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Medical Updates



Planning to Prevent Behavioral Emergencies

by Gregory Miller, MD, Medical Director for OMH Division of Adult Services; and Lloyd Sederer, MD, OMH Medical Director

From time to time, people with mental illness can experience a “behavioral emergency.” This means that their safety and that of others requires immediate intervention. When emergencies happen, a doctor’s decision to give a medication is a difficult medical judgment. In this article we want to talk to recipients of mental health services and discuss that difficult moment and decision.

Collaboration is **always** the better path. We can plan collaboratively, even for emergencies.

Collaborate to Prevent:

Behavioral emergencies don’t come out of the blue. For the consumer, painful feelings that don’t go away are a common warning sign. Collaboration here means involving supportive people, like your treatment team or peers. It is best to make a plan that will help you feel better **before** an emergency happens. Here’s how you can make a plan:

- **Identify triggers:** Make a list of stresses that cause you to feel upset. Common triggers are disagreements with others; disappointments; loss of a relationship or work; feeling misunderstood; or feeling confused. After you make your list share it with others whom you trust. Then review the list with your doctor or counselor so they too can help you prevent a crisis.
- **Identify remedies:** Make a list of what helps you to feel calmer during tough times. Remedies might involve finding a soothing place, such as a favorite room or a quiet setting; talking to someone you trust; pushing yourself to get involved in activities that divert your attention from worries; or taking a medication to calm down. When you and everyone around you know upfront what the triggers and remedies are, together you can use them to quite yourself.
- **Communicate:** Effective plans require communication. Talk to others, peers and counselors, early on when you feel bad. Tell them that it is time you put your remedies into action. You are the best judge of how you feel. Don’t hesitate to get others who can help involved - as early as possible.

Collaborate to Anticipate:

Plan ahead for the possibility of an emergency. That way you can

voice your preferences about how you want an emergency handled.

- **Anticipate:** During times when you are not in crisis and doing well, discuss with your doctor or counselor what to do in an emergency. That way your doctor knows what you want; how else would he or she know? The conversation itself will help you to know what to do if an emergency happens. If you have not done this before an emergency, try to have this conversation after an emergency so you use that moment to learn and have others learn as well. In hospitals, this discussion is called “de-briefing”. It is a special opportunity for mutual problem solving.
- **Advance Directives:** Psychiatric advance directives are written, legal documents where you record your preferences for how a behavioral emergency should be managed. With an Advance Directive you can also assign a family or friend as a “proxy” decision maker to participate in treatment decisions if you cannot. Every state has a different legal process for creating advance directives. For more information check out [The National Resource Center on Psychiatric Advance Directives website](#) .

Recovery is possible but it takes work – and it takes collaboration because everything is better when we get trustworthy and caring people involved. Successful recovery includes anticipating and planning for tough times. A good plan improves your response to crisis and your chances for a successful recovery.

Deadly consequences: why we need to integrate health and mental health

by Lloyd Sederer, MD, OMH Medical Director

Roger Craig was 38 when he died. His age and his weight doubled from the time he had his first psychotic break when still in high school. His illness was later diagnosed as bipolar disorder and he struggled with it until he died of a sudden cardiac attack one evening in 2007 in his parents' home. But it was not his bipolar illness or suicide -- which we often consider the cause of death in people with a serious mental illness (SMI) -- that killed him. It was heart disease, the greatest killer of all (in the USA). But it took his life a good 30 or more years earlier than someone who does not have SMI.

At 6'4" Roger could almost carry the additional 150 pounds he gained. That is, carry it on his large and formerly athletic frame. But his arteries, heart and lungs (which had trouble breathing at night, a condition called sleep apnea that is highly related to weight) could not stand the strain. His loss is like too many others who suffer SMI and die too young of the chronic diseases that afflict us all.

Alarming evidence has emerged in recent years, that adults with serious mental illness die on average 25 years earlier than the general population. For a decade or two before their demise they suffer from early onset diabetes, high blood pressure, heart and lung disease and cancer. Why? Their habits place them at great risk for these conditions. They eat poorly, are sedentary and don't have a primary care doctor -- or if they do they don't go and get preventive and ongoing physical healthcare. They smoke heavily, with more than three out of four being nicotine dependent.

The psychiatric medications many receive for their mental illnesses increase the likelihood of weight gain, diabetes and cardiovascular disease. Mental health professionals have discovered what the Craig family painfully learned: physical disability and early death add to the burden of mental illness for those affected *and* their families. The burden does not stop there since our health care system shoulders the extraordinary health costs of this high need population.

What can be done? A lot.

We have to start early. Mental illness itself starts early, with half of all mental disorders appearing by age 14 and three-quarters by 24 (these are the ages when the illnesses begin, though it is typically many years before the problem behaviors are understood, diagnosed and treated).

We have to diagnose before we can treat. In 2006, the American Academy of Pediatrics (AAP) released a practice toolkit for doctors called *Feelings Need Check Ups Too*. Last year, AAP released a report defining what pediatric primary care physicians need to know about mental health care since most children with mental illness are seen in pediatric primary care, not in specialty mental health settings. Once diagnosed these children require early intervention with treatment programs that stress education and work as the goals of care, and skill-building to achieve those ends and prevent disability. This is the mental health side of the equation.

From the health side for youth, it is easier to prevent weight gain and nicotine dependence than it is to rid ourselves of these conditions after they have already damaged the body's metabolism and polluted the lungs with carcinogens. Activity, nutrition and smoking prevention need to become essential elements of integrated medical and mental health care. Finally, we now know that in as few as 12 weeks that second generation antipsychotic medications (olanzapine in particular) can produce unhealthy changes in lipid levels and the functioning of insulin in young bodies putting them at risk for the chronic diseases that can erode the quality of their lives and kill them

prematurely. All medications have benefits and risks; this is not a call for not using medications but a call for using them judiciously: psychiatric medication prescribing must follow principles of no more than one drug (if possible), at the minimally effective dose and only for as long as needed.

Adults with SMI typically lack what our health care system now aspires to achieve: a medical home. Their primary site for treatment of their principal medical condition, namely a mental illness, is a mental health clinic, where medical care, even medical attention to basics like smoking, blood pressure and weight, has traditionally been someone else's business. Primary care settings that welcome people with SMI, and effectively engage them in smoking cessation, diet and exercise as well as proper care of any physical health condition are *really* hard to find. The answer, easy to say but *very* difficult to achieve, is the integration of health and mental health. What is needed are integrated health and mental health medical homes.

The critical principles of a medical home include: ready access to care, an ongoing relationship with a personal (primary care) physician, attention to the whole person, a team approach to care, a commitment to measuring and improving quality, and coordinated and/or integrated care. In an effective medical home, the primary care physician coordinates the work of a team of clinicians. For most adults, and almost all youth, with mental illnesses like depression, ADHD, and anxiety disorders, their "point of care" is the primary care, or family, practitioner. But people with a SMI will need something different. Their primary attachment is a mental health clinic which, through its psychiatrists and other clinicians, will need to take on basic tasks of measuring health indicators, providing wellness and prevention services, coordinating care and working closely with primary care practitioners to ensure that patients get what they need.

Early last year OMH implemented health monitoring in all its 66 statewide outpatient clinics. Adults are monitored every three months for blood pressure, BMI and smoking -- and youth for BMI, smoking, activity and alcohol and drug use. We have developed wellness programs to offer solutions to individuals who make health a part of their recovery.

Innovators exist who are integrating health and mental health. Some are doing so with the primary site being medical and some where the primary site is mental health: we need both. Maimonides Hospital in Brooklyn has co-located a primary care clinic with a state mental health outpatient clinic and has a Federal grant to develop a model and standards for mental health medical homes. Group Health of Puget Sound has been a leader in integrating primary care with mental health, especially in the diagnosis and treatment of

depression. Intermountain Healthcare in Salt Lake City has what it calls *Mental Health Integration* where both health and mental health are provided in the same site, to the satisfaction of patients and providers. Six chronic disease demonstration projects are underway in New York State where partnerships between mental health and health providers (led by the former!) will work with individuals with serious mental illness and chronic physical disorders towards stabilizing their conditions, improving their health and diminishing their taxpayer burden since these recipients all are on Medicaid.

But we are just getting started. Health reform will open paths for integration, and we would do well to search for and travel them. Imagine if Roger Craig had been treated differently from the time he was an adolescent. He might be alive today. While it is sadly too late for the Craig family, I know they would have some solace in knowing that integrating health and mental health will allow others to not suffer the same fate that he did.

This article originally appeared in the May 11, 2010 Huffington Post.

Ensuring a System Responsive to Need

Meet the Newest Members of the Mental Health Services Council

The Mental Health Services Council plays a crucial advisory role to our State on matters related to improving mental health services. It advises OMH on the establishment of statewide goals and objectives for services and supports. It also reviews prior approval applications (for examples, a change in bed capacity) and proposed rules and regulations.

The Council consists of the Commissioner of Mental Health, the Chairman of the Conference of Local Mental Hygiene Directors, in addition to 26 members appointed by the Governor with the advice and consent of the State Senate.

The Chair of the Council is Dr. Jeffrey Borenstein, the chief executive officer and medical director of Holliswood Hospital in Queens and host of the public television series, *Healthy Minds*. In April, Dr. Borenstein welcomed four new members to the Council following their appointment by Governor Paterson and confirmation by the State Senate.

- **Todd Benham, PsyD**

A former Army Medical Services Corp Major, Dr. Benham is the Chief of the Behavioral Health at Fort Drum, where he has responsibility for overseeing clinical and administrative operations for timely and accessible behavioral health, substance abuse, domestic abuse and traumatic brain injury

services for about 42,000 Soldiers and beneficiaries assigned to the Fort Drum 10th Mountain Division that serves in Afghanistan and Iraq. In 2007, he served as a PTSD Working Group subject matter expert for the U.S. Army Surgeon General. Instrumental in building a strong partnership between the military and civilian regional health care sectors, Dr. Benham has overseen an expansion of services and supports at Fort Drum in response to the behavioral health needs of Soldiers and their families.

Dr. Benham earned his doctoral degree in clinical psychology from the Biola University Rosemead School of Psychology and his bachelor's degree in psychology from Northwestern College. Before being assigned to Fort Drum, he completed his psychology internship at Tripler Army Medical Center in Hawaii.

- **Janice L. Cooper, PhD**

Currently the Interim Director of the National Center for Children in Poverty (NCCP), Dr. Cooper is a health services researcher who specializes in the social-emotional well-being of children and youth. Among her research interests are quality of care for children and youth, social-emotional wellbeing for young children, cultural and linguistic competence and mental health financing. Since 2005, she has led the work of "Unclaimed Children Revisited," a series of policy and impact analyses of mental health services and supports for children, youth and their families. In addition to having teaching responsibilities at the Mailman School of Public Health, Columbia University, Dr. Cooper serves on the Board of Advisors for Community Alliance for the Ethical Treatment of Youth (CAFETY). She previously served as a board member of the American College of Mental Health Administration (ACMHA) and has served as an advisory board member for the Sesame Workshop "Families Stand Together" project, which focuses on healthy coping during tough economic times.

Dr. Cooper holds a doctorate in health policy from Harvard University, where she was an Archibald Bush Foundation Leadership Fellow and a fellow in medical ethics at Harvard Medical School. She also holds undergraduate and graduate degrees from the University of Essex, Colchester, England, and Columbia University.

- **David Hamilton, PhD, LMSW**

Dr. Hamilton serves as Executive Secretary to the State Boards of Social Work and Mental Health Practitioners for the

Office of the Professions in the New York State Education Department. In this capacity, he works with the Board of Regents, which has the legal authority for the licensure, practice, and discipline of individuals in the “learned professions.” Before joining the State Education Department, Dr. Hamilton was the associate director for Catholic Charities for the New York State Catholic Conference and he also worked in several capacities for the New York State Chapter of the National Association of Social Workers, primarily in the areas of lobbying, political action and professional ethics.

Dr. Hamilton received his bachelor’s degree in psychology from Loyola Marymount University, a master’s degree in social work from the University of California at Los Angeles, and his doctorate in social work from Virginia Commonwealth University.

- **David Kaczynski**

Mr. Kaczynski is executive director of New Yorkers for Alternatives to the Death Penalty (NYADP) and the brother of Theodore Kaczynski—the so-called Unabomber—who was arrested in 1996 after Mr. Kaczynski and his wife approached the FBI with their suspicions that Theodore might be involved in a series of bombings that caused three deaths and numerous injuries over 17 years. In 1998, Mr. Kaczynski and his wife received a \$1 million reward from the Justice Department for their role in the Unabom investigation, which they subsequently dedicated—minus attorney’s fees and taxes—to the victims and their families.

In his work with NYADP, Mr. Kaczynski advocates for effective, rational, and humane approaches to the problem of violent crime in a time when the death penalty has been abolished. NYADP collaborates with crime victims, members of law enforcement, families of persons who are incarcerated, mental health advocates, clergy and others to promote community initiatives that address the root causes of violence and that provide meaningful assistance to those directly affected. He is the author of a chapter titled “Missing Parts” in *Brothers: 26 Stories of Love and Rivalry*, published by Jossey-Bass. Mr. Kaczynski received his bachelor’s degree in English from Columbia University.

Other members of the Council include: Lori Accardi, LMSW; Sigfrido Benitez, Kunsook Song Bernstein, PhD; Mantosh J. Dewan, MD; Philip Endress, LCSW; Mark H. Fuller, MBA; Sherry Grenz, Eli B. Hoch, PhD; Commissioner Hogan, Thomas E. Holt, John Kastan, PhD; Diane Lang, Glenn Liebman, Luis Marcos, MD; Steven Miccio,

Grant Mitchell, MD; Neville Morris, Stephanie Orlando, Kathleen Plum, PhD; Richard Rosenthal, MD; Moira A. Rynn, MD; Euphemia Strauch, MSW; and Katherine Suhr.

From the Field



[Enlarge](#)

Public Management Institute: What does this program mean for you and me?

by Constance Bowers—Hudson River Field Office

The Public Management Intern (PMI) program is a two year program that prepares participants for management positions of increasing responsibility within state agencies. For me these two years have gone by very quickly. Finishing up the program this month provides an opportunity to look back and consider what an excellent opportunity it has been to learn both the duties of a job as well as the intricacies of the system in which the job exists. The program has offered me the opportunity to grasp more fully the foundational basis for agency operations, to develop an understanding of the challenges faced by counties and non-profits, and to understand the extent and importance of my role in the context of other agency activities.

The PMI program has a few different components which include: placement at a host agency, rotational assignments, and workshops that provide various opportunities for learning and growth. My placement over the past two years has been with the Office of Mental Health at the Hudson River Field Office located in Poughkeepsie, NY. Through this placement I have gained an appreciation for service to those who have a mental health diagnosis and their ability to recover. I understand the importance of our system as a safety net for the public through provision of services through programs such as Personalized Recovery Oriented Services (PROS). Through a rotational assignment within our licensing unit, I was able to see first hand, how a clinic operates and how such services assist our recipients in maintaining healthy lifestyles within the community.

Although I am technically assigned to the fiscal unit in the Field Office, the experience of working in the licensing unit enabled me to more clearly see how my role supports the program and licensing staff in the office, as well as the agencies and non-profits in the community. I was able to help agencies to maximize the use of existing resources to ensure integral service provision.

Another important aspect of the program included the opportunity to complete externships in the OMH Central Office of Financial Management and in the Westchester County Fiscal Department. This multi-tiered approach to training helped me to see the working relationship between Field Office and Central Office and how both these offices interact with county and provider level fiscal operations.

Workshops offered by the PMI program enabled me to better work with my co-workers. I learned that people have different strengths and it is important to build on those strengths so that agency objectives are achieved by a team that capitalizes on everyone's skills. Participation in the workshops has also allowed me to develop an understanding of the foundational basis for mental health operations through activities such as the discussion of Article XVII section 4 of our state constitution which says that: "the care and treatment of persons suffering from mental disorder or defect and the protection of the mental health of the inhabitants of the state may be provided by state and local authorities...".

Field Office Director's Note: Constance is graduating from the PMI program this month and will join the ranks as a full-fledged fiscal analyst. Her placement with the office as a PMI has provided a unique opportunity to add a staff person who has had the benefit of a comprehensive education and training program. This makes a significant difference in how she approaches and completes her assigned tasks. We are very pleased that we could participate in this program. It allows employees to more fully contribute to the office they are assigned, to assist with the attainment of the agency mission and enhances public service overall.

OMH News is published monthly for people served by, working, involved or interested in New York State's mental health programs. [Contact the editor.](#)

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