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Medical Updates



The Psychology of Resilience

by Lloyd I Sederer, M.D., OMH Medical Director

Why is it that two boys from the same desperate, impoverished and dangerous neighborhood -- be it Watts, Bedford-Stuyvesant or downtown Detroit -- can turn out so differently? One is using drugs and committing petty crime by the age of 12, and in prison for a violent offense by 20; the other stays in school, attends college, gets married and finds employment?

Why is it that in wake disasters such as 9/11 and Katrina, some who were directly affected suffer terrible PTSD (post-traumatic stress disorder), depression, alcohol and drug abuse while others feel distress yet go about rebuilding their lives, families and communities? Why is it that some soldiers deployed, even for multiple tours, in Iraq and Afghanistan, develop severe psychological problems while others go about their lives and their missions and return home never forgetting but not impaired by the horrific exposure they have had?

Perhaps the best concept we have to explain such radically different responses to extraordinary, even life threatening, stress is called *resilience*. Resilience is a term that originates from physics and refers to the capacity of a substance to return to its original state after being subject to intense levels of pressure, heat or other external force. What a great term for human nature to adopt. It conveys a capacity to return to what was after experiencing trauma, tragedy, life threatening danger, persistent adversity or all of these profound and too often inescapable fates that humans encounter. Sometimes resilience is called adaptation, but resilience has a dynamic feeling to it, a sense that we all can tap into properties that enable us to rebound to where we were before misfortune, natural or manmade, strikes.

I had the privilege of recently participating in a small conference hosted by the Columbia University/Mailman School of Public Health, where Dr. Linda Fried is dean and Dr. Sandro Galea and Dr. Thomas D'Aunno are leaders in departments whose work focuses on the topic of the meeting, "Resilience in the Face of Adversity." (*Disclosure: I hold my university faculty appointment at this school.*) The Mailman School recognizes that a field of public mental health is emerging and that Columbia and its experts must aim to serve in a leadership position to advance public mental health. We all understand public health, with its honored traditions of reducing neonatal and maternal death and childhood infectious illnesses, containing diseases like tuberculosis, AIDS and avian flu, promoting nutrition and sanitation and in recent times focusing upon chronic illnesses like heart disease,

diabetes and asthma.

But what too few people appreciate is that principles of public health apply to mental health: focus on a health problem with profound quality and/or duration of life consequences affecting large numbers of individuals; identify scientifically proven interventions that can be feasibly and effectively delivered to that population; mobilize a campaign to reduce the impact of that problem (which includes public education, community engagement and methods of prevention or treatment); and measure to see if what the campaign purports to be doing is being accomplished. The Columbia meeting was a needed step in establishing that resilience is central to improving the public mental health, much like immunity has achieved that status in public health.

We now have a sound scientific base about disaster and trauma. We know, for example, that in disasters the greater the degree of exposure to the horror and danger during and after an event the greater the risk of post-traumatic psychological disease. We know that supportive families and cohesive communities reduce the risk of developing mental disorders while fostering resilience.

Problem-solving help -- not merely emotionally expressive therapies - - that conveys a spirit of hope and belief that something can be done are what people need in the wake of catastrophe, acute or chronic. Belief in something bigger than oneself strengthens both individuals and families, and promotes recovery. Helping others helps. Seeking meaning, even in the darkest of moments (as documented by concentration and prisoner of war camp survivors), can be sustaining. And, very recently, we are discovering the neurobiological correlates of resilience.

A colleague, Dr. Glenn Saxe, discovered that children with severe burns given higher doses of morphine had fewer problems with post-traumatic symptoms, like low mood, anxiety and flashbacks. This finding that we can mitigate how brain neurotransmitters process and encode traumatic experiences has led the military to explore a similar approach in wounded soldiers and may be applicable in emergency rooms for victims of trauma, assault and rape.

Troubled and threatening communities are pervasive throughout the world. Natural disasters strike without regard to who will be affected or when. Man-made trauma such as war, domestic abuse, crime and violence, genocide and terrorism, are our contemporary demons. We are not on the cusp of eliminating these modern day plagues as we have with polio and smallpox. But we have a growing body of science

and practice that informs us about how to prepare for disaster and trauma, how we must respond in its immediate aftermath, and how we can promote recovery in impacted individuals and communities. The core concept for policy and practice is resilience and its field of study is public mental health.

This column originally appeared in the September 23, 2010 Huffington Post.

Supporting Recovery for Adults

Career Development Initiative: A Creative Approach to Employment Possibilities

by John Allegretti-Freeman, LCSW-R

In “Achieving the Promise” (July 2003) the President’s New Freedom Commission reports that individuals with psychiatric disabilities are among the least likely to obtain employment opportunities. The national employment rate for these individuals tends to hover around 15% regardless of what services are provided despite the fact that about 70-85% of these individuals report a desire to work. Employment numbers for those receiving SSI/SSD for psychiatric disability have been reported at 5.5% nationally. The barriers to employment are huge and include financial disincentives, stigma, and perceived limitations.

Joe Marrone, a leading advocate in the field, states that employment is an expectation of everyone in our society, except for those with mental illness. For some reason, a “pass” is given to this population despite the fact that, when asked, they express a desire to participate in the community and share work responsibilities. Denise Bissonette, an employment services trainer from California, states that “any employer will hire any employee as long as the potential to increase revenue exists.” The art is in assisting individuals in creating employment opportunities that match their skills and interests, and which also meet the needs of employers. Connie Ferrell, a pioneer in Supported Employment, has long stated that there is a unique job match for everyone.

The New York State Office of Mental Health has been involved in various activities to promote employment over the years. OMH operates sixteen adult psychiatric centers across NYS representing 18,000 individuals receiving outpatient services. In 2002, OMH partnered with the Cornell University School of Labor Relations Employment Disability Institute to design a new approach to assisting individuals achieve their employment goals. Entitled the “Career Development Initiative”, facilities across New York State embarked on developing common language and a defined skill set in order to assist individuals reach their goals. Under the theme, “Work: It’s

Everybody's Business," the role of every staff, family member, and individual receiving services was identified and valued. Each facility assessed its current progress in the employment field and developed concrete steps to place employment on the agenda of their facility.

Identifying individual facility goals was a definite detour from the traditional approaches to management that view each facility alike. Individual goals allowed for each facility to focus on the unique barriers that a facility faces – be it administrative buy-in, clinician acceptance of the role of work in recovery, or lack of direct job seeking skills on the part of staff who were to participate in delivering these services.

Learning communities were established to bring staff involved in the project together to discuss issues they were facing, be exposed to new ideas and approaches and to develop a network of support among facilities. This forum allows the staff to identify the supports that are needed for them to move their goals forward and to learn from other's experiences. These communities have met quarterly since the program started.

Career Development Initiative teams formed, identified where they were in terms of progress toward assisting individuals obtain employment and determined where they wanted to be in the near future; goalposts were established for them to reach these goals. The teams were then challenged to "Shake It Up", meaning that they were to challenge the existing ways that facilities have been working to achieve vocational goals and to identify alternative methods to achieve these goals. This involved looking at employment in different ways. It involved challenging treatment teams to consider the role of employment in recovery, and to look beyond traditional job development in assisting individuals secure work.

In response, facilities began to advocate for the role of employment in recovery with their administration as well as with the clinical teams. Employment Fairs were held in various locations to increase the visibility of work, newsletters were started, and some vocational service programs changed course to secure more competitive employment opportunities rather than traditional non-integrated forms of work. Some facilities began exploring the world of self-employment with individuals desiring to start their own businesses. Small start-up grants were offered to individuals with sound business plans. Employment Proposals, rather than traditional resumes, have been popping up to market the unique skills of the individuals we serve.

Currently, the CDI is focused on reaching out within and outside the

traditional walls to discuss employment and share approaches with clinical staff as well as our community partners who share this journey with us. Facility teams are doing their best to promote the value of work in recovery in both inpatient and outpatient settings. We are moving forward with developing whole teams through the “Communities of Practice” which brings together a variety of disciplines throughout a facility to support a more person-centered approach to recovery and work.

As a part of this project, Employment Indicator Reports were developed two years ago. These reports are compiled quarterly, and identify the employment status of all outpatients in state-operated services. The competitive employment rate of those receiving outpatient clinical services in our state operated programs has risen to 14.6% from a baseline of 13.8%. The baseline data was secured five years into the project, but maintaining these employment gains in a very difficult employment market is noteworthy – especially when the corresponding SSI/SSD employment rate remains at 5.9% in New York State.

At the same time, we have decreased our reliance on non-competitive employment and sheltered work. Reliance on non-competitive employment was reduced from 6.7% to 3.4% over the past two years.

In the end, the relationship to the individual and his/her dream is essential to achieving employment success. Vocational development must be an integrated part of the total recovery plan and it is part of everyone’s responsibility to assist consumers to realize their dreams. For more information, contact your local state facility CDI representative. See how you can connect and partner with us as we move to exceed the traditional employment outcomes.

From the Field

A Recovery Journey Begins with Hope

by Elizabeth Patience, Regional Advocacy Specialist, Central New York Field Office



[Enlarge](#)

As a person with both physical and mental health disabilities, I recognize that the road to recovery is often a seemingly hidden path yet to be discovered or sometimes found again. All too often people with disabilities are marginalized by society, sometimes stripped of dignity, and led into dependency upon others. Sometimes the best intentions within systems actually create a dependency and put up barriers to true recovery. All too often people lose faith and hope in themselves, become apathetic, struggle to find hope again and sometimes tragically give up on life.

In my own personal journey, I too had lost hope and faith. I had an accident which led to a spinal disability and also was still struggling with how to manage my mental health needs. I had been told that I couldn't hold a job due to my cross disabilities and that my life would be existing on Social Security and other benefits. It was expected that I would remain on medications lifelong. All of this led to a deeper depression and self-loathing. After all, I was told that I wouldn't amount to anything or hold any meaningful job that would lead to independence. There is no worse feeling than the despair of lost hope and faith in one's self.

But one day, I met people who understood the true nature of recovery. They encouraged me to volunteer at their agency and discover my own talents. Their belief in me beyond labels was the key to unlocking my own recovery. Their gift to me was that they believed in me. They gave me very important tasks such as sitting on their executive steering committee and representing them at conferences. All the time I volunteered beside them, they gave me back my sense of self that had been seemingly taken from me. Eventually, they offered me a job and I took it. I became a powerful leader within the disability community including changing the course of a national disability rights organization.

Now in my role as Regional Advocacy Specialist I strive to help peers, families, providers and communities see the value of recovery. Walking side by side in the field with my peers who have lost hope, I see them beginning to challenge themselves again and to strive for goals they never thought possible. I have assisted one man to strive for his collegiate goals that he had given up on years ago. He has finished his first two semesters of online college courses, utilizing the personnel at the college for support for his disability. I have assisted peers in understanding how to look for and connect to natural community supports to become more independent. I have also assisted agencies and Directors of Community Services in understanding the tools that the Office of Consumer Affairs provides, to help them to connect further with the people they serve and to include them in all aspects of planning and service provision. I have worked with the field office to empower peer groups to communicate their needs to the providers in their community to enhance recovery options.

One of the keys to helping a person on their recovery journey is to remind ourselves to look beyond the disability and see the potential of the person. Buddha said, "All that we are is the result of what we have thought. The mind is everything. What we think we become." So as I continue my work with people, I shall continue to help people find hope and success in recovery.

Providing Culturally Competent Services

South Beach PC's Bill Henri Receives OMH's Journey Award

by Frances Priester, OMH Office of Cultural Competence

The Journey Award is the Commissioner's annual award to recognize innovative leadership toward the development of cultural competence programs in New York State.

This award is the first of its kind, and although the award process has not been officially developed, we could not miss the opportunity to make William (Bill) Henri, recently retired Executive Director of South Beach Psychiatric Center, the first recipient. Who else could set the standard for us? He has provided us with the most brilliant expressions of what cultural competence is and has elevated the importance of this as a foundational premise to recovery.

The Commissioner, the Bureau of Cultural Competence and I would like to take this opportunity to recognize Bill Henri, a pioneer and visionary in creating culturally competent activities at South Beach Psychiatric Center, Baltic Street, Heights Hill and Fort Hamilton.

Bill has set the stage for others. When others ask, "how?," he answered the question by looking at the human condition. His programs respect people by honoring their traditions, beliefs, and culture. He considered existing policies, programs and service delivery for inpatients and outpatients and factored in the voices of those we serve. He creatively collaborated with other stakeholders to tailor services to satisfy unspoken needs. His journey includes the development of culturally specific treatment programs, intentional employment/placement of staff that reflects the population served, and language access for non-English speaking consumers, to list just a few of his business practices. He is a living model of cultural competence in action.

He has reached out to racial and ethnic minorities and other natural community partners embracing cultural brokers and inviting them as partners in culturally appropriate service delivery.

The spiral in the background of this award is the Native American symbol for journey. This symbolizes our goal toward cultural competence which we know changes outcomes so that "people" are made better.

Congratulations from all of us Bill, we we send you on with great expectations for the future and we have been made better by walking with you.

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