact information at the end of this short questionnaire. In addition to publishing our survey in this issue of *Mental Health News*, it will also appear it in the upcoming Summer issue of *Autism Spectrum News*. We will also be mailing the survey to everyone on our postal mailing list, and put the survey online at SurveyMonkey.com. All information filled out in our survey will be kept in the strictest confidence.

Staying Relevant In an Ever-Changing Environment

We live in a world today that communicates by the click of a computer mouse or a finger-swipe on a mobile device screen. Most hand-written letters have been replaced by E-mail, and Social Media formats such as Facebook, Twitter, Blogs and other new mediums have changed the way people gather and share their opinions. Print media is being replaced by electronic media. More and more people are reading their favorite newspaper, magazine, or book, on their iPhone, Droid, iPad, Zoom, or Kindle.

Following our Readership Survey we will take a look at developing a Social Media presence for *Mental Health News* and *Autism Spectrum News.* We've known for some time that we're only scratching the surface in terms of our readership audience for both of our publications. Having a Social Media presence may help us attract a whole new audience of readers who are looking for a trusted source of mental health and autism education. On a deeper level, we will be able to regularly read comments and reply to reader's questions who follow us on Facebook and Twitter.

The final way we can plug in to today's ever-changing media environment will be to offer *Mental Health News* and *Autism Spectrum News* on mobile devices such as the iPhone and iPad.

Why, How and When?

If we could flip a switch tomorrow and create a Social Media presence and have our publications available on electronic devices we would. The "Why" is simple—it would broaden our readership audience and our ability to communicate with you, our readers. The answer to "How" and "When" are a bit more complicated.

As a small nonprofit organization, we need to develop the financial resources needed to bring a Social Media consultant and an Electronic Media consultant on board to guide us through the intricacies of these projects. Once established these media projects need to be monitored and maintained on a weekly basis.

We can't yet say when our plans for the future will come to fruition. We know that it will take additional financial resources that we do not yet have in our annual budget. If there are any angels out there that want to help us get there, we would love to hear from you.

The Mental Health News Upcoming Calendar of Topics

We have an exciting lineup of topics for the fall, winter and spring issues of *Mental Health News.* Our upcoming fall issue (deadline: August 1st) will focus on the topic: "Health Reform and Mental Health Parity and their Impact on People and Service Providers." Our winter 2012 issue will examine the issue of "Housing for People with Mental Illness." Next spring we will take an in-depth look at "Understanding and Treating Depression." Next summer we will take a compelling look at "Understanding and Coping with Suicide."

As always, I look forward to reading your articles, and hearing your comments, suggestions, and ideas. Please write to me at iraminot@mhnews.org.

Mental Health News - Autism Spectrum News Readership Survey
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1. Overall, how satisfied are you with the quality of educational content in:

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Autism Spectrum News (ASN) Very Satisfied ( ) Somewhat Satisfied ( ) Needs Improvement ( )

Comments: _____

2. How would you rate each publication on keeping you informed about:

Mental Health News	Excellent	Good	Fair	Poor
Scientific & Evidence-Based Practices	( )	( )	( )	( )
Model Programs	( )	( )	( )	( )
Government Policies & Regulations	( )	( )	( )	( )
Interviews with Leaders in the Field	( )	( )	( )	( )
Consumer Issues	( )	( )	( )	( )

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Scientific & Evidence Based Practices	( )	( )	( )	( )
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Interviews with Leaders in the Field	( )	( )	( )	( )
Consumer Issues	( )	( )	( )	( )

3a. Of the last four issues of each publication – how many have you read?

Mental Health News: 4/4 ( ) 3/4 ( ) 2/4 ( ) 1/4 ( ) 0/4 ( )
Autism Spectrum News: 4/4 ( ) 3/4 ( ) 2/4 ( ) 1/4 ( ) 0/4 ( )

3b. Do you usually take the time to read each issue of MHN & ASN:

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About 3/4	MHN ( )	ASN ( )
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At Work ( ) At Home ( ) Treatment Program ( ) Other _____

3d. Have you ever (check all that apply):

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Quoted an article in a speech or memo	( )
Clipped an article for your own files	( )

Other uses _____

4a. How many people at your site read Mental Health News? ____# Autism Spectrum News ____#

4b. Out of the total number of people at your site, about what percent would you estimate read:

Mental Health News ____% Autism Spectrum News ____%

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5. What topic(s) do you think MHN & ASN should focus on in a future issue?

_____

6a. Have you ever visited our websites:

MHN: www.mnhews.org Yes ( ) No ( )
ASN: www.mhnews-autism.org Yes ( ) No ( )

6b. If yes, for what purpose? Research ( ) Read Current/Past Issues ( ) Other _____

6c. Would you prefer to read your issue of MHN or ASN online or in hard copy?

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6d. Would you be interested in participating in MHN/ASN online discussion groups or blogs?

MHN: Yes ( ) No ( ) ASN: Yes ( ) No ( )

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13. I Am A: Consumer ( ) Parent ( ) Treatment Professional ( ) Administrator ( ) Other _____

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The Mom of a Mentally Ill Child Needs Understanding

By Marcia Eckerd, PhD

Being the mother of a child with mental illness is a grueling job. First, being female doesn't help. Besides usually being the primary caretaker of the child, being female in our culture can mean being taken less seriously. There's also an assumption, rarely directly expressed, that a mom should be able to handle any family-related situation, no matter how difficult or complex. The mom also has a child with a chronic illness and the illness is "mental." A "mental" illness, even if based in biological processes, usually carries some kind of stigma even in today's so-called enlightened society. A parent of any child with a chronic disability knows that every day brings a new reminder of the difficulty of navigating a world that comes easily for those without the same challenges.

This caretaking job is usually 24/7. Mom is present at every moment of her anorexic daughter's refusal to eat, when the child with bipolar disorder is melting down, or when the child with an anxiety disorder is panicking. She's usually the one shepherding the child through the field of therapists and experts, dealing with the logistics of multiple appointments and listening to the instructions given, which may be contradictory at times if she's dealing with multiple professionals. She has to be the child's advocate at school, trying to achieve understanding, dealing with problems and assuring needed support services. Any moment can turn into a crisis.

Marcia Eckerd, PhD

These issues are similar to those experienced by a mother of a child with a "physical" illness or disability, with one significant difference. The stigma attached to mental illness makes it more difficult to talk about the diagnosis and the challenges. Moms frequently find that many otherwise well meaning people don't "believe" in psychiatric diagnoses. They feel that mental illness reflects inadequate limit setting. Family members and friends often don't understand the behavior of the child. They may suggest that that the child's behavior is the result of bad parenting; this doesn't happen to the mother of a child with juvenile diabetes. Mom hears "Give that child two weeks in my house, and he'd be straightened out," or "You must have done something wrong."

Isolation can be a significant problem. Often there is stress between the parents, since they may handle anxiety differently. Mom may be immersed in action and Dad may withdraw. He may not agree with the diagnosis or the instructions of the doctor and isn't there to be part of the child's behaviors as frequently. He may feel neglected or left out as the Mom spends so much of her time absorbed in the day-to-day issues of the child's care. Some friends pull away out of discomfort. Even talking with friends who are sympathetic can be overwhelming at times when she doesn't have the energy to rehash what's going on or the time to keep up her end of the friendship. Often she feels it's too burdensome to share her feelings. She can feel alienated from parents of children who are going about age appropriate lives without apparent difficulty: attending birthday parties, having friends, checking out colleges, etc.

The mother has to deal with her own emotions as well as the needs of the child. The role of mothering is central to the identity of most mothers; even mothers who work often feel themselves to be mothers first, then workers/wives/daughters and so on. The problems of the child can feel like a reflection of the failure of her parenting and nurturance. This is true even when the child's illness is clearly biologically based. A host of feelings can come up: failure, hopelessness, anxiety, guilt, anger and loss are common. She feels out of control of her life. A sense of failure can lead to feelings of shame that eat at her, especially if she's isolated from other mothers going through the same experience.

A mom is also frightened for her child and her family. What does the future hold for her child? Will she or he ever become a normally functioning adult? If the child is suicidal or endangered, how can she prevent this from happening? How does she handle the impact on her other children, who may feel neglected, angry, worried or all of these? How can she manage the stresses on her marriage? If she works outside her home, how does she manage that effectively? She can feel pulled in all directions.

Although mothers need support, they sometimes don't get enough recognition from the professionals in their lives. Unfortunately, there are mental health providers who fail to communicate empathy. In maintaining professional roles (and distance), they may not offer the mother the understanding and validation she needs. Some even communicate blame, the idea that dysfunction in the family has played a significant role in the child's condition. For a Mom already struggling, this adds fuels to the fire of self-blame. Even if this idea has merit, she's usually doing the best she can. She can be more open to constructive guidance if she feels her efforts are appreciated.

Everyone has the same physiological response to chronic stress; stress produces physical as well as emotional reactions. We all react to normal emergency situations by changes in our breathing, heart

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responses to these changes.[4] They may also have a history of other mood disorders and differences in brain chemistry that cause them to be more sensitive to menstruation-related hormone changes. Scientists are exploring how the cyclical rise and fall of estrogen and other hormones may affect the brain chemistry that is associated with depressive illness.[5,6,7]

Postpartum Depression

Women are particularly vulnerable to depression after giving birth, when hormonal and physical changes and the new responsibility of caring for a newborn can be overwhelming. Many new mothers experience a brief episode of mild mood changes known as the "baby blues," but some will suffer from postpartum depression, a much more serious condition that requires active treatment and emotional support for the new mother. One study found that postpartum women are at an increased risk for several mental disorders, including depression, for several months after childbirth.[8]

Some studies suggest that women who experience postpartum depression often have had prior depressive episodes. Some experience it during their pregnancies, but it often goes undetected. Research suggests that visits to the doctor may be good opportunities for screening for depression both during pregnancy and in the postpartum period.[9,10]

Menopause

Hormonal changes increase during the transition between premenopause to menopause. While some women may transition into menopause without any problems with mood, others experience an increased risk for depression. This seems to occur even among women without a history of depression.[11,12] However, depression becomes less common for women during the postmenopause period.[13]

Stress

Stressful life events such as trauma, loss of a loved one, a difficult relationship or any stressful situation-whether welcome or unwelcome-often occur before a depressive episode. Additional work and home responsibilities, caring for children and aging parents, abuse, and poverty also may trigger a depressive episode. Evidence suggests that women respond differently than men to these events, making them more prone to depression. In fact, research indicates that women respond in such a way that prolongs their feelings of stress more so than men, increasing the risk for depression.[14] However, it is unclear why some women faced with enormous challenges develop depression, and some with similar challenges do not.

What illnesses often coexist with depression in women?

Depression often coexists with other illnesses that may precede the depression, follow it, cause it, be a consequence of it, or a combination of these. It is likely that the interplay between depression and other illnesses differs for every person and situation. Regardless, these other coexisting illnesses need to be diagnosed and treated.

Depression often coexists with eating disorders such as anorexia nervosa, bulimia nervosa and others, especially among women. Anxiety disorders, such as post-traumatic stress disorder (PTSD), obsessive-compulsive disorder, panic disorder, social phobia and generalized anxiety disorder, also sometimes accompany depression.[15,16] Women are more prone than men to having a coexisting anxiety disorder.[17] Women suffering from PTSD, which can result after a person endures a terrifying ordeal or event, are especially prone to having depression.

Although more common among men than women, alcohol and substance abuse or dependence may occur at the same time as depression.[17,15] Research has indicated that among both sexes, the coexistence of mood disorders and substance abuse is common among the U.S. population.[18]

Depression also often coexists with other serious medical illnesses such as heart disease, stroke, cancer, HIV/AIDS, diabetes, Parkinson's disease, thyroid problems and multiple sclerosis, and may even make symptoms of the illness worse.[19] Studies have shown that both women and men who have depression in addition to a serious medical illness tend to have more severe symptoms of both illnesses. They also have more difficulty adapting to their medical condition, and more medical costs than those who do not have coexisting depression. Research has shown that treating the depression along with the coexisting illness will help ease both conditions.[20]

How does depression affect adolescent girls?

Before adolescence, girls and boys experience depression at about the same frequency.[13] By adolescence, however, girls become more likely to experience depression than boys.

Research points to several possible reasons for this imbalance. The biological and hormonal changes that occur during puberty likely contribute to the sharp increase in rates of depression among adolescent girls. In addition, research has suggested that girls are more likely than boys to continue feeling bad after

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Our Patients Are Mothers Too

By Nikole Benders-Hadi, MD
Psychiatrist, Rockland Psychiatric Center, and Public Psychiatry Fellow, Columbia University/New York State Psychiatric Institute

The impact of serious mental illness on mothers has received little attention when compared to the study of outcomes for children of parents with mental illness. Mental health providers may not routinely inquire about the parenting status of seriously mentally ill women, or consider whether they have ongoing contact with their children. Although individualized, recovery-oriented care is often sought for our patients, the special service needs of mentally ill mothers have been only rarely addressed in the medical literature. Given the fact that mothers with serious mental illness have more unplanned pregnancies, less stable partnerships, and more frequently lose custody of their children, the experiences of this population is worthy of increased attention.

A 1993 study on policies of State Mental Health Authorities across the country for the identification and treatment of mothers with serious mental illness revealed that only 16 states routinely collect data on mentally ill mothers (Nicholson J, et al: State Policies and Programs That Address the Needs of Mentally Ill Mothers in the Public Sector. Hospital and Community Psychiatry 44(5): 484-489, 1993). Even this data collection varied considerably and was not necessarily entered into a statewide information management system. In order to get a more current picture of patients as mothers at one hospital, we did a study here at Rockland Psychiatric Center. Data was collected via electronic medical records, face-to-face interviews, and focus groups to determine both the number of female inpatients who were mothers, as well as the perceived needs of this group.

Nikole Benders-Hadi, MD

Although the study is ongoing, preliminary results have been surprising. Despite long-term hospitalized women being a subgroup of the most seriously ill, at least 38% of female inpatients at the hospital were identified as being mothers. The mothers showed a mean age of 54.7 years, and most were diagnosed with Schizophrenia or Schizoaffective disorder. The average length of hospitalization for all mothers was 30 months. Thirty six percent of mothers were never married, and 54% were either separated, divorced, or widowed.

We have also found that mothers at this hospital have more contact with children than we might have guessed, with 50% reporting they have at least weekly contact with their children (of that 50%, half reported contact multiple times per week). Focus groups and face-to-face interviews revealed the motherhood role to be an important source of pride, and also served as a motivating factor for getting and staying well. Patients voiced a real interest in being educated about resources available to them as mothers, as well as interest in being a source of support for one another.

The number of women with serious mental illness who are mothers is greater than we might have guessed, and is likely being overlooked in many cases as the question is often not posed. This forgotten role of motherhood among the seriously mentally ill has resulted in mental health professionals becoming involved only at the point of crisis management or child removal. As our data continues to come in, we will be thinking about how to better serve our patients who are mothers at Rockland Psychiatric Center. Promoting roles for the people we serve aside from that of "patient" is just one component of recovery-focused and person-centered treatment. Hopefully this study can make us all pause and remember to ask our patients about whether they have children, and consider the potentially great impact of parenting on mental illness treatment and outcomes.

Discovering Hope from page 8

experiencing difficult situations or events, suggesting they are more prone to depression.[21] Another study found that girls tended to doubt themselves, doubt their problem-solving abilities and view their problems as unsolvable more so than boys. The girls with these views were more likely to have depressive symptoms as well. Girls also tended to need a higher degree of approval and success to feel secure than boys.[22]

Finally, girls may undergo more hardships, such as poverty, poor education, childhood sexual abuse, and other traumas than boys. One study found that more than 70 percent of depressed girls experienced a difficult or stressful life event prior to a depressive episode, as compared with only 14 percent of boys.[23]

How does depression affect older women?

As with other age groups, more older women than older men experience depression, but rates decrease among women after menopause.[13] Evidence suggests that depression in post-menopausal women generally occurs in women with prior histories of depression. In any case, depression is NOT a normal part of aging.

The death of a spouse or loved one, moving from work into retirement, or dealing with a chronic illness can leave women and men alike feeling sad or distressed. After a period of adjustment, many older women can regain their emotional balance, but others do not and may develop depression. When older women do suffer from depression, it may be overlooked because older adults may be less willing to discuss feelings of sadness or grief, or they may have less obvious symptoms of depression. As a result, their doctors may be less likely to suspect or spot it.

For older adults who experience depression for the first time later in life, other factors, such as changes in the brain or body, may be at play. For example, older adults may suffer from restricted blood flow, a condition called ischemia. Over time, blood vessels become less flexible. They may harden and prevent blood from flowing normally to the body's organs, including the brain. If this occurs, an older adult with no family or personal history of depression may develop what some doctors call "vascular depression." Those with vascular depression also may be at risk for a coexisting cardiovascular illness, such as heart disease or a stroke.[24]

How is depression diagnosed and treated?

Depressive illnesses, even the most severe cases, are highly treatable disorders. As with many illnesses, the earlier that treatment can begin, the more effective it is and the greater the likelihood that a recurrence of the depression can be prevented.

The first step to getting appropriate treatment is to visit a doctor. Certain medications, and some medical conditions such as viruses or a thyroid disorder, can cause the same symptoms as depression. In addition, it is important to rule out depression that is associated with another mental illness called bipolar disorder. A doctor can rule out these possibilities by conducting a physical examination, interview, and/or lab tests, depending on the medical condition. If a medical condition and bipolar disorder can be ruled out, the physician should conduct a psychological evaluation or refer the person to a mental health professional.

The doctor or mental health professional will conduct a complete diagnostic evaluation. He or she should get a complete history of symptoms, including when they started, how long they have lasted, their severity, whether they have occurred before, and if so, how they were treated. He or she should also ask if there is a family history of depression. In addition, he or she should ask if the person is using alcohol or drugs, and whether the person is thinking about death or suicide.

Once diagnosed, a person with depression can be treated with a number of methods. The most common treatment methods are medication and psychotherapy.

Medication

Antidepressants work to normalize naturally occurring brain chemicals called neurotransmitters, notably serotonin and norepinephrine. Other antidepressants work on the neurotransmitter dopamine. Scientists studying depression have found that these particular chemicals are involved in regulating mood, but they are unsure of the exact ways in which they work.

The newest and most popular types of antidepressant medications are called selective serotonin reuptake inhibitors (SSRIs) and include: fluoxetine (Prozac), citalopram (Celexa), sertraline (Zoloft), paroxetine (Paxil), escitalopram (Lexapro), and fluvoxamine (Luvox).

Serotonin and norepinephrine reuptake inhibitors (SNRIs) are similar to SSRIs and include: venlafaxine (Effexor), and duloxetine (Cymbalta).

SSRIs and SNRIs tend to have fewer side effects and are more popular than the older classes of antidepressants, such as tricyclics - named for their chemical structure - and monoamine oxidase inhibitors (MAOIs). However, medications affect everyone differently. There is no one-size-fits-all approach to medication. Therefore, for some people, tricyclics or MAOIs may be the best choice.

People taking MAOIs must adhere to significant food and medicinal restrictions to avoid potentially serious interactions. They must avoid certain foods that contain high levels of the chemical tyramine, which is found in many cheeses, wines and pickles, and some medications including decongestants. Most MAOIs interact with tyramine in such a way that may cause a sharp increase in blood pressure, which may lead to a stroke. A doctor should give a person taking an MAOI a complete list of prohibited foods, medicines and substances.

For all classes of antidepressants, people must take regular doses for at least three to four weeks, sometimes longer, before they are likely to experience a full effect. They should continue taking the medication for an amount of time specified by their doctor, even if they are feeling better, to prevent a relapse of the depression. The decision to stop taking medication should be made by the person and her doctor together, and should be done only under the doctor's supervision. Some medications need to be gradually stopped to give the body time to adjust. Although they are not habit-forming or addictive, abruptly ending an antidepressant can cause withdrawal symptoms or lead to a relapse. Some individuals, such as those with chronic or recurrent depression, may need to stay on the medication indefinitely.

In addition, if one medication does not work, people should be open to trying another. Research funded by NIMH has shown

see Discovering Hope on page 19

Mental Health Treatment in Westchester

The VNSW Mental Health Home Care Program provides:

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

Program Features

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

The Big Picture

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

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

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

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

Visiting Nurse Services in Westchester
Home. Health. Care.

360 Mamaroneck Ave.
White Plains, NY
1-888-FOR-VNSW
www.vns.org

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

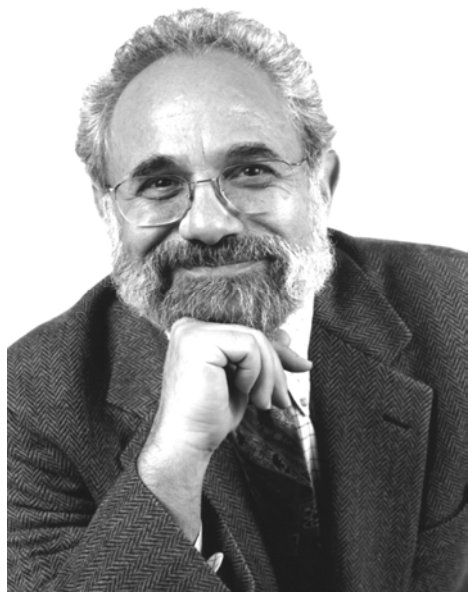
— Point of View —
The Vulnerability of Women with Serious Mental Illness: Time for Action

By Michael B. Friedman, LMSW

Women with serious and persistent mental illnesses often have hard lives. They usually have experienced significant trauma during their childhoods. They are far more likely than those without mental illness to be homeless at one time or another, and life outdoors takes a toll on the body and the mind. They are more likely than other women to be victims of crime, particularly assault and rape, which also take a terrible toll on body and mind. Many abuse drugs at some point during their lives, with consequent risks for malnutrition and communicable diseases such as HIV/AIDS, hepatitis, and sexually transmitted diseases. They are also likely to live in poverty, struggling to make do for themselves and sometimes their children too with income from Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), and food stamps.

These are not the only reasons, but they certainly are among the most important reasons, why women with serious mental illness have poorer health and die considerably younger than women without serious mental illness.

Many women with serious mental illness also experience the deep disappointment of having their children taken from them to be raised by other people. Sometimes this is necessary to protect the children from a mother who simply cannot manage the tasks of parenthood or, on rare occasion, because the mothers are made dangerous by their hallucinations or delusions. But often these mothers lose their children because the child welfare system tilts towards removal without adequate understanding of the difference between being mentally ill and being dangerous. As a result, many women with serious mental illness who have children avoid contact with the mental health system, fearing that they will be reported to the child protective service and that they will then be stripped of what is absolutely most important to them.



Michael B. Friedman, LMSW

These facts have been known for many years, and I wish that I could say that our health and human service systems have responded appropriately. But the truth of the matter is that the mental health, physical health, substance abuse, child welfare, education and other service systems have not done well by women with serious mental illness.

What should be done?

Address Childhood Trauma: The negative impact of childhood trauma on adult life is hardly news, and from time-to-time during the 20th century preventive efforts were made, sadly with very limited effectiveness. A recent study on the impact of "adverse childhood events" has given new impetus to the hope for prevention. Both at the federal and state levels, there is talk about the importance of building emotional strength—sometimes called "resiliency."

But will effective action be taken? It will cost money I am sure, and there seems to be a political consensus (not to be confused with an empirical reality) that our society cannot afford to spend as much as we do already on human troubles. In addition, it is not at all clear that there is a preventive technology ready to go on a wide scale.

Prevent Homelessness: Again this is a need that has been recognized for a very long time, and there has been real progress in the development of housing for homeless people. But it has been slow, leaving many people out. Much of it is now on hold for fiscal reasons. And supportive housing for women with serious mental illness with their children is rare.

Reduce Crime: Protecting women with serious mental illness from assault and rape without violating their rights to liberty in a free society is exceedingly difficult. What is particularly distressing, however, is that this has never been a priority for our mental health system. Safety, it seems to me, is a precondition of recovery. The risk of being a victim needs to be taken far more seriously than it has been.

Reduce Co-Occurring Serious Mental Illness and Substance Abuse: This, of course, has been a priority of the mental health and substance abuse systems for a very long time. Some progress has been made, but not nearly enough. What is needed is integrated treatment for people with co-occurring disorders, something there is far too little of. And it is not at all clear that merger of the two service systems—again under discussion—would do anything soon to increase the availability of integrated treatment.

Improve Health Promotion and Health Care: Happily, this does seem to be a high priority for the physical and behavioral health systems at both state and federal levels. Health care reform includes an emphasis on both integrated care and prevention via "medical homes," "health homes," and "accountable care organizations." Let's hope that some of these organizational experiments are effective.

Reduce Poverty: Poverty may be the single most important determinant of poor health and mental health, but maintaining people with disabilities in poverty is the core of our society's policy with regard to disability. That may seem a strange and harsh way to characterize the policy, but sadly income maintenance payments and food stamps do not raise people out of poverty or remove them from its risks.

Change Child Custody Laws and Practice: Without doubt, our society needs to protect children from parents who seriously neglect or abuse their children; and without doubt, parents with mental illness are sometimes guilty of abuse or neglect. But so are parents with many other kinds of illnesses that may from time-to-time make them incapable of being adequate parents. Yet, there is nothing in law to suggest that diabetes, obesity, cancer, Parkinson's Disease, etc. may be the cause of child maltreatment. Language in the law that singles out mental illness as a cause of child maltreatment should be removed. In addition, child protective service workers need to be helped to distinguish between a parent who is dangerously mentally ill—quite rare—and a parent with mental illness who is not dangerous to her (or his) children. Here's an action that could be taken at very little cost that might have a great impact on women who avoid getting treatment because they are afraid of losing their children.

In sum, reducing the risks of trauma, crime, homelessness, and poverty—major determinants of poor health and mental health; improving access to integrated treatment for co-occurring disorders; and respecting as much as possible the importance of children to mothers with mental illness—are all measures that would make a very big difference in the hard lives of women with serious and persistent mental illness. Let's get them on our society's agenda for action.

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Mental Health News
2011 - 2012 Theme and Deadline Calendar

Fall 2011 Issue:
"Health Reform and Mental Health Parity"
Deadline: August 1, 2011

Spring 2012 Issue:
"Understanding and Treating Depression"
Deadline: February 1, 2012

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

Summer 2012 Issue:
"Understanding and Coping with Suicide"
Deadline: May 1, 2012

— The NYSPA Report —
Achieving the Promise of the Mental Health Parity and Addiction Equity Act

By Irvin L. "Sam" Muszynski, JD
Director, Office of Healthcare Systems and Financing,
American Psychiatric Association

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, the Parity Act) ushered in a new era for health insurance coverage for mental health and substance use (mh/sud) disorders. The foundation for this was laid by the Mental Health Parity Act of 1996, and, significantly, the Patient Protection and Affordable Care Act (the ACA) that was passed in 2010 contains a number of provisions that expand the reach of the mental health parity requirements of MHPAEA through yet-to-be-established health plans .

These laws have the potential to create significant changes in the coverage for and medical management of individuals with mh/sud conditions. However, experience and research tell us that the requirements and potential of the law will not be fulfilled without our involvement. It is vital that we understand the law and target our intervention priorities based on that understanding.

The law and the regulations for its implementation are complex, and it is a difficult task to create practitioner and patient/consumer awareness of what is covered in them. Health plan provisions will likely flow from narrow rather than broad interpretations of the law's requirements. Federal and state authorities have limited resources for overseeing compliance and enforcement. The advocacy community clearly has its work cut out for it.

In brief, the Parity Act bars health plans from having separate cost sharing or treatment limits for covered mh/sud benefits than for medical and surgical (med/surg) benefits. The Act also prohibits a plan from imposing any financial or treatment limitations that are more restrictive than those in place for medical surgical benefits. These parity requirements apply to both in- and out-of-network benefits.

The Parity Act generally covers all insured or self-insured group health plans that offer medical and surgical as well as mh/sud benefits, and this includes plans where the mh/sud use disorder benefits are managed by "carve-out" companies such as ValueOptions or Magellan.

It is important to understand that plans are not required to offer mh/sud coverage, and plans offering these benefits may limit the range of disorders they do cover. However, insured health plans remain subject to state insurance and mental health parity laws in addition to the federal Parity Act requirements. For example, the New York State mental health parity law, known as Timothy's Law, does create a mandatory mental health benefit. Timothy's Law and the MHPAEA reinforce each other such that the requirements of the federal law apply to the benefits required by the NYS law. The parity requirements also apply to Medicaid managed care plans and state CHIP programs. CMS has regrettably not yet issued definitive guidance to states to

Irvin L. "Sam" Muszynski, JD

assure compliance with the Interim Final Rule (IFR) implementing the Parity Act.

The IFR was issued on February 3, 2010, and the regulations became effective for health plan years beginning on or after July 1, 2010. The regulations are far reaching, including both quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs), but since space precludes a complete analysis, our primary focus here is given to the provisions regarding: NQTLs, Scope of services, and Medical necessity and coverage criteria.

NQTLs

The regulations define treatment limitations to include both QTLs and non-quantitative limitations (NQTLs). The NQTL provision is critical. An NQTL is a limitation that, while not expressed numerically, otherwise limits the scope or duration of benefits for treatment under the plan. The regulations include the following as illustrations of NQTLs:

- Standards for provider admission to participate in a network, including reimbursement rates;
- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Plan methods for determining usual, customary, and reasonable charges; and
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first or step therapy protocols).

It is highly significant that the regulations have identified these non-quantitative elements as parity issues. It is clear this creates the potential for redressing many existing health plan practices that are discriminatory.

Despite the advent of these parity regulations, we have witnessed a number of health plans instituting new non-quantitative requirements that limit access to mental health and substance use disorder services.

The IFR sets forth a special test for determining whether an NQTL is acceptable, but at this point there is still ambiguity about how this test will be applied. The implications of this for bringing health plan practices into alignment with the parity regulations are discussed more fully below.

Scope of Services

Respecting scope of services, the IFR establishes a classification of benefits scheme that includes inpatient and outpatient care, both in-network and out-of-network; as well as emergency care and prescription drugs. A plan that provides mh/sud benefits must provide those benefits in every classification in which it provides medical/surgical benefits.

The regulations, however, are silent on the scope of services a plan must provide within each classification and how comparable they must be to the scope offered for med/surg benefits within the same classification. The regulators have made it clear that this will not be addressed until the final regulations are issued in the future. This has presented a number of problems for mh/sud services coverage. As the rule currently stands, a plan may offer just one service within a classification and still be in compliance. For example, for psychiatric inpatient care, it can offer care only in a general hospital and no other settings or levels of care. Some health plans have dropped specialty hospital care and residential care because there is no medically analogous service. Similarly, many plans have dropped partial hospitalization coverage, stating that because there is no medically analogous service, the Parity Act does not require them to cover this. These developments are alarming, and proper resolution of this "scope" issue will require considerable work by the advocacy community. Without satisfactory resolution , the parity requirement could result in some adverse, unanticipated consequences for the delivery of mental health care.

Medical Necessity and Coverage Criteria

The regulations require that the criteria for medical necessity determinations made under the plan for mh/sud benefits be made available to any current or potential participant, beneficiary, or contracting provider upon request. It is important to note that medical necessity determinations are NQTLs and are subject to the regulations' comparability test. It is critical to be able to compare the criteria for denial of mh/sud services with the criteria used for med/surg services.

While the reason for any specific denial of reimbursement or payment for mh/sud services must be made available by the plan upon request, it will be critical to

see NYSPA Report on page 27

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MENTAL HEALTH ASSOCIATION

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The Economics of Recovery: System Reform

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

New York State Governor Andrew M. Cuomo's Medicaid Redesign Team gathered an impressive list of suggestions to stem the growth of New York's 50+ billion dollar Medicaid program. I was particularly impressed with their adoption of the 80/20 concept developed by business marketers in the 70's. Market research for a variety of goods and services found that about eighty percent of the sales were accounted for by only twenty percent of the consumers! Studies applying the 80/20 rule to the consumption of health care services found similar results. This, I believe, led to the creation of "Health Homes" (365 -1), probably the most effective system reform tool in the bunch.

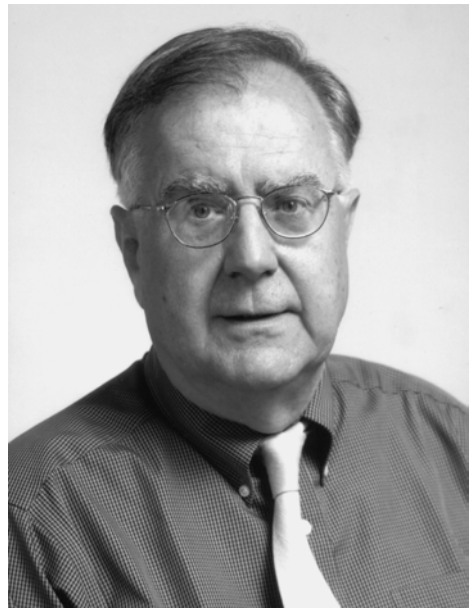
However, we feel two other promising paradigms were overlooked: 1) Reducing consumer demand and 2) Applying existing technology. To explore these options we asked some twenty-four recipients, "If they had a choice, how often would they want to see each of their health care providers?" We found our consumers wanted to reduce the number of visit to their psychiatrists by fifty-eight percent; from an average of 9.5 visits/year to 3.9 visits/year!

Similarly, if given a choice, they also wanted to reduce the number of visits to their therapists by fifty-eight percent; from an average of 13.6 visits/year to 5.6 visits/year!

If consumers had the power to decide how often they see their doctors and therapists, this alone could reduce Medicaid costs by billions.

The question is, does the patient have the ability to make their own mental health decisions regarding how often they want to see their caregivers?

We then gave our folks eight written health care concepts which utilize various technologies to deliver services and asked them to rate each one on how likely they were to use them. The results are below.



Donald M. Fitch, MS

24/7 Tele-Hotline Doctor – *"Reach a medical Doctor, Internist, Psychiatrist, etc. from your mobile or home telephone, any time of the day or night, to answer your questions" (77% rated this "very/somewhat likely" to use).*

Smart phones provide new opportunities for the next-generation of psychological health content, particularly among teens and young adults. They provide "always-on" support for the highly mobile, rural and underserved populations. Users receive two-way contact with support systems during a crisis or to manage unexpected acute symptoms. Frequent issues include alcohol and substance abuse triggers, coping with suicidal thoughts, and anger management.

A recent study of group telephone counseling of people at risk of heart disease found the tele-sessions were effective in helping people adhere to their exercise, diet and smoking cessation programs (R. Nolan, 2011). Custom Facebook groups have also proven effective.

Create Your Own Health Plan (VOUCHER) – *"With this option the Government would give you a lump sum of money (e.g. $3,000) for you to pay all your health needs for a year. You would decide who to go to and how often, and you would get to keep whatever monies are left over" (73% rated this "very/somewhat likely" to use).*

Republicans in the House recently voted to transform Medicare from a program in which the Government pays medical bills directly to a Voucher system that would enable people to purchase private health insurance. A variation of the Voucher Plan is "concierge medicine" where doctors limit their practice to patients who pay a fee of about $1,500 a year, for unlimited access, time and attention. It is catching on out in the west.

24/7 Tele Hotline Therapist – *"Reach a Psychotherapist from your cell or home phone, anytime, day or night, to help you with managing your feelings" (73% rated this "very/somewhat likely" to use).*

International Tele-Health call centers would be available to help people cope with sleep disorders, anxiety, anger, depression and suicidal thoughts, drug and alcohol abuse, tobacco, physical injury, sexual issues, spouse and children, work adjustment, etc.

A British study found Cognitive Behavioral Therapy (CBT) could be effective in treating depression when administered via instant messaging (Kessler, 2009). Twitter could also be effective.

Video Therapy – *"Talk and see your regular Doctor or Therapist through the computer at your regularly scheduled day and time – instead of having to travel to the office" (73% rated this "very/somewhat likely" to use).*

We first heard about this technique in the fall of 2009, Dr. Timothy Sullivan, M.D. formerly of Saint Vincent's Hospital, was able to continue his weekly psychotherapy sessions with patients who moved away.

One-Stop Health Care – *"Instead of having to travel all over town to see your different health care providers, you could see them all in one place, on the same day" (64% rated this "very/somewhat likely" to use).*

Convenience is the key attraction with this health-care model. The logistical challenge, of course, is arranging all the appointments on the same day. A prime example to check out is www.westmedgroup.com, a pioneering HMO here in Westchester County, NY.

Medication Free Health Plan – *"This plan would only treat your illness with natural products; e.g. vitamins and herbs, no chemicals or prescription drugs. It would also incorporate yoga, acupuncture, meditation, exercise, social relationships, etc." (64% rated this "very/somewhat likely" to use).*

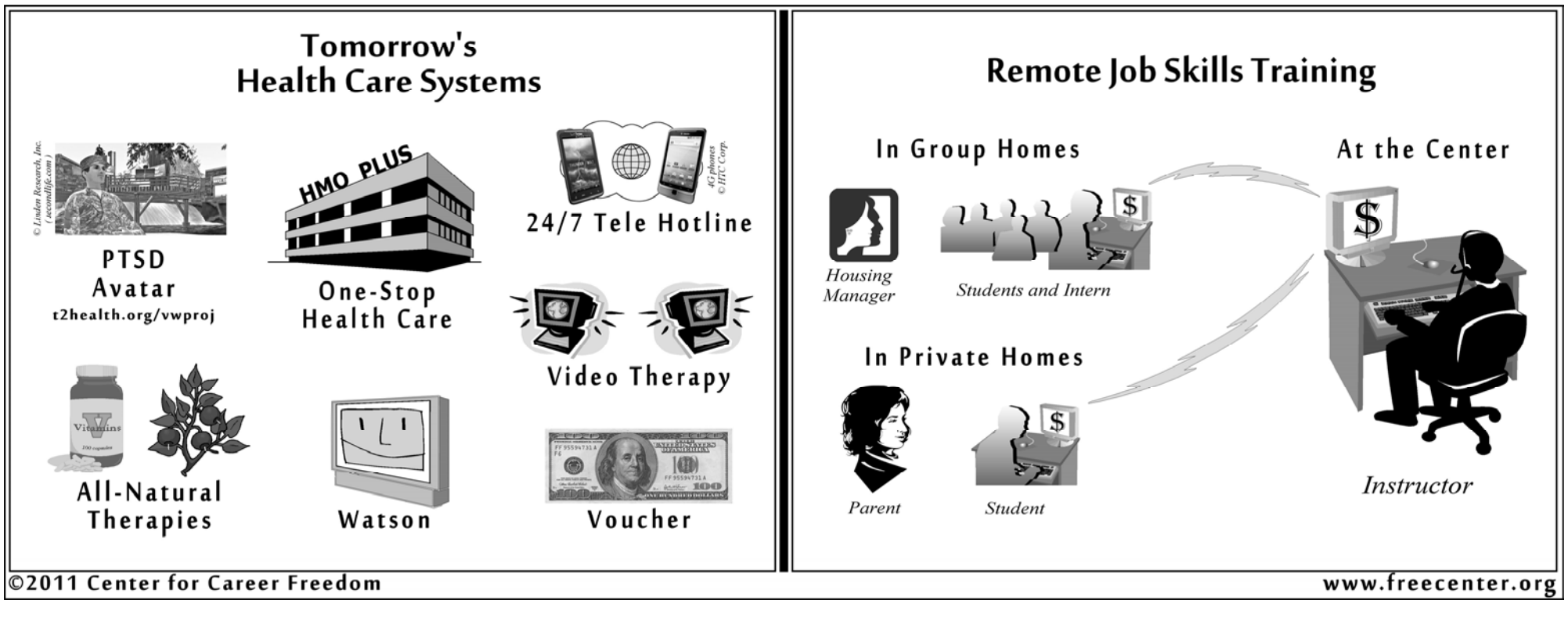
While about two-thirds of our folks liked this plan, no one questioned the treatment plans' efficacy. This group also felt "very satisfied" about "their ability to make their feelings known to the Doctor," "being an active partner in their treatment plan," and "their ability to make their own medical treatment decisions."

WATSON –*"IBM recently created a powerful talking computer which could provide you with information on a variety of topics; Government benefits, housing, education, work, medical, legal, etc. with no need to type your questions; just ask" (33% rated this "very/somewhat likely" to use).*

Watson is just one component of IBM's Smarter Healthcare initiative designed to master a complex system, including vast networks of doctors, patients, hospitals, clinics, pharmacies, insurers, medical equipment, and the millions of pieces of data, images, prescriptions, documents, and other information that get exchanged every day (www.ibm.com, 2010).

Virtual PTSD Game/Avatar – *"This game helps people cope with their post traumatic stress and phobias by placing them in a stressful environment, but one in which they can control. The Army developed it for returning warriors"*

see System Reform on page 33



THE MENTAL HEALTH LAWYER

A Mother's Challenge: Planning for the Transition of Decision-making

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

On a recent airing of National Public Radio's "This American Life" the narrator tells the story of Emily Feldman, a New Jersey woman in her 70's who has been caring for her 39 year old autistic son, Scott, all his life. Emily is getting on in years and she knows she cannot continue to care for Scott much longer. So Emily buys her son a house and begins a long, but ultimately unsuccessful journey to find someone to help care for Scott when she no longer can. She questions officials at City Hall, puts fliers in the newspaper, and even knocks on neighbors doors, all with a single task in mind; help my son when I'm gone. Despite Emily's lack of success the story does have a happy ending. Scott, despite his autism, is high functioning and more resilient than his mother gave him credit for. He learns to fend for himself where he can, and more to the point, ask neighbors and others for help when he can't.

In the world of individuals with serious mental illness and Autism Spectrum disorders, and the mothers who care for them, usually adult children, there are a myriad of stories like Emily and Scott Feldman's. Mothers of children with mental illness often play the simultaneous roles of mother, health care decision maker and financial manager. They are intimately involved in their often adult child's medical and psychiatric care as well as managing their finances and paying their bills. This article will attempt to answer the vexing questions that arise when these mothers are either no longer capable of taking on this herculean task due to age or illness, or are no longer around because they have passed away. Questions arise, such as who will make psychiatric and medical decisions for them and how can I ensure that they are financially taken care of and protected from abuse.

Advance Directives

While it is impossible to find someone with a mother's dedication to her differently abled child, the law does allow for several avenues by which others can make medical decisions. A Health Care Proxy allows a mentally ill person to appoint another individual to make medical decisions in that person's place. Moreover, a Health Care Proxy can be created which can appoint the individual's mother as the initial decision maker (Health Care Agent), and then a successor Agent who will step in to make decisions when the mother is no longer capable of doing so. This all assumes that the child in need has the capacity to choose a health care agent

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and successor agent and one is available to act in that role.

In the event that the person is lacks the capacity to appoint an agent, the newly enacted Family Health Care Decisions Act allows for family, and/or friends to make decisions even if a Health Care Proxy is not completed. The law creates a hierarchy of decision makers; the spouse, if not legally separated from the individual, or the domestic partner; a son or daughter eighteen years of age or older; a parent; a brother or sister eighteen years of age or older; or a close friend.

It is important to note, however, that whether applying a Health Care Proxy or the Family Health Care Decisions Act, no one may make decisions to involuntarily hospitalize an individual or to force someone to take medication over their objection.

When dealing with end of life issues, there are other options, such as a Living Will or Do Not Resuscitate Order, which will ensure that an individual's medical needs and desires will be properly cared for. These instruments create specific instructions for health care providers on what treatment the person wants and does not want in the event they are suffering from a disease that will surely take their life. (Again assuming the person has the mental capacity to execute such a document or directive.)

Financial Planning

Perhaps the easiest way to make sure a differently abled finances will be cared for when the parent no longer can take on these duties is the creation of a Durable Power of Attorney. A Durable Power of Attorney allows an individual to make financial decisions on behalf of the child. Unlike the Health Care Proxy, which only goes into affect when the person loses capacity to make decisions, a Durable Power of Attorney authorizes the agent, called an "attorney-in-fact", to make decisions while the person is capacitated and also when the person loses capacity. A Durable Power of Attorney can be as broad or limited as the individual would like, authorizing the "attorney-in-fact" to make all or only specific financial decisions.

Another option, which becomes very important in protecting access to government benefits, is the creation of a Supplemental Needs Trust. Any assets placed in this kind of Trust will not affect an individual's eligibility for Medicaid, Social Security Disability, or Social Security Income provided that the funds are used to supplement nut supplant benefits already received. This type of Trust can be created for anyone who has a severe and long-term disability. Generally, people with severe mental illness who receive Social Security Disability will qualify for the creation of a Supplemental Needs Trust. Once the Trust is created a Trustee will approve all money expended from the Trust and has a fiduciary duty to make sure that the money is spent for the benefit of the person for whom the Trust was created.

The downside to a Supplemental needs Trust, however, is that the Trustee administering the Trust, often a bank, will take administration fees. Not only does this diminish the value of the Trust, but unless the Trust is very large it will be difficult to find a Trustee to administer it. In this event, one should look to Pooled Trusts, typically run by a charity, where many people pool their money together. The drawback of a Pooled Trust is that once the person dies, any money still in the Trust must either stay in the Trust, or if it is removed from the Trust it must be used to payback Medicaid for money it has expended on the person's medical expenses.

Guardianship

Another possibility is to petition the Court to have a Guardian appointed for the child in need of assistance. A Guardian can be granted extremely wide ranging authority, such as making medical decisions, financial decisions, where the person should live, if they can travel, and what their social environment can be. Likewise, Guardianships can be tailored to be less restrictive and therefore a Guardian will only have limited authority over a person's life. The flexible nature of the Guardianship proceeding is one of its distinct advantages. Moreover, a Guardianship proceeding allows the mother to choose exactly whom they think will make the best decisions for her child. Another advantage that a Guardianship has over the other options already discussed in this article is that a Guardian

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that those who did not get well after taking a first medication often fared better after they switched to a different medication or added another medication to their existing one.[25,26]

Sometimes other medications, such as stimulants or antianxiety medications, are used in conjunction with an antidepressant, especially if the person has a coexisting illness. However, neither antianxiety medications nor stimulants are effective against depression when taken alone, and both should be taken only under a doctor's close supervision.

Is it safe to take antidepressant medication during pregnancy?

At one time, doctors assumed that pregnancy was accompanied by a natural feeling of well being, and that depression during pregnancy was rare, or never occurred at all. However, recent studies have shown that women can have depression while pregnant, especially if they have a prior history of the illness. In fact, a majority of women with a history of depression will likely relapse during pregnancy if they stop taking their antidepressant medication either prior to conception or early in the pregnancy, putting both mother and baby at risk.[27,12]

However, antidepressant medications do pass across the placental barrier, potentially exposing the developing fetus to the medication. Some research suggests the use of SSRIs during pregnancy is associated with miscarriage and/or birth defects, but other studies do not support this.[28] Some studies have indicated that fetuses exposed to SSRIs during the third trimester may be born with "withdrawal" symptoms such as breathing problems, jitteriness, irritability, difficulty feeding, or hypoglycemia. In 2004, the U.S. Food and Drug Administration (FDA) issued a warning against the use of SSRIs in the late third trimester, suggesting that clinicians gradually taper expectant mothers off SSRIs in the third trimester to avoid any ill effects on the baby.[29]

Although some studies suggest that exposure to SSRIs in pregnancy may have adverse effects on the infant, generally they are mild and short-lived, and no deaths have been reported. On the flip side, women who stop taking their antidepressant medication during pregnancy increase their risk for developing depression again and may put both themselves and their infant at risk.[28,12]

In light of these mixed results, women and their doctors need to consider the potential risks and benefits to both mother and fetus of taking an antidepressant during pregnancy, and make decisions based on individual needs and circumstances. In some cases, a woman and her doctor may decide to taper her antidepressant dose during the last month of pregnancy to minimize the newborn's withdrawal symptoms, and after delivery, return to a full dose during the vulnerable postpartum period.

Is it safe to take antidepressant medication while breastfeeding?

Antidepressants are excreted in breast milk, usually in very small amounts. The amount an infant receives is usually so small that it does not register in blood tests. Few problems are seen among infants nursing from mothers who are taking antidepressants. However, as with antidepressant use during pregnancy, both the risks and benefits to the mother and infant should be taken into account when deciding whether to take an antidepressant while breastfeeding.[30]

What are the side effects of antidepressants?

Antidepressants may cause mild and often temporary side effects in some people, but usually they are not long-term. However, any unusual reactions or side effects that interfere with normal functioning or are persistent or troublesome should be reported to a doctor immediately.

The most common side effects associated with SSRIs and SNRIs include: headache - usually temporary and will subside; nausea - temporary and usually short-lived; insomnia and nervousness (trouble falling asleep or waking often during the night) - may occur during the first few weeks but often subside over time or if the dose is reduced; agitation (e.g., feeling jittery); and sexual problems - women can experience sexual problems including reduced sex drive and problems having and enjoying sex.

Tricyclic antidepressants also can cause side effects including: dry mouth - it is helpful to drink plenty of water, chew gum, and clean teeth daily; constipation - it is helpful to eat more bran cereals, prunes, fruits, and vegetables; bladder problems - emptying the bladder may be difficult, and the urine stream may not be as strong as usual; sexual problems - sexual functioning may change, and side effects are similar to those from SSRIs and SNRIs; blurred vision - often passes soon and usually will not require a new corrective lenses prescription; and drowsiness during the day - usually passes soon, but driving or operating heavy machinery should be avoided while drowsiness occurs. These more sedating antidepressants are generally taken at bedtime to help sleep and minimize daytime drowsiness.

FDA Warning on Antidepressants

Despite the relative safety and popularity of SSRIs and other antidepressants, some studies have suggested that they may have unintentional effects on some people, especially adolescents and young adults. In 2004, the Food and Drug Administration (FDA) conducted a thorough review of published and unpublished controlled clinical trials of antidepressants that involved nearly 4,400 children and adolescents. The review revealed that 4 percent of those taking antidepressants thought about or attempted suicide (although no suicides occurred), compared to 2 percent of those receiving placebos.

This information prompted the FDA, in 2005, to adopt a "black box" warning label on all antidepressant medications to alert the public about the potential increased risk of suicidal thinking or attempts in children and adolescents taking antidepressants. In 2007, the FDA proposed that makers of all antidepressant medications extend the warning to include young adults up through age 24. A "black box" warning is the most serious type of warning on prescription drug labeling.

The warning emphasizes that patients of all ages taking antidepressants should be closely monitored, especially during

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Preventing Depression in Teenagers

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In this article, we summarize research indicating that women experience depression more frequently than men, and that this difference emerges during the adolescent years. There are several reasons girls may be at higher risk for depression than boys, but researchers still do not fully understand this. We are currently testing whether we can prevent depression in adolescents using a Cognitive Behavior Therapy (CBT) prevention program. We are testing this among girls and boys but hope to examine whether girls respond differently to the intervention. In future research, we hope to tailor interventions that can target female-specific vulnerabilities.

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The lifetime prevalence rate of Major Depressive Disorder (MDD) is 1.7 to 2.7 times greater in women than in men (Weissman et al., 1993), with 21.3% of women between the ages of 15 and 54 years old having experienced a depressive episode at some point in their lives, compared to 12.7% of men (Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993). Depression in adolescents is more common than was once believed. It is estimated that the one-year prevalence rate of depression in adolescents is between 1.6% and 8.9% (Angold & Costello, 2001). In fact, half of all individuals who have a mental illness during their lifetime report that the onset occurred by age 14, and three quarters report onset by age 24 (Keuhn, 2005). Mid to late adolescence is the most commonly reported age of first onset for depression or significant symptoms (e.g., Burke, Burke, Regier, & Rae, 1990), which has also been demonstrated across diverse cultures (Cross-National Collaborative Group, 1992).

Adolescents are vulnerable to depression for many reasons. Depressed youth expect rejection from peers and lack problem solving skills, instead mulling over their problems without coming to helpful solutions. Adolescents expect that trying to solve problems will be unsuccessful, so they might avoid the problem, or they approach the problem impulsively. In addition, perfectionistic standards and a negative attributional style (blaming oneself for losses or failures) tend to decrease an adolescent's sense of self-esteem (Reinecke & Jacobs, 2008).

Before adolescence, girls and boys experience depression at about the same rate (Bebbington et al., 2003). However, by early adolescence (about age 13), rates of depression in girls increases sharply while boys' rates remain low, and may even decrease. By late adolescence, girls are twice as likely as boys to be depressed (Nolen-Hoeksema, 2001), and there are multiple reasons for this that range from the biological and hormonal changes that occur during puberty, to the cognitive vulnerabilities typically experienced by girls that perpetuate depressive thoughts and feelings (Hankin & Abramson, 2001). For example, one consistent difference has been found in the self-concepts of males and females, more specifically their interpersonal orientations. Defined as the tendency to be concerned with the status of one's relationships and the opinions others hold of oneself, as early as childhood, girls appear more interpersonally oriented than boys, and this gender difference increases in adolescence (Zahn-Waxler, 2000). When interpersonal orientation leads girls to value their own needs below those of others, they can become excessively dependent, and need a higher degree of approval and success to feel secure than boys (Cyranowski, Frank, Young, & Shear, 2000; Calvete & Cardenoso, 2005).Girls also tend to doubt themselves, doubt their problem-solving abilities and view their problems as unsolvable more so than boys (Calvete & Cardenoso, 2005). Furthermore, by adolescence, girls appear to be more likely than boys to respond to stress and distress with rumination—focusing inward on feelings of distress and personal concerns rather than taking action to relieve their distress (Nolen-Hoeksema, 2001).

Finally, girls are more likely to undergo more hardships and stressful life events, such as poverty, poor education, and traumas (Cyranowski, Frank, Young, & Shear, 2000). Traumas may contribute directly to depression, by making women feel they are helpless to control their lives,

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Inequality in the Effects of Disaster Trauma in Women

By April Naturale, PhD, Director
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Over the past decade, the U.S. has seen an increase in large scale disasters both man-made and natural, from 9-11-01, the Virginia Tech and the Fort Hood Shootings to Hurricanes Katrina, Rita and Ike. These events have the potential to create states of acute emotional distress in people who are exposed to the disasters as well as the threat of developing a psychological disorder, such as posttraumatic stress, in certain high risk populations.

From the mental health perspective, trauma is defined as the psychological effects of events that disrupt the emotional equilibrium of an individual causing stress and grief or; the collective trauma that causes damage to the bonds and social fabric of communities. The primary experience of trauma is that of exposure to life threatening events such as physical and psychological abuse, auto accidents, disasters, torture and war. Yet, because each individual has their own unique personality traits developed as a result of genetic or biological make up as well as life experiences that they bring to each event, their perception significantly influences their actual experience of traumatic events. Thus, there are an extensive number of variables that have the potential to determine how any one trauma affects the individual emotionally and psychologically. This broad scope of possibilities also influences 'collective trauma,' which refers to the effects of an event on a particular family, group or community. This article talks briefly about how women are affected as they experience disaster trauma based on their unique experience of belonging to this gender group.

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It is important to note here that the majority of people exposed to traumatic events have sufficient internal strengths which allow them to recover without any type of crisis intervention or formal mental health treatment. This characteristic is generally referred to as resilience which is defined as the ability to return to, bounce back or recover from illness or adversity. While resilience is most often innate, it can also be accomplished with learned coping skills, cognitive tools and other emotional supports that can enhance recovery.

Despite the innate ability to bounce back and continue to function as one did prior to the experience of a disaster trauma, women are at a disadvantage. In an extensive study of 60,000 disaster victims, Norris, et al., (2002)[1] reported that the variable of female gender consistently increased the likelihood of adverse outcomes. We do not know exactly why this is the case, but suggest here possible reasons.

First, in emergency situations, women put the care of others ahead of themselves (Nomura & Chemtob, 2009)[2]. As primary caretakers, women most often have the responsibility for children and other family members who require supervision and physical care. The stress and pressure that many women experience as they try to help their children and in many cases, also a frail parent while attempting to rally themselves back to normalcy may create obstacles to their own emotional recovery.

Research informs us that serious emotional disorders such as posttraumatic stress develop in approximately 7 percent of women as a result of trauma (Kessler et al., 1996)[3]. This is 4% higher than rates for men excluding those involved in war (where there is high exposure to violence, death and continued imminent threat of death). Again, we do not know the causation for this disproportionate number of women who suffer with posttraumatic stress disorder, but we do know that social support-connectedness to family and friends-as well as early intervention and treatment when needed, do help.

Social supports are well known to assist individuals and groups in the aftermath of disasters (Norris, et at., 2002)[4]. Overall, women have been reported to have more positive network orientations (Kaniasty& Norris, 2000). These networks should be of assistance to women in the post disaster recovery process, yet when Kaniasty and Norris (2000) evaluated the role of ethnicity in relation to help seeking in a population of disaster affected women, they found that social supports were not utilized. In a population of low income African American women who had easy access to highly developed networks of relatives and friends that were seen as willing to provide support, the researchers found that these women asked for assistance

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Trauma Assessment for Women Receiving Mental Health Services

By Amanda Watson, MSW

The National Institute of Mental Health states that in any given year 25% of adults in the United States are diagnosable for one or more mental disorders. Of that 25%, 6% meet the criteria for severe mental illness. Women are not more likely to meet the criteria for a diagnosis however; women are more likely to enter into treatment (either inpatient, outpatient, or prescription drugs) to help alleviate the symptoms of their mental distress. Women are 50% more likely than men to be diagnosed with a mood disorder, 60% more likely to be diagnosed with an anxiety disorder, and 70% more likely to be diagnosed with depression than men. As mental health professionals it is vital that we understand how trauma affects the mental health of the women that we are providing service for.

Women are more likely to be traumatized in their interpersonal relationships than men. Women are more likely to be physically and sexually assaulted by someone they know. In the general population between 17 and 35% of women report a history of physical or sexual abuse, where as in mental health setting that statistic rises to 35-50% (van der Kolk et al., 2005). These statistics again increase when taking into consideration women with co-occurring disorders: 48% of women with a co-occurring disorder in community samples report histories of interpersonal trauma and 90% of women with co-occurring disorders in inpatient settings report interpersonal trauma (Becker et al., 2005).

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Symptoms of trauma can be manifested in ways that may not meet the criteria for Post Traumatic Stress Disorder (PTSD), often times women experience depression and anxiety in response to trauma. In part this may be due to the definition of traumatic events according to the DSM-IV-TR, which states that a traumatic event is one in which an individual experiences the threat of death or serious injury and emotional response of fear, helplessness, or horror at the time of the event. A stressful life event often constitute the normal fluctuations of life such as divorce, loss, serious illness, or expected death of a loved one, which an individual may experience as traumatic. All of the aforementioned life events require and individual to cope and adapt which of course can bring about psychological changes. When dealing with a traumatic event the difference often becomes the individual's adaptive capacities to be overwhelmed which leaves the individual unable to cope effectively.

Research has shown the link between child abuse and severe mental illness as well as the link between child abuse and PTSD (Frueh et al., 2009; Read 1997; Read et al., 2005; Mueser et al., 2001; Herder & Redner, 1991). Severe Mental Illness (SMI) is defined as: Schizophrenia, a Schizophrenia Spectrum Disorder, Bipolar Disorder, or Treatment Resistant Depression. Recent research has shown that the symptoms of PTSD can be very similar if not identical to the symptoms of SMI (Herder & Redner, 1991; Mueser et al., 2002). Lifetime rates of interpersonal violence range between 43 and 97% in women with SMI who seek treatment (Cusak, Morrissey, & Ellis, 2007).

In the past fifteen years researchers have taken an interest in the effects of trauma on SMI. Studies have found repeatedly and consistently that individuals diagnosed with SMI are far more likely to have suffered a trauma than those individuals in the general population (Read, 1997; Frueh et al.,2009; Herder & Redner, 1991; Mueser et al.2002; Mueser et al. 2001; Read et al. 2005). Individuals diagnosed with a SMI are far more likely to be the survivors of physical abuse, sexual abuse, or both physical and sexual abuse (ibid). Most often this abuse occurred before the age of 18. These individuals are also more susceptible to being further victimized in their adult lives (Mueser et al. 2002).

Historically when researchers would study the long-term effects of child abuse, they did not to include individuals diagnosed with SMI, especially individuals with some form of psychosis (Read, 1997; Read et al. 2005). However, recent research studies indicated that individuals diagnosed with a psychotic disorder have the highest rates of child abuse. This population tended not to be studied as it was thought that due to their symptoms of psychosis they would not be reliable

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Mental Health Care Monitoring Teams

By Nora Weinerth

It is now known that some mental health care providers in New York City can fail some seriously mentally ill people. Some people try to get treatment, and can't. Others, who have been getting treatment in a program, are dropped without warning or apparent reason. Some people stop taking their medications because their prescription runs out and their provider fails to renew it—or there is a glitch with their Medicaid. Some people stop taking their medications because they think they're cured. Others sometimes go to the pharmacy for a refill only to be sent away empty handed because their Medicaid has been cut off. Some people with serious mental illness just disappear: they become homeless, and no one knows where to look for them. Some people end up in jail, or in the hospital. They are forgotten or ignored, and have no family or advocate to speak up for them when their treatment back in the community has been terminated. And, usually, nobody seems to know— until something terrible results from these breaks in service.

A Tragic Wakeup Call

That's what happened in 2007 and 2008, when violent incidents took place in New York City: the incidents involved people with serious mental illness as either victims or perpetrators. In perhaps the most widely reported incident, David Tarloff, a man living with schizophrenia for decades, killed a psychologist on the Upper East Side. Tarloff had not been engaged in the care he needed. His attack may have been the tragic outcome of a befuddled plan to get his aged mother released from a nursing home.

In another notorious incident, during a domestic disturbance, a woman called the police on her mentally ill 18-year-old son. He was believed to have a gun; but it was only a hairbrush he was holding. He was shot to death by the police.

The Governor and the Mayor responded to the crisis boldly and humanely, appointing the New York State / New York City Mental Health and Criminal Justice Panel to investigate the problem. The Panel spent a year investigating individual incidents and systemic problems before issuing its report.

Findings of the Panel

The system failed Mr. Tarloff. The panel found poor coordination, fragmented oversight, and a lack of accountability in the mental health treatment system. The panel found inconsistencies in the quality of care within the system. And it found that the mental health and the criminal and juvenile justice systems weren't sharing information. Here's a direct quote from the report: *In the cases it examined, the Panel saw tragic outcomes resulting from fragmented care and a failure to detect and respond to signs of in- adequate care, deterioration in mental health, and increasing signs of potential violence.*

Although people with serious mental illness are less likely to be violent than the general population, the panel's research showed that the risk of violence is increased among "high-need" individuals with mental illness who do not receive adequate mental health care.

The panel found that the system was not getting care to the people who needed it most. For example, the average length of treatment 32% of the time was one session. Sixty percent of the time, people were getting only one to four sessions. This is hardly adequate treatment for anyone—particularly for "high need" people.

Perhaps it's no wonder that Tarloff, like others, had disappeared off the radar of the system. No one was paying attention and no one was held accountable when this "high need" patient was reportedly refused treatment. For most individuals who slip through the cracks of the system, the consequences are only increased suffering. In this case, the lack of coordination, accountability, and provider oversight led to tragedy. Receiving less, if any, media attention are "high-need" individuals who commit suicide.

Recommendations of the Panel

The panel then proposed progressive, humane, and practical recommendations for plugging up the gaps and fixing the inadequacies in the mental health system.

The most important of the Panel's recommendations: It mandated the development of new standards of care for providers, with a focus on periodically assessing risk for violence and suicide; it also mandated the creation of a database to track aspects of provider performance, such as patterns of use. The panel urged better communication among providers working with the same mentally ill individual and those who are court-mandated to receive treatment, as well as those who cycle in and out of emergency rooms and hospitals.

The panel also recommended the development of a *Mental Health Care Monitoring Initiative*. Its mission is to improve quality and coordination of care for people with serious mental illness aged 18 and older. The project involves identifying "high-need populations," including people receiving Assertive Community Treatment or case management services, as well as those with recent histories of involvement with the criminal justice system or frequent emergency room visits and/or psychiatric hospitalizations.

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What Gets in the Way: Latinas Who Don't Access or Stay in Treatment

By Lauren Henríquez-Bentiné, LMSW, Therapist, JBFCS: Harry Blumenfeld Pelham Counseling Center

As social workers in urban settings, we often hear about the traumas our female clients endure. These include experiencing or witnessing: sexual assaults, parental abuse/neglect, domestic violence, child fatalities, and life-threatening illnesses/injuries (Gaillot 2010). Women are more likely to develop Post-Traumatic Stress Disorder (PTSD) in response to trauma (Gaillot 2010). While the need for mental health treatment for women in general is great, this article will focus on the obstacles Latinas face when accessing and remaining in treatment.

The primary barrier preventing Hispanic women with unresolved traumas from entering or continuing treatment is their role as parents. When overwhelmed by their children's acting out, women first seek treatment for their children. It was through treating Jacqueline, a 12 year-old exhibiting behavioral problems, that I discovered that her mother, Joanna, had had her nose fractured by Jacqueline's father when she was pregnant. Once, because of another mother's judgmental attitude towards her daughter, Samantha, my sassy client, I grew angry with the mother. Two years into treatment, when I found out Samantha was conceived by

Lauren Henríquez-Bentiné, LMSW

rape, I began to empathize with her mother. A woman who I felt lacked adequate parenting skills had endured a horrific trauma and was expected to deal with the result of it – a child – for the rest of her life.

Even Hispanic women who enter treatment for themselves may focus sessions on their children. The trauma(s) a woman endures will undoubtedly affect how she parents her children. A mother might not know how to demonstrate affection, resulting in poor parenting. This can become the main topic of sessions, preempting the focus of trauma. Enid and Gabriela, both Latinas in their 30s, have difficulty displaying affection to their children. Enid, who began wearing prosthetic legs as an infant, was verbally abused by her mother because of her disability. She did not experience maternal love, so she does not know how to demonstrate it. Gabriela, who was molested as a child by her brothers, felt awkward bathing her son because she feared being accused of molestation. In addition to facing challenges in caring for her children, an Hispanic woman may go to extremes to protect her children or may become too permissive. Selena, 43, molested by her uncle and experiencing intrusive trauma symptoms, utilized much of her sessions to discuss the issues that resulted from her permissive parenting.

When an Hispanic woman does not have childcare or has limited finances, this further impedes treatment. Kathy, 28, was held hostage by a female friend and the friend's father. When we commenced treatment two years ago, Kathy attended sessions with her children who were too young to be left in the waiting area. Despite her partially speaking Spanish (so the children could not understand) and whispering some words, the circumstances did not allow her to freely express her emotions. It was not until Kathy's homemaking services were put into place that she and I were able to explore her feelings about this tragic event impacting her ability to trust. A woman's limited finances can also hinder treatment. She may not have health insurance or her finances for co-payments and carfare may be limited (Davis et. al. 2008). Annabelle, 24, was sexually abused by her mother's boyfriend and her adoptive uncle. One way that her PTSD manifests itself is in her inability to travel alone. She cancels sessions because she lacks travel expenses for her and her family.

Women with PTSD are twice as likely as men to report concern over being judged for their trauma(s). One reason for this disparity is that women and men experience different traumas. Women are more likely to experience rape and molestation, which may be perceived as more stigmatizing (Gaillot 2010). Women who have endured sexual traumas may become promiscuous, which is a form of detachment from the trauma. The woman no longer views sex as a connection between individuals who care for each other; it is simply a physical act. Myrna, 49, experienced multiple traumas, including domestic violence, rape and a home invasion. She engaged in risky, unprotected sex with multiple partners. Myrna did not disclose this until many months into treatment, indicating that she felt shame about this behavior. Latinas may also be hesitant

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the initial weeks of treatment. Possible side effects to look for are worsening depression, suicidal thinking or behavior, or any unusual changes in behavior such as sleeplessness, agitation, or withdrawal from normal social situations. The warning adds that families and caregivers should also be told of the need for close monitoring and report any changes to the physician. The latest information is available from the FDA.

Results of a comprehensive review of pediatric trials conducted between 1988 and 2006 suggested that the benefits of antidepressant medications likely outweigh their risks to children and adolescents with major depression and anxiety disorders.[28] The study was funded in part by the National Institute of Mental Health.

Also, the FDA issued a warning that combining an SSRI or SNRI antidepressant with one of the commonly-used "triptan" medications for migraine headache could cause a life-threatening "serotonin syndrome," marked by agitation, hallucinations, elevated body temperature, and rapid changes in blood pressure. Although most dramatic in the case of the MAOIs, newer antidepressants may also be associated with potentially dangerous interactions with other medications.

What about St. John's wort?

The extract from the herb St. John's wort (Hypericum perforatum), a bushy, wild-growing plant with yellow flowers, has been used for centuries in many folk and herbal remedies. Today in Europe, it is used extensively to treat mild to moderate depression. In the United States, it is a top-selling botanical product.

To address increasing American interest in St. John's wort, the National Institutes of Health (NIH) conducted a clinical trial to determine the effectiveness of the herb in treating adults suffering from major depression. Involving 340 patients diagnosed with major depression, the eight-week trial randomly assigned one-third of them to a uniform dose of St. John's wort, one-third to a commonly prescribed SSRI, and one-third to a placebo. The trial found that St. John's wort was no more effective than the placebo in treating major depression.[32] Another study is underway to look at the effectiveness of St. John's wort for treating mild or minor depression.

Other research has shown that St. John's wort can interact unfavorably with other drugs, including drugs used to control HIV infection. On February 10, 2000, the FDA issued a Public Health Advisory letter stating that the herb appears to interfere with certain drugs used to treat heart disease, depression, seizures, certain cancers, and organ transplant rejection. The herb also may interfere with the effectiveness of oral contraceptives. Because of these and other potential interactions, people should always consult their doctors before taking any herbal supplement.

Psychotherapy

Several types of psychotherapy—or "talk therapy"— can help people with depression.

Some regimens are short-term (10 to 20 weeks) and other regimens are longer-term, depending on the needs of the individual. Two main types of psychotherapies-cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT)-have been shown to be effective in treating depression. By teaching new ways of thinking and behaving, CBT helps people change negative styles of thinking and behaving that may contribute to their depression. IPT helps people understand and work through troubled personal relationships that may cause their depression or make it worse.

For mild to moderate depression, psychotherapy may be the best treatment option. However, for major depression or for certain people, psychotherapy may not be enough. Studies have indicated that for adolescents, a combination of medication and psychotherapy may be the most effective approach to treating major depression and reducing the likelihood for recurrence.[33] Similarly, a study examining depression treatment among older adults found that patients who responded to initial treatment of medication and IPT were less likely to have recurring depression if they continued their combination treatment for at least two years.[34]

Electroconvulsive Therapy

For cases in which medication and/or psychotherapy does not help alleviate a person's treatment-resistant depression, electroconvulsive therapy (ECT) may be useful. ECT, formerly known as "shock therapy," used to have a negative reputation. But in recent years, it has greatly improved and can provide relief for people with severe depression who have not been able to feel better with other treatments.

Before ECT is administered, a patient takes a muscle relaxant and is put under brief anesthesia. She does not consciously feel the electrical impulse that is administered. A person typically will undergo ECT several times a week, and often will need to take an antidepressant or mood stabilizing medication to supplement the ECT treatments and prevent relapse. Although some people will need only a few courses of ECT, others may need maintenance ECT, usually once a week at first, then gradually decreasing to monthly treatments for up to one year.

ECT may cause some short-term side effects, including confusion, disorientation and memory loss. But these side effects typically clear shortly after treatment. Research has indicated that after one year of ECT treatments, patients showed no adverse cognitive effects.[35] A person should weigh the potential risks and benefits of ECT and discuss them with her doctor before deciding to undergo ECT treatment.

What efforts are underway to improve treatment?

Researchers are looking for ways to better understand, diagnose and treat depression among all groups of people. New possible treatments, such as faster-acting antidepressants, are being tested that give hope to those who live with difficult-to-treat depression. Researchers are studying the risk factors for depression and how it affects the brain. NIMH continues to fund

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Latina Teen Suicide Surges
One in Five in Brooklyn Attempt Suicide - Rate Almost Doubles in Two Years

By Rosa M. Gil, DSW
Founder, President and CEO
Comunilife, Inc.

More than one Latina teenager out of every five living in Brooklyn attempted suicide during 2009 – a rate that was almost twice the level just two years earlier, according to a new report by the U.S. Centers for Disease Control and Prevention (CDC). In New York City as a whole, one in seven young Latinas attempted suicide in 2009 – a substantially higher rate than for the U.S. as a whole. Latina teens generally attempt suicide at a rates far greater than their non-Hispanic counterparts – more than twice the rate of white youth in New York City (14.7% versus 6.2%) and 44% more frequently than teenage African-American girls (14.7% versus 10.2%).

"It is a great tragedy, and it gets worse every year," says Dr. Rosa Gil, Founder and Chief Executive Officer of Comunilife, Inc. "New York City already had among the highest rates of Latina teen suicide in the nation."

The CDC's Youth Risk Behavior Surveillance System report for 2009 found that the levels of suicide attempts by Latina teenagers were also shockingly high in the City's other boroughs: 15.3% in the Bronx, 16.5% in Staten Island, 12.2% in Queens and 11.7% in Manhattan.

In response to this rapidly growing epidemic, Comunilife created its *Life is Precious™* suicide prevention program for Latina teens in 2008. *Life is Precious™* addresses the unique cultural drivers – as well as the underlying psychological causes – of Latina teenage suicide. Unfortunately, loss of funding may force the program's closure despite the obviously growing need for these targeted services.

First launched in the Bronx through a grant from the New York Community Trust, *Life is Precious™* works with Latina teens who have either attempted suicide or expressed suicidal thoughts. During its first year and one-half of operation, *Life is Precious™* was successful in preventing further suicide attempts by the almost 100 girls participating in the program.

A federal grant supported by Congresswoman Nydia Velázquez allowed Comunilife to expand the *Life is Precious ™* program to Brooklyn, where it is partnering with Woodhull Medical and Mental Health Center and other local service providers. Of the 200 adolescents younger than 18 seeking emergency help at Woodhull for suicide attempts and suicidal thoughts during 2008, 45% were Latinas.

"We find that culture is a major factor," says Program Coordinator Beatrize Coronel. Unlike American families which often focus on fostering the hopes and dreams of their children, Hispanic culture frequently demands that children – particularly girls – put their responsibilities to family first. In poor, immigrant families, the pressures can be overwhelming. "Rather than go to school, you have to help out in the house, take care of your siblings or serve as a translator for mom," explains Coronel. These demands then clash with the perceived norms of America's youth-focused, consumer driven society, creating additional psychological pressures.

"We provide Latina adolescents - at risk of suicide - a safe and nurturing space, hope, and the tools to become self-confident, discover their 'hidden treasures', enjoy positive family relationships, improve their academic performance, pursue their dreams and become successful Latina women," says Comunilife CEO Rosa Gil. "*Life is Precious™* also provides a supportive environment for their mothers, fathers and siblings, as family is the core of Latino culture."

"It helps you with your emotions and how to talk with your family," said one program participant describing her experience with Comunilife's *Life is Precious™*.

Comunilife is currently seeking ongoing funding from foundations, individual donors and government sources to support continued operation of the *Life is Precious™* program.

Comunilife is a 501-c-3 not-for-profit organization committed to enhancing the quality of life and creating a healthier tomorrow for underserved children, adolescents, adults and families living with special needs in New York City.

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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determine if these denials, in fact, meet the NQTL test. Discovery, review, and analysis of discriminatory medical review issues will be essential.

The Parity Act
and the Challenges it Presents

Much has been accomplished in laying a foundation for future parity work. However, collectively we have only touched a small part of the universe of parity issues that have already arisen or are likely to arise in the future.

There are several operational factors that impede the translation of the Act's potential into reality, including:

1. The actualization of requirements embedded in the complex rules set forth in the IFR is not automatic or straightforward. While the IFR rules are favorable, they do not provide a bright line on the NQTL and scope of practice issues. Hence, these are open to different interpretations by completing stakeholders and will require extensive adjudication by federal and state regulators.

2. Health plans, other than making adjustments to more favorable copays, deductibles, etc., are establishing new or maintaining prior medical management protocols, which, in our view, are not lawful. These plans invariably claim compliance with the Parity Act. They need to be challenged aggressively and most must be handled on a case-by-case basis. We have already been successful with some of these challenges, but it is clear we will have to remain vigilant.

3. The federal agencies charged with compliance and enforcement of the Parity Act are now simultaneously overwhelmed with the health reform provisions of the ACA. Their ability to do the necessary fact-finding and development necessary to perform appropriate reviews is very limited. In order to receive due consideration of an issue by the federal regulators, the advocacy community must fully develop a "case." This is extremely labor intensive and requires a high level of technical expertise.

In summary, the Parity Act requirements represent considerable potential for redress of discriminatory practices by health plans. However, as noted, the process is complex and the amount of work needed to adjudicate disputed matters is considerable.

It is imperative that the mh/sud communities understand the significance the Parity Act can have, and that all of their members monitor the health plans with which they're involved so that infractions can be reported to the regulators and action taken. The website maintained by the American Psychiatric Association and the Parity Implementation Coalition, www.mentalhealthparitywatch.org, provides timely information about the Act and serves as a conduit for asking questions, securing guidance, and reporting issues. We need input from the troops in the field to be able to effectively advocate for enforcement of the Act. We urge you to participate in this process.

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cutting-edge research into this debilitating disorder.

How can I help a friend or relative who is depressed?

If you know someone who has depression, the first and most important thing you can do is to help her get an appropriate diagnosis and treatment. You may need to make an appointment on her behalf and go with her to see the doctor. Encourage her to stay in treatment, or to seek different treatment if no improvement occurs after six to eight weeks.

In addition, you can also: offer emotional support, understanding, patience and encouragement; engage her in conversation, and listen carefully; never disparage feelings she expresses, but point out realities and offer hope; never ignore comments about suicide, and report them to your friend's or relative's therapist or doctor; invite your friend or relative out for walks, outings and other activities; keep trying if she declines, but don't push her to take on too much too soon; although diversions and company are needed, too many demands may increase feelings of failure; and remind her that with time and treatment, the depression will lift.

How can I help myself if I am depressed?

You may feel exhausted, helpless and hopeless. It may be extremely difficult to take any action to help yourself. But it is important to realize that these feelings are part of the depression and do not reflect actual circumstances. As you recognize your depression and begin treatment, negative thinking will fade. In the meantime: engage in mild activity or exercise; go to a movie, a ballgame, or another event or activity that you once enjoyed; participate in religious, social or other activities; set realistic goals for yourself; break up large tasks into small ones, set some priorities and do what you can as you can; try to spend time with other people and confide in a trusted friend or relative; try not to isolate yourself, and let others help you; expect your mood to improve gradually, not immediately; do not expect to suddenly "snap out of" your depression; often during treatment for depression, sleep and appetite will begin to improve before your depressed mood lifts; postpone important decisions, such as getting married or divorced or changing jobs, until you feel better; discuss decisions with others who know you well and have a more objective view of your situation; and be confident that positive thinking will replace negative thoughts as your depression responds to treatment.

Where can I go for help?

If you are unsure where to go for help, ask your family doctor. Others who can help are: mental health specialists, such as psychiatrists, psychologists, social workers, or mental health counselors; health maintenance organizations (HMOs); community mental health centers; hospital psychiatry departments and outpatient clinics; mental health programs at universities or medical schools; state hospital agencies or clergy; peer support groups; private clinics and facilities; employee assistance programs; and local medical and/or psychiatric societies.

You can also check the phone book under "mental health," "health," "social services," "hotlines," or "physicians" for phone numbers and addresses. An emergency room doctor also can provide temporary help and can tell you where and how to get further help.

What if I or someone I know is in crisis?

Women are more likely than men to attempt suicide. If you are thinking about harming yourself or attempting suicide, tell someone who can help immediately.

You should call your doctor; call 911 for emergency services; or go to the nearest hospital emergency room.

For additional help call the toll-free, 24-hour hotline of the National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255); TTY: 1-800-799-4TTY (4889) to be connected to a trained counselor at a suicide crisis center nearest you.

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Updates To Our Winter 2011 Race and Racism Issue

Staff Writer
Mental Health News

Thanks to our attentive readers, several corrections to our Winter 2011 issue (Vol. 13 No. 1) "The Impact of Race and Racism on Mental Health Clients, Practitioners, Organizations, and Delivery Systems," have been brought to our attention.

Due to space constraints, the first seven photos below of the authors, were omitted from the article on page 18 entitled: "Transforming Service Delivery Systems, Organizational and Administrative Structures." The next photo of Robert Hawkins, MPA, MA, PhD was omitted from his article on page 17 entitled: "Building a Race Conscious Research Agenda." The photo after that, of Maurice Lacey, LMSW, MS Ed, was omitted from his article on page 19 entitled: "Challenges of Black Males with Mental Illness." Please also note the following two corrections to the "Anti Racism Recourses" found on pages 38 and 39:

"Ron Chisom, The People's Institute and Me," Gail K. Golden, Ed.D, LCSW

"Guidelines for Choosing Trainers," Gail K. Golden, Ed.D, LCSW

Mary Pender Greene, LCSW-R

Paul Levine, LCSW

Lisa Blitz, PhD, LCSW-R

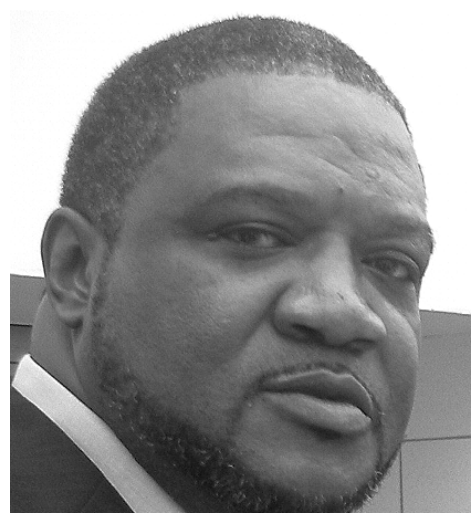
Christiana Best-Cummings, PhD

Phyllis Frank

Elwanda Young, LMSW

Willie Tolliver, PhD, and Steve Burghardt, PhD

Robert Hawkins, PhD, MPA



Maurice Lacey, LMSW, MS Ed

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Credits:

NIMH: "Women and Depression: Discovering Hope" A booklet that describes the symptoms, treatment and factors contributing to depression that are unique to women. http://www.nimh.nih.gov/health/publications/women-and-depression-discovering-hope/index.shtml

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reporters (ibid). However, the inter-rater reliability for this population was the same for the general population when asked the same questions (Read et al. 2005; Mueser et al. 2001). Often, once it was found that a patient suffers from any form of psychosis they were not included in child abuse studies (Read 1997; Herder & Redner, 1991; Mueser et al. 2001). This type of research practice obviously distorts the data of the long term effects of child abuse. Unfortunately it was not until 2004 that large scale research studies started to address the issue of child abuse and psychosis (Read et al. 2005).

Studies have also shown that in patient charts, abuse is not regularly assessed or documented. In one study charts were reviewed to determine if a child abuse history was documented. The patients were then interviewed to determine if they were victims of child abuse. It was found that only 14% of the charts had documented child abuse, but 70% of the patients interviewed reported having been the victims of child abuse (Read, 1997). Due to the aforementioned data regarding the relationship between child abuse and SMI, researchers began to look at the prevalence of PTSD in individuals diagnosed with SMIs (Mueser et al., 2002; Mueser et al., 2001; Frueh et al., 2009). Research show that there is a comorbidity of PTSD and SMI ranging between 29% and 43% (ibid). The prevalence of PTSD in the general population is about 10% (ibid).

In 2009 a study was conducted to determine whether SMI patients in a multisite community mental health clinic met the criteria for PTSD. The study found that 98% of the patients diagnosed with a SMI had a history of trauma; 42% when assessed met the criteria for PTSD (Frueh et al., 2009). The researchers then reviewed the patient's charts to determine how many of the patients had a diagnosis of PTSD. Only 2% of the appropriate patient charts documented a diagnosis of PTSD (ibid). This indicates that clients who meet the criteria for PTSD are not being treated for PTSD, which is obviously problematic. The study also found that most mental health clinicians do not treat the symptoms of PTSD, rather just the symptoms of the SMIs. This is problematic, in that PTSD remains largely untreated and undiagnosed in the SMI population (ibid). It would be like a person having a diagnosis of diabetes and emphysema, and only treating the emphysema.

The Women, Co-Occurring Disorders, and Violence Study (WCDVS) was a large government funded study that aimed to determine the effectiveness of integrated and trauma informed services for women with Co-Occurring Disorders (McHugo et.al, 2005). The data that was gathered from this study has been tremendous leading to many others to examine the data and thus provided the mental health world with important information that can help to facilitate proper mental health treatment to women who have been affected by trauma and stressful life events.

One of the invaluable tools that was gained from the WCDVS was a modified assessment tool that mental health professionals can utilize when assessing clients for trauma and stressful life events. The WCDVS used a modified version of the Life Stressor Checklist Revised (LSC-R) during the study to evaluate a woman's trauma and stress exposure. The LSC-R and the WCDVS version of the LCS-R does not assess for symptoms of trauma or stress rather it asks questions regarding a person's exposure to trauma and stress that the mental health professional can take into consideration when working with the client in determining how these events currently fit into the woman's mental health (McHugo et. al, 2005).

As the statistics show, women are more likely to be victims of both physical and sexual abuse often beginning before the age of 18. Once victimized women are more likely to be re-victimized especially if they have a mental health diagnosis. The research is very clear that these aforementioned forms of trauma have a high correlation with substance abuse and mental health issues. It is clear that in mental health service provision of women, trauma needs to be taken into consideration. It is important for women to be assessed for trauma in order to accurately and appropriately diagnose and thus provide appropriate treatment. The research also shows that women can tolerate a sensitive assessment such as the LSC-R which will enable mental health practitioners to be better informed of a woman's trauma history which may help to understand a woman's symptoms. As mental health professionals we can treat the symptoms that women present with, but we need to ask ourselves: Are we treating the cause?

Understanding Eating Disorders: An Overview from the NIMH

By The National Institute of Mental Health (NIMH)

An eating disorder is marked by extremes. It is present when a person experiences severe disturbances in eating behavior, such as extreme reduction of food intake or extreme overeating, or feelings of extreme distress or concern about body weight or shape.

A person with an eating disorder may have started out just eating smaller or larger amounts of food than usual, but at some point, the urge to eat less or more spirals out of control. Eating disorders are very complex, and despite scientific research to understand them, the biological, behavioral and social underpinnings of these illnesses remain elusive.

The two main types of eating disorders are anorexia nervosa and bulimia nervosa. A third category is "eating disorders not otherwise specified (EDNOS)," which includes several variations of eating disorders. Most of these disorders are similar to anorexia or bulimia but with slightly different characteristics. Binge-eating disorder, which has received increasing research and media attention in recent years, is one type of EDNOS.

Eating disorders frequently appear during adolescence or young adulthood, but some reports indicate that they can develop during childhood or later in adulthood. Women and girls are much more likely than males to develop an eating disorder. Men and boys account for an estimated 5 to 15 percent of patients with anorexia or bulimia and an estimated 35 percent of those with binge-eating disorder. Eating disorders are real, treatable medical illnesses with complex underlying psychological and biological causes. They frequently co-exist with other psychiatric disorders such as depression, substance abuse, or anxiety disorders. People with eating disorders also can suffer from numerous other physical health complications, such as heart conditions or kidney failure, which can lead to death.

Eating Disorders are Treatable Diseases

Psychological and medicinal treatments are effective for many eating disorders. However, in more chronic cases, specific treatments have not yet been identified.

In these cases, treatment plans often are tailored to the patient's individual needs that may include medical care and monitoring; medications; nutritional counseling; and individual, group and/or family psychotherapy. Some patients may also need to be hospitalized to treat malnutrition or to gain weight, or for other reasons.

Anorexia Nervosa

Anorexia nervosa is characterized by emaciation, a relentless pursuit of thinness and unwillingness to maintain a normal or healthy weight, a distortion of body image and intense fear of gaining weight, a lack of menstruation among girls and women, and extremely disturbed eating behavior. Some people with anorexia lose weight by dieting and exercising excessively; others lose weight by self-induced vomiting, or misusing laxatives, diuretics or enemas.

Many people with anorexia see themselves as overweight, even when they are starved or are clearly malnourished. Eating, food and weight control become obsessions. A person with anorexia typically weighs herself or himself repeatedly, portions food carefully, and eats only very small quantities of only certain foods. Some who have anorexia recover with treatment after only one episode. Others get well but have relapses. Still others have a more chronic form of anorexia, in which their health deteriorates over many years as they battle the illness.

According to some studies, people with anorexia are up to ten times more likely to die as a result of their illness compared to those without the disorder. The most common complications that lead to death are cardiac arrest, and electrolyte and fluid imbalances. Suicide also can result.

Many people with anorexia also have coexisting psychiatric and physical illnesses, including depression, anxiety, obsessive behavior, substance abuse, cardiovascular and neurological complications, and impaired physical development. Other symptoms may develop over time, including: thinning of the bones (osteopenia or osteoporosis); brittle hair and nails; dry and yellowish skin; growth of fine hair over body (e.g., lanugo); mild anemia, and muscle weakness and loss; severe constipation; low blood pressure; slowed breathing and pulse; drop in internal body temperature, causing a person to feel cold all the time; and lethargy.

Treating Anorexia involves three components: restoring the person to a healthy weight; treating the psychological issues related to the eating disorder; and reducing or eliminating behaviors or thoughts that lead to disordered eating, and preventing relapse.

Some research suggests that the use of medications, such as antidepressants, antipsychotics or mood stabilizers, may be modestly effective in treating patients with anorexia by helping to resolve mood and anxiety symptoms that often co-exist with anorexia. Recent studies, however, have suggested that antidepressants may not be effective in preventing some patients with anorexia from relapsing. In addition, no medication has shown to be effective during the critical first phase of restoring a patient to healthy weight. Overall, it is unclear if and how medications can help patients conquer anorexia, but research is ongoing.

Different forms of psychotherapy, including individual, group and family-based, can help address the psychological reasons for the illness. Some studies suggest that family-based therapies in which parents assume responsibility for feeding their afflicted adolescent are the most effective in helping a person with anorexia gain weight and improve eating habits and moods.

Shown to be effective in case studies and clinical trials, this particular approach is discussed in some guidelines and studies for treating eating disorders in younger, nonchronic patients.

Others have noted that a combined approach of medical attention and supportive psychotherapy designed specifically for anorexia patients is more effective than just psychotherapy. But the effectiveness of a treatment depends on the person involved and his or her situation. Unfortunately, no specific psychotherapy appears to be consistently effective for treating adults with anorexia. However, research into novel treatment and prevention approaches is showing some promise. One study suggests that an online intervention program may prevent some at-risk women from developing an eating disorder.

Bulimia Nervosa

Bulimia nervosa is characterized by recurrent and frequent episodes of eating unusually large amounts of food (e.g., binge-eating), and feeling a lack of control over the eating. This binge-eating is followed by a type of behavior that compensates for the binge, such as purging (e.g., vomiting, excessive use of laxatives or diuretics), fasting and/or excessive exercise.

Unlike anorexia, people with bulimia can fall within the normal range for their age and weight. But like people with anorexia, they often fear gaining weight, want desperately to lose weight, and are intensely unhappy with their body size and shape. Usually, bulimic behavior is done secretly, because it is often accompanied by feelings of disgust or shame. The binging and purging cycle usually repeats several times a week. Similar to anorexia, people with bulimia often have coexisting psychological illnesses, such as depression, anxiety and/or substance abuse problems. Many physical conditions result from the purging aspect of the illness, including electrolyte imbalances, gastrointestinal problems, and oral and tooth-related problems.

Other symptoms include: chronically inflamed and sore throat; swollen glands in the neck and below the jaw; worn tooth enamel and increasingly sensitive and decaying teeth as a result of exposure to stomach acids; gastroesophageal reflux disorder; intestinal distress and irritation from laxative abuse; kidney problems from diuretic abuse; severe dehydration from purging of fluids

As with anorexia, *Treatment for Bulimia* often involves a combination of options and depends on the needs of the individual.

To reduce or eliminate binge and purge behavior, a patient may undergo nutritional counseling and psychotherapy, especially cognitive behavioral therapy (CBT), or be prescribed medication. Some antidepressants, such as fluoxetine (Prozac), which is the only medication approved by the U.S. Food and Drug Administration for treating bulimia, may help patients who also have depression and/or anxiety. It also appears to help reduce binge-eating and purging behavior, reduces the chance of relapse, and improves eating attitudes.

CBT that has been tailored to treat bulimia also has shown to be effective in changing binging and purging behavior, and eating attitudes. Therapy may be individually oriented or group-based.

Binge-Eating Disorder

Binge-eating disorder is characterized by recurrent binge-eating episodes during which a person feels a loss of control over his or her eating. Unlike bulimia, binge-eating episodes are not followed by purging, excessive exercise or fasting. As a result, people with binge-eating disorder often are overweight or obese. They also experience guilt, shame and/or distress about the binge-eating, which can lead to more binge-eating.

Obese people with binge-eating disorder often have coexisting psychological illnesses including anxiety, depression, and personality disorders. In addition, links between obesity and cardiovascular disease and hypertension are well documented.

Treatment options for Binge-Eating Disorder are similar to those used to treat bulimia. Fluoxetine and other antidepressants may reduce binge-eating episodes and help alleviate depression in some patients.

Patients with binge-eating disorder also may be prescribed appetite suppressants. Psychotherapy, especially CBT, is also used to treat the underlying psychological

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infrequently. Additionally, Hispanic women reported receiving the least emotional and tangible support overall.

The unique stressors that women experience place them at higher risk for experiencing the negative effects in the aftermath of disasters. It is likely that women will continue to put the needs of others ahead of their own and as such, the social networks that do exist for women need to be taken advantage of. As with all disaster survivors, women need to look out for and offer each other support especially in circumstances such as the aftermath of a disaster.

Disaster crisis counselors and mental health professionals should be aware of one of the basic principles of disaster assistance as identified in the Psychological First Aid Field Operations Guide (2006), 'connecting with social supports.' When and where appropriate, disaster survivors should be encouraged to reach out to each other as well as family members and friends who are perceived as supportive. If women seem hesitant to ask for help, turn the example around and ask if they would offer support to others as a way of letting them know that it is ok to ask for assistance. Disaster counselors may assist in bringing women survivors together through homogeneous groups that address their concerns, such as 'talking to children about disasters,' or 'how to return to normal family activities post disaster' as examples. In addition women survivors should also be made aware of the professional services that are available to address the emotional pain of traumatic events. Resources may be found at: www.samhsa.gov/Disaster and www.ptsd.va.gov/. Providers who wish to become trained in post disaster response can take the Psychological First Aid training online for free CEU's at http://learn.nctsn.org/course/category.php?id=11

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Care Monitoring Teams

The Mental Health Care Monitoring Teams (CMTs) were created to do the actual monitoring of service providers, to make sure client needs are being met.

The method is creative and simple. Instead of tracking client compliance (which is difficult, intrusive, and costly), it tracks the client's service use and link it to providers—and reach out to providers, as necessary, to have them reach out to clients.

A vendor, Community Care, was contracted to use Medicaid claims data to identify patterns of service use, and to identify service lapses, which would signal the need for prompt intervention.

The aim of the Mental Health Care Monitoring Initiative is to close gaps in the system by reaching out to providers to encourage them to re-engage clients in treatment, thus improving communication, co ordination and provider accountability.

Notification Flags

Monthly provider reports will list individuals whose patterns of use or lack of use indicate that they are not getting needed services. The patterns, or " flags" include: (1) No psychiatric medication prescriptions filled in the prior 60 days, (2) No community-based treatment contacts in the prior 120 days, and (3) Two or more psychiatric emergency room visits and/or hospitalizations in the prior 120 days.

When these situations are flagged, the monitoring team will consult with the provider about reaching out to the individuals so they don't become lost to the mental health system. These interventions aim to engage the individual in continuing treatment, and to prevent individuals from dropping out of care or from being dropped.

In other words, the goal of the Care Monitoring Teams is to locate, then reach out to "high need" people who have not been getting adequate service, and correct the problem—before people deteriorate to the point that they become a danger to themselves or others.

What Causes Loss of Service?
Some Examples

If Medicaid records show that a psychiatric medication or an antipsychotic has not been dispensed in three months, a Care Monitoring Team intervention is triggered. The investigation may reveal a problem with Medicaid. In that case, the provider is encouraged to help the client solve the problem with Medicaid.

Likewise, if Medicaid records show that the individual has not had any clinic visits in four months, the cause may be found to be that the individual's case was prematurely closed. In that case, the team endeavors to assess risk with the provider and to encourage outreach to the client.

Psychiatric hospitalization, itself a sign of "high need," can further increase the risk of falling through the cracks. The lack of a mailing address may cause vital mail not to reach the individual. The same is true of homelessness and imprisonment. Urgent requests for Medicaid recertification may be missed, causing services to be cut off. No Medicaid? No clinic, and no pharmacy services, either. When Medicaid is cut off, the Care Management Team will reach out to the provider to encourage it to help the client solve the problem with Medicaid, and re-open lines of communication between Medicaid and providers in the community (clinics, drugstores).

Though the initiative focuses on "high-need" individuals, its increased oversight of providers will benefit the entire client community. It will help providers become more efficient and accountable. It will improve service, and make service failures rarer throughout the entire system.

The initiative aims to find providers who give good care, who are helping consumers, and to identify where the system is breaking down. The first Care Monitoring Team started at Kingsboro Psychiatric Center in Brooklyn in October 2009, and a second team began in the Bronx in Fall 2010.

Contact Information

Individuals and family members are encouraged to become an active part of the mental health treatment team, and to reach out to the provider whenever there is a gap in service. In addition, if a provider is failing you or a family member—if your family member has been dropped from his or her program and wants to be reinstated, or if his or her meds have been cut off for no clear reason, or if you or a family member is refused treatment, you are encouraged to contact the NYC Office of Consumer Affairs at 347) 396-7194, or call 1-800- LIFENET.

Nora Weinerth is an independent advocate and consultant with the Office of Consumer Affairs, New York City Department of Health and Mental Hygiene.

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and may also contribute indirectly, by increasing their reactivity to stress (Nolen -Hoeksema, 2001). Furthermore, sexual assault during childhood has been more consistently linked with the gender difference in depression than sexual assault that first occurs during adulthood, and rates of childhood sexual assault are significantly higher for girls (between 7 and 19%) than they are for boys (between 3 and 7%) (Cutler & Nolen-Hoeksema, 1991).

While researchers do not yet understand why girls experience depression more than boys, it has been found that young people with an untreated mental illness may suffer debilitating symptoms during their most productive years, including problems with educational attainment and career and family building (Kessler, Avenevoli, & Merikangas, 2001). Despite these detrimental consequences, depressed adolescents are a largely underserved population that faces multiple barriers to receiving treatment (Mufson, Dorta, Olfson, Weissman, & Hoagwood, 2004; Flaherty, Weist, & Warner, 1996).

We are currently conducting a study to evaluate the effectiveness of a preventive Cognitive Behavior Therapy (PCBT) program among teenage girls and boys who may be vulnerable to depression (due to the fact that a parent has experienced depression) at Columbia University/New York State Psychiatric Institute. CBT is a psychological therapy that has been found to be helpful in treating depressed children and adolescents. CBT is designed to address unhelpful thinking patterns and ways of behaving that contribute to depression. If you are interested in participating in the study (HAPPY Study: Helping Adolescents stay Positive and Prevent depression in their Youth), we are looking for adolescents ages 12 to 18 who have a parent who has experienced depression. We are comparing PCBT to study skills training. Adolescents will have a free depression screening, participate in a MRI scan, and will be randomized to participate in either 12 weeks of PCBT or 12 weeks of study skills.

In sum, we are currently studying how to prevent depression in adolescence as well as how to prevent depression from continuing across generations in families. This research is particularly important for adolescent girls given what we know about depression. For more information about the study, or if your family is interested in participating, please contact the HAPPY study: Dr. Rachel Jacobs and Dr. Karen Shoum at 212-543-5187 or jacobsr@childpsych.columbia.edu and shoumk@childpsych.columbia.edu.

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can make decisions for the person even if and when the person disagrees with the decision.

Like Health Care Proxies and the Family Health Care Decisions Act, under New York Law, a Guardian cannot make psychiatric decisions for a patient over their objection. Only a psychiatric hospital can involuntarily hospitalize someone and only a Court can order treatment over a person objection.

Psychiatric Case Management or Geriatric Care Manager

A Psychiatric Case Manager or Geriatric Care Manager is someone specially trained, generally a social worker or a nurse, who can assist on a daily basis with the logistics of overseeing the care, interventions or management of an individual with serious mental illness or Autism Spectrum disorder. They often can most efficiently and effectively monitor and make active the proposed psychiatric and/or medical care plan as well as keep a close eye out for financial management in the best interest of the individual or potential financial abuse, and intervene timely and appropriately.

Conclusion

Mother's who have cared for their differently abled child all their lives must plan in advance of their declining years to ensure that their child will have someone to make the decisions they no longer can. It is important to talk with your child to see what it is they want, and what it is they can handle on their own. Some children may be perfectly capable of handling their medical and psychiatric care and only need some help for financial matters, others cannot. It is also helpful to contact a legal specialist in this area, for example a mental health attorney, who is familiar with mental health issues and has the specific experience to advise and guide a mother through an often extremely difficult and confusing array of options.

System Reform from page 16

(18% rated this "very/somewhat likely" to use).

A recent Rand Report found about one -fifth of all service members returning from Iraq and Afghanistan screen positive for mental health problems, and that multiple barriers prevent about half from seeking the information and care they require. These barriers include "perceived stigma, physical access barriers, and limited resources."

The T2 Virtual PTSD Experience is a self-guided exploration which immerses the visitor in a simulated combat-related traumatic event to demonstrate how PTSD may be acquired, its triggers, the role of avoidance, and the "use of time outs" through a series of interactive activities controlled by the visitor. It is anonymous, available anytime and free of charge.

Preliminary research has shown it is a significant adjunct to web-based resources and face-to-face care. Future applications could include suicide prevention, how to avoid substance abuse and sexually transmitted diseases, pregnancy, etc. among teens and pre-teens.

Remote Job Skills Training

While distance learning has been around for many years, we are just beginning to explore its full potential for vocational training at group and private homes with special needs populations (e.g. Autism Spectrum Disorders/ Asperger's Syndrome, mild Mental Retardation, and the physically challenged).

The Center for Career Freedom began handing out webcams to those students who lived too far away to come to our Microsoft Office training classes every day and to student in group homes who had difficulty accessing the proper transportation. The webcams enabled folks to participate in live interactive classes from the comfort of their own home, regardless of the weather. Facial expressions are clear, through the audio can have a slight delay and there are a few "bugs" that need to be worked out. Files are easily transmitted including templates, completed work, quizzes, teacher feedback, etc.

Cameras run from $20 - $80. Skype.com provides free 1:1 video services. Other applications we are exploring include: staff training, family video visits, building your on-line community, "Town Hall" meetings, health screening, and dispute resolution.

We may agree challenging times requires innovative thinking (creative problem solving, new tools, experimentation, pilot studies, etc.) but I believe the most effective and efficient solution(s) will be found by providers who have the skills to listen and learn from their clients and the courage (and funding) to turn "solutions" into action.

Publisher's note: This is Don's final column for Mental Health News. He is busy launching the Center for Career Freedom's Microsoft Office Skills Employment Program for persons with mental and physical disabilities. We wish him all success.

Latinas from page 25

to speak openly about sexual traumas, out of fear of being disloyal to the family or being perceived by their community as disloyal.

PTSD symptoms of avoidance and hyper-vigilance may cause women to terminate treatment prematurely. A client who is normally very compliant may avoid sessions once she is processing her trauma(s) (Davis et. al. 2008). Hispanic women may experience this in a more conflicting manner. On the one hand, they want to avoid painful feelings, yet they want to uphold the cultural value of "saving face." Case in point, as a child, Tanya, now 33, was sold for sex by her mother, enabling her mother to purchase drugs. As our work intensified, Tanya began to skip sessions. When this avoidance was addressed, Tanya said "I did not want to disappoint you." She valued me as her therapist and thought I would be bothered by her not wanting to explore her trauma. Clients may also dread the realistic fear that hyper-arousal symptoms will resurface or get worse as the treatment progresses. A mother's symptoms of hyper-vigilance, which had dissipated, resurfaced when she became increasingly concerned about her daughter. The mother's fear that someone would break into her home caused her to sleep with a knife under her pillow. This was her way of gaining back control.

Other barriers to accessing treatment for a Latina survivor of trauma include a lack of therapists who speak her native language, ineligibility for services, active self-mutilating behaviors/being actively suicidal and past or current substance abuse (Davis et. al. 2008). Dealing with one's trauma(s) can trigger a relapse, as can any crisis. An example is Alma's grief over the death of her 21 year-old nephew, who hung himself. During stressful times, Alma's unresolved grief compelled her to consume more alcohol to escape painful emotions. Another example is a mother who resumed drugs when she realized her daughter's hypersexuality mirrored her own behavior that resulted from her traumas. An additional obstacle is that the therapeutic relationship is built on trust, and a Latina's traumatic history can make establishing such a rapport difficult. Hispanic women who have experienced sexual traumas and whose perpetrators were men will have an extremely hard time opening up to male therapists, if at all.

When treating Latinas with traumatic histories, clinicians must take into account the aforementioned barriers. The following are practice considerations when working with Hispanic women: 1) When a Latina's sessions revolve around her children, the therapist must acknowledge the importance of her family, while assessing whether her focus is resulting from avoidance. 2) An Hispanic client who lacks childcare may need the therapist to help her obtain childcare. Or, the therapist may postpone dealing with emotionally laden issues while waiting for such services. 3) In order to remove the burden of traveling with limited finances, the therapist might consider home visits. 4) The therapist must uphold the Latino value of "respeto" (not bringing shame to one's family/community) that a Hispanic woman may feel when processing her trauma. Of equal value is acknowledging that silencing painful traumas will not help her feel better. 5) A woman receiving Trauma-Focused Treatment must be informed that she will likely feel worse before she feels better. A Latina experiencing avoidance may feel the double bind of not wanting to deal with the pain of the trauma and not wanting to disappoint her therapist. The therapist will need to acknowledge this and possibly allow the processing of the trauma to slow down. As therapists, we must commend Latinas who, despite all these barriers, are able to effectively process their traumas.

Understanding from page 8

rate, brain wave patterns, and internal biochemistry. When a stressor is time limited, our bodies return to their usual state. Ongoing stress can produce what Herbert Benson MD calls a "pathological stress response" where these physical changes persist. A mother constantly experiencing pathological stress can have more frequent illness due to a depressed immune system, depression, anxiety, physical problems such as headaches and stomachaches, and even decreased fertility. Being overly stressed can make her more likely to overreact.

Based on my work with many Moms, there are strategies that help, even if they don't solve the underlying situation. Combating isolation is critical. A support group can be important to counter her sense of alienation. Other Moms who know of resources, strategies and tips for managing school, home and family issues are invaluable and give hope. If this kind of support group doesn't exist, a professional, organization or even religious group might help form one. Friends can be helpful if Mom can reach out and let them know how to be helpful, whether by providing emotional or logistical support or simply time out from worrying. Mental health providers working with the child should communicate empathy and understanding; parents can feel less defensive and more open to change. The feeling of distance or even blame only intensifies the stress and the reactions to stress that are detrimental to all involved.

Therapy can be important in bringing together parents, or parents and children, in a constructive way. Marital therapy can help address the differences in roles and perceptions between the Mom and Dad. It can help him understand the illness if he doesn't and take a more active role so the mother is less burdened (and resentful). The parents can become a team. Family therapy can validate the feelings of siblings, and address family issues exacerbated by having a child with such strong needs. Therapy for the mother can help her with self-blame and provide a more balanced understanding of the situation.

Moms often put their own needs last on their "to-do" lists; they are often "running on empty." Outside activities that refuel her, such as exercise, yoga or music can be a break, give some pleasure, and a sense of having a part of life independent of being a caretaker. Mindfulness meditation can lower the baseline level of stress and diminish the ongoing level of the stress response.

Having worked with the hundreds of mothers I've seen in my 25 years of practice, unfortunately what I've described here is commonplace. I've seen them worn down and in tears when they feel someone "gets it." I've seen Moms who feel helpless and hopeless about having life improve. Some respite services are now available, but unfortunately, many mothers hesitate to be open about their needs. They fear looking inadequate or out of control. One Mom used the image of a duck to express how she felt: from the surface it looks like it's gliding along, but it's paddling furiously underwater. It's important to remember that Moms in particular need the encouragement of families, friends and professionals to meet their own needs, to have stamina and the calm to persevere.

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issues associated with binge-eating, in an individual or group environment.

FDA Warnings On Antidepressants

Despite the relative safety and popularity of SSRIs and other antidepressants, some studies have suggested that they may have unintentional effects on some people, especially adolescents and young adults. In 2004, the Food and Drug Administration (FDA) conducted a thorough review of published and unpublished controlled clinical trials of antidepressants that involved nearly 4,400 children and adolescents. The review revealed that 4% of those taking antidepressants thought about or attempted suicide (although no suicides occurred), compared to 2% of those receiving placebos.

This information prompted the FDA, in 2005, to adopt a "black box" warning label on all antidepressant medications to alert the public about the potential increased risk of suicidal thinking or attempts in children and adolescents taking antidepressants. In 2007, the FDA proposed that makers of all antidepressant medications extend the warning to include young adults up through age 24. A "black box" warning is the most serious type of warning on prescription drug labeling.

The warning emphasizes that patients of all ages taking antidepressants should be closely monitored, especially during the initial weeks of treatment. Possible side effects to look for are worsening depression, suicidal thinking or behavior, or any unusual changes in behavior such as sleeplessness, agitation, or withdrawal from normal social situations. The warning adds that families and caregivers should also be told of the need for close monitoring and report any changes to the physician. The latest information from the FDA can be found on their Web site at www.fda.gov.

Results of a comprehensive review of pediatric trials conducted between 1988 and 2006 suggested that the benefits of antidepressant medications likely outweigh their risks to children and adolescents with major depression and anxiety disorders.28 The study was funded in part by the National Institute of Mental Health.

How Are Men And Boys Affected?

Although eating disorders primarily affect women and girls, boys and men are also vulnerable. One in four preadolescent cases of anorexia occurs in boys, and binge-eating disorder affects females and males about equally.

Like females who have eating disorders, males with the illness have a warped sense of body image and often have muscle dysmorphia, a type of disorder that is characterized by an extreme concern with becoming more muscular. Some boys with the disorder want to lose weight, while others want to gain weight or "bulk up." Boys who think they are too small are at a greater risk for using steroids or other dangerous drugs to increase muscle mass.

Boys with eating disorders exhibit the same types of emotional, physical and behavioral signs and symptoms as girls, but for a variety of reasons, boys are less likely to be diagnosed with what is often considered a stereotypically "female" disorder.

How Are We Working To Better Understand And Treat Eating Disorders?

Researchers are unsure of the underlying causes and nature of eating disorders. Unlike a neurological disorder, which generally can be pinpointed to a specific lesion on the brain, an eating disorder likely involves abnormal activity distributed across brain systems. With increased recognition that mental disorders are brain disorders, more researchers are using tools from both modern neuroscience and modern psychology to better understand eating disorders.

One approach involves the study of the human genes. With the publication of the human genome sequence in 2003, mental health researchers are studying the various combinations of genes to determine if any DNA variations are associated with the risk of developing a mental disorder. Neuroimaging, such as the use of magnetic resonance imaging (MRI), may also lead to a better understanding of eating disorders.

Neuroimaging already is used to identify abnormal brain activity in patients with schizophrenia, obsessive-compulsive disorder and depression. It may also help researchers better understand how people with eating disorders process information, regardless of whether they have recovered or are still in the throes of their illness.

Conducting behavioral or psychological research on eating disorders is even more complex and challenging. As a result, few studies of treatments for eating disorders have been conducted in the past. New studies currently underway, however, are aiming to remedy the lack of information available about treatment.

Researchers also are working to define the basic processes of the disorders, which should help identify better treatments. For example, is anorexia the result of skewed body image, self esteem problems, obsessive thoughts, compulsive behavior, or a combination of these? Can it be predicted or identified as a risk factor before drastic weight loss occurs, and therefore avoided?

These and other questions may be answered in the future as scientists and doctors think of eating disorders as medical illnesses with certain biological causes. Researchers are studying behavioral questions, along with genetic and brain systems information, to understand risk factors, identify biological markers and develop medications that can target specific pathways that control eating behavior. Finally, neuroimaging and genetic studies may also provide clues for how each person may respond to specific treatments.

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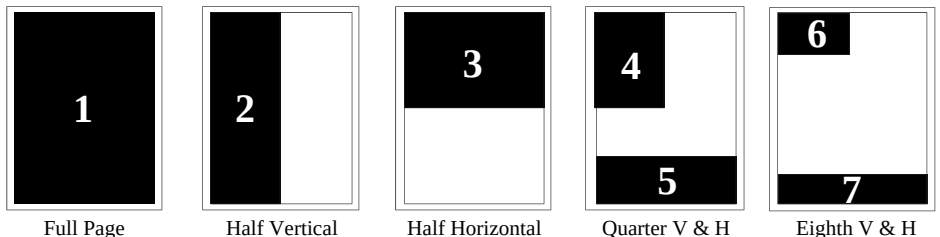

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