



The Center Page

Newsletter for the
Center for Behavioral
Health

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Electronic Clinical Records

by Dennis P. Morrison, Ph.D.



The Center for Behavioral Health will be converting from paper records to computerized patient records (CPR) in the near future. Some may ask why we are making this conversion, and why now?

For the past several years we have known that we would be moving to a CPR at some point. The advantages of the CPR over a paper record are many. Of primary benefit is that the quality of services we provide will improve. At the very least, all clinicians who have a need to see a record will be able to do so when it is stored electronically. We frequently have clients who obtain services in a variety of CBH venues. When this happens the clinical record may not be available because it is physically held in another location. Consequently, a clinician attempting to provide services today can not know what services were rendered to this client at another office yesterday. This problem disappears with the electronic record. Computerized patient records also offer advantages beyond access. Physicians and advanced practice nurses, with prescriptive authority, can automatically check for drug interactions and flag potential problems. Similarly, all clinicians can see if someone else on the treatment team has already rendered a needed service.

There are other clinical benefits, as well. Without doubt the most popular benefit to clinical and administrative staff is that they now have a legible record. No longer will hand-written notes have to be guessed at or deciphered. This leads to errors or omissions on the part of anyone attempting to use the record. Often, hard-to-decipher notes are ignored by clinicians, defeating the purpose of having the record available to the entire treatment team.

There are numerous benefits to managers as well. Computerized patient records provide a tool by which clinical trends can be observed and interventions made when necessary. Many of the manual audit functions we currently use to assure quality and consistency in our billing practices can be automated through the use of a CPR.

The final reason for deciding to implement the record at this time is the recent requirement by the federal government to meet the guidelines outlined in the Health Insurance Portability and Accountability Act (HIPAA).

In some ways, the requirements of HIPAA are not new to those of us in behavioral healthcare, but HIPAA takes the issues of confidentiality and communication of electronic clinical information to a new level of accountability. Trying to meet the HIPAA guidelines with a paper-based system would have been difficult at best and eventually recreated once we did implement a computerized patient record system. Consequently, it seems prudent to make the transition now to meet HIPAA requirements and improve the quality of the services we render.

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(“Electronic Clinical Records”...Continued)

Like any change, this one will require a rethinking of both what we do and how we do it. Anyone who uses the CPR will have to be comfortable with the use of computers since all notes and information will be entered via a keyboard or other data input device. We are currently looking at what jobs will require which type of supportive technology. For example, clinicians who work in a single office have little need for mobile computing. However, clinicians who work in multiple offices may find it helpful to have a laptop that can be easily connected to our network.

Implementing a CPR is a costly venture, but we believe that the return on this investment will more than pay for itself over time. Other organizations that have implemented electronic records have experienced this type of return. For example, a small community behavioral healthcare center in Illinois (Heritage Behavioral Healthcare) saved approximately \$50,000 per year in Medicaid paybacks caused by poor documentation. Two years ago, they also won a Davies Award for the best implementation of an electronic record. Their story can be read on: www.CPRI-HOST.org.

Our organization is not alone in this effort. Many healthcare organizations have implemented or are currently implementing CPRs. We have identified several other PsychConsult users throughout the nation with whom we can compare notes and learn from their experiences.

While this effort constitutes a significant change in the way in which we provide services, the ultimate beneficiary will be the clients we serve.





Multi-problem Families: The “Incredible Years” Approach

Deb Mishler, MSW



The most common reason children and families are referred to mental health centers are for out-of-control or noncompliant children. Common statements are that problems have occurred “since birth”; “nothing works”; or “I thought they would out grow it.” Often the family is in crisis, struggling to meet the demands and needs of changing situations and environments. The problem is presented in terms of the child—more specifically the child’s problematic behavior.

In multi-problem families, there are high rates of major and minor life stressors and social isolation or a lack of social support. As infants, children with disorders frequently did not reinforce parenting efforts to nurture or comfort them. Marital or partner discord is highly correlated with disruptive behavior problems in children. Depression in mothers has been shown to put a child at higher risk for behavior problems. Mother’s negative perceptions of social support and social contacts put the family at high risk for relapse and failure to maintain any treatment effects.

Seldom recognized is what parents of disruptive children experience. Relationships within the marriage, siblings, grandparents, teachers, outside systems, and agencies are affected and influenced by living with a disordered child. The partner or spouse may feel resentful of the attention devoted to parenting. What time is left for one’s self or relationships may be fraught with intense emotion leftover from attempts to parent effectively or troubleshoot difficulties from the child’s disruptive behavior. Siblings’ needs are put on the back burner. They may help share the parenting role, as well as being expected to be the model child.

Frequently a parent will identify a need to be hypervigilant to the potential for anger or aggression within a family system. Often ignored is the reaction of the other children in the family or with peers who refuse to play with the aggressive child and retaliate by covertly staging a situation where the disordered child receives disapproval or acts out in a way that provokes punishment. These families are often isolated and stigmatized in their daily lives.

When children with disorders are hyperactive, verbally provocative, or impulsively use aggressive language they become recipients of ridicule and rejection. Furthermore such conflicts act as conduits for isolating the child from social events and lead to avoidance by the parents of other children. Often the negative attention these children receive serves to increase aggressive acts or noncompliance and can lead to sensitivity or reactivity to others’ moods. This makes it even more difficult for parents to address issues due to fear of the child’s response. All of these characteristics create problems for what are often common or normal developmental transitions and cause an inability for the children to adapt to social environments.

The impact of these tensions are that parents begin to feel like victims, as if they’ve lost control or predictability in their lives. Families have little time or energy left for other relationships or themselves due to the need for constant communication, monitoring, and child discipline. A common response is mounting anger as an effort to regain control. Anger and fear of losing control sometimes increases parental self-blame and feelings of incompetence.

Extended family often attributes misbehaviors to ineffective parenting and may be critical of parental approach/abilities. Consequently, a parent may tend to withdraw from or avoid gaining family support or become angrier toward others who complain about their child. Other parents in the family’s community may give additional negative feedback for observed misbehaviors, and the family may react with increased isolation and feelings of stigmatization. The message is that they should be better parents and people.

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(*"Incredible Years"* ...continued)



Many parents search for causes as a part of their coping process, hoping that they can be eliminated. Sometimes they seek new schools and neighborhoods in an effort to find an environment more sensitive to their child's personality and needs.

At times parents analyze their own painful childhood experiences and similarities. However, this often causes feelings of helplessness to change what they may perceive as their genetic path.

Families often seek help from pediatricians, friends, ministers, or other professionals. These efforts are a result of feeling rejected by daycare providers' or teachers' reactions and complaints about the child's impact on the classroom. Feelings of inadequacy and self-blame can be reinforced by professionals' speculations about the causes of misbehavior in children. However, most people outside of the family system have a superficial view and can only interpret from their own more positive parenting experiences.

"That doesn't work with my child," is a common report. Desperate families have tried a variety of approaches with their child. Parents have been inconsistent, with limited success. Commonly, as a new approach is implemented and the child's behavior escalates, the parent perceives this as confirmation that even with their best effort "nothing works," and the situation is uncontrollable. In other words, the family is negatively reinforced by feedback from the child *and* from other systems. The child is reinforced for his/her behavior as he/she escapes or avoids consequences by escalating negative behaviors. Parents attribute this to personal inadequacy and feel helpless.

The implications for treatment are that the parent must begin to have expectations of success and control outcomes in the child's behaviors. Creating new expectations for parents is paramount to overcoming learned helplessness that has become a part of the family's motivational deficit. Validating the parent's reality builds a collaborative relationship that empowers parents to maintain hope and modify expectations.

Most group treatment approaches help provide social support. A group approach can provide realistic and modified expectations, with immediate feedback about the efficacy of effort. Using *The Incredible Years* program approach, parents experience a sense of relief and surprise as they build support and collaboration with the therapist and other parents who have had similar experiences and responses. Coping and collaboration are key features the therapist models while introducing, and helping parents determine how to implement, strategies with their unique child. The process a parent must experience is one of gradually gaining competence and control. Parents' anger toward support systems and family tends to lessen as they become aware that their lack of support was from misunderstanding. Parents in such a program gain knowledge and a safe place to express feelings related to not being able to interact more effectively with their child.

An understanding of social learning theory is enormously valuable to a professional trying to help parents make sense of these struggles with their children. It postulates that abnormal behavior, like normal behavior, can be modified. In other words, abnormal behavior is learned behavior or a failure in learning. (Parents are often amazed to learn that normal children do not comply 1/3 of the time.) Most parents become optimistic as they begin to understand that problem behavior in children indicates a need for new learning.

The *Incredible Years* program utilizes a parent coaching and collaboration approach. Parents are taught that there is no quick fix; behavior change is approached in a systematic way with only one or two negative behaviors targeted at a time. Parents are often confused about the beginning phase of the program as it focuses on building a warm relationship and developing a "bank" of positive feelings for the parent and child to draw on in times of conflict. They learn that studies show children tend to have fewer behavior problems when they receive supportive attention and praise. They

"...behavior is approached in a systematic way with only one or two negative behaviors targeted at one time.."

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(“*Incredible Years*” Continued...)

also learn that discipline is defined as “training that develops self-control and efficacy,” and that this can be taught through supportive attention or play that fosters a sense of belonging and attachment.

Additionally, they are taught about the need for repetition of strategies (it takes hundreds of times to change the negative pattern of coercion). Often parents try techniques four-to-six times and then believe they don’t work. Parents may be unaware of how a matter-of-fact approach to consequences fosters motivation and communication in children. Helping parents focus on long-term payoff by riding through the outburst, rather than short-term capitulation (giving in to the child’s escalating behaviors) is a major focus of therapeutic support. Parents receive information about social learning processes and the program philosophy “what you pay attention to is what you get more of.”

The *Incredible Years* program is a process of gaining knowledge, control, support, and competence to cope with stresses. Part of its philosophy is that parents are the experts on their children; they need our collaboration. It is also important that parents understand that it is common to come back into therapy for booster sessions. Parents are taught how to problem-solve and “refuel” themselves so that they may better cope with and buffer the disruptive effects of constant environmental challenges. It is music to a therapist’s ear when a parent’s report changes from “nothing works,” to “this stuff really works!”

Long-lasting benefits from the *Incredible Years* program are reduced aggression, reduced conduct problems, and the prevention of child and substance abuse. *The Incredible Years* program is the only child- and parent-training program that has been shown to be effective in random trials in university, mental health, elementary, and Head Start settings. It has been selected by the US Office of Juvenile Justice and Delinquency Prevention as one of the most promising early interventions for preventing delinquency in the US.

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Like a Phoenix Bird Rising

Ronald H. Bricker, Ed.D, HSPP

It was March 29th, 2002; I remember it well. Our 17-year-old building, once the Center for Behavioral Health (CBH) in Lawrence County, was empty and destined to be demolished. The staff was glad to leave. They had no special attachment to this building except for Sandy Gruell, the office manager—a 20-year employee of CBH who was present when the building was fresh and new. She remembers when it opened as well as the many staff who have come and gone. Nostalgia set in as she recalled the funny things that often happen in a workplace...and the hard times. Sandy really cares about CBH, its clients and staff, and takes great pride in her job performance. Countless times she was the last worker to leave, as she was on this occasion. Alone, she walked the halls one last time before departing.

The Lawrence County CBH was originally constructed as a pole barn. Built without footings or a solid foundation, the roof was vulnerable to wind and storms. With each gust of wind the building swayed; the metal roof shifted; and each nail hole expanded. Rainwater seeped in and eventually most of the insulation became wet. Combined with heat, that wet insulation spawned mold and spores. The building stood there—empty, with all the doors and windows boarded up—a symbolic repository of years of hurt, pain, and secrets told by thousands of Lawrence County residents. Confidences remain, even though the walls will soon fall.

We face a new challenge: the old site had 6,500 square feet and the “new” Parker Building contains a mere 3,500 square feet. Some described our new “digs” as “attractive but cramped” while others tactfully called it “cozy.” We learned to cope. All case managers now work in one open space. Sandy lost her own office and three office professionals work in a space designed for two people. Gone are the play therapy room and staff lounge. There is no space for a Partial Hospitalization Program (PHP) group room and PHP kitchen so those activities were moved to the “apartments.” Despite these shortcomings, a spirit of comradery and determination emerged among the staff. Each therapist knows what really matters (doing therapy) and it can still take place in their 9’x 10’ space. The quality of client care is not sacrificed.

Although we are in a smaller building, we continue to make significant advances in the community. Positive front-page newspaper articles from the Bedford *Times-Mail* told our story. A new Lawrence County Mental Health Association was established. CBH developed alliances with the Lawrence County Public Health department and other citizens concerned about mental health. CBH is a founding member of the *Lawrence County Circle of Care* program for children needing a wide variety of services. We collaborate with other community agencies such as the schools, Children and Family Services, Juvenile Probation, Healthy Families, and First Steps. The goal of *Circle of Care* is to provide coordinated wrap-around services to children who are already involved with three or more agencies.

Good old-fashion networking and marketing led to establishing an informal partnership with Adult Probation. They needed a quality intensive outpatient program for many of their substance abuse offenders. Eric Kinser developed an Intensive Outpatient Program (IOP), maintains good communications with Probation. The IOP group took off like a rocket and continues to expand. Jamie Woody now runs the morning session.



Center for Behavioral Health

(“Phoenix”...Continued)

Thanks to the hard work of Stephanie LaFontaine (CBH grant writer), along with the support of Mayor John Williams and the Bedford City Council, CBH received a \$495,000 grant to pay a portion of the cost of the new building. Soon, bulldozers, backhoes, and front-loaders will knock down the old building (including the cement foundation), and haul it all away.

On exactly the same spot, like the Phoenix bird rising, a new CBH building will emerge. The architect renderings depict a beautiful building, perhaps the flagship among CBH structures. It will be built on footings with a solid foundation and be the place where new and better (efficacy-based) therapies are provided.

A groundbreaking ceremony and later a ribbon cutting event are planned to signify the opening of the new building. There will be proud administrators and public officials. But best of all, there will be adequate space for psychiatrists, therapists, and case managers to provide high quality treatment to children, the seriously mentally ill, and to those who abuse drugs and alcohol.



Architect's Rendering of Proposed Lawrence Co. CBH



Transitional Care Facility: Bridge to Health

Mike Wisuri, M.S., RN
Manager, Transitional Care Facility (TCF)



From its beginning in 1968, Center for Behavioral Health (CBH) has sought to meet the challenges of integrating clients into society through community based care. In its continuum of services, CBH offers specialized programs for adults with a variety of disorders, including severe and persistent mental illnesses and drug and alcohol addictions. One such program is the Transitional Care Facility (TCF). TCF opened in 1998 to provide sub-acute care in a residential setting for clients with severe mental disorders as well as persons requiring a medically supervised detoxification from alcohol and other drugs. TCF is an eleven-bed residential setting offering an intermediate level of care for clients in danger of decompensating who, with close supervision, can be managed outside a hospital. It is also a setting for clients discharged from the hospital but in need of further stabilization before returning home. Bed space is allocated for individuals requiring 24-hour medical monitoring during the detoxification process as well. TCF has seven single- and two double-occupancy rooms, a living room/recreational and group room, a laundry, baths, dining room, medication room, and offices. Clients have access to an outdoor smoking pavilion and meals are provided by Bloomington Hospital. Round-the-clock staffing is provided at TCF along with phone access to a CBH psychiatrist and an on-call R.N. This allows for 24-hour residential crisis intervention. Any immediate medication changes deemed necessary by the MDs or Clinical Nurse Specialists (CNS) can be acted upon day or night.

Services at TCF are accessed through the CBH medical staff, or CNS. Clients are also welcome at TCF for evaluation. In conjunction with the on-call psychiatrist, staff determine whether TCF is the appropriate level of care for the client; TCF does refer clients to more- or less-secure settings as deemed appropriate. Admissions are based on

criteria used to ensure the safety of the clients and the TCF staff.

A multi-disciplinary team of CBH staff, which consists of a psychiatrist, an advanced practice nurse, a TCF casemanager, and nurse, decides treatment issues. Input may be elicited from other staff and the client to help formulate a therapeutic plan of care. Most residents are seen at least several times a week by a psychiatrist or advanced practice nurse. Rounds are conducted daily and progress evaluated so treatment goals can be adjusted accordingly, to provide the most effective care needed.

To offer structure throughout the day and evenings, TCF offers nine-to-eleven hours of PHP programming. Clients are encouraged to attend as many groups as they can. Group topics include problem-solving, reality exercises, health education, and community meetings, among others. Time is set aside during the day to allow for individual counseling sessions as well. Staff members encourage residents to adopt a healthy

lifestyle by promoting nutritious meals and snacks, providing opportunities for exercise, and stressing the importance of a good night's sleep. Medication is monitored; adjustment training and education are also provided. Social skills training and daily living activities are regularly addressed, both in the PHP programming and at TCF. Many TCF services are also provided on an outpatient basis for clients who need extra support.

Providing services for clients who might otherwise be hospitalized so that they may have more intense care than other CBH outpatient clients is an important part of their journey to good mental/physical health. TCF works closely with other CBH departments such as Addictions, Community Social Services, Emergency, and Residential Services to provide effective, quality care for clients in the least restrictive environment possible. Such a safe haven for individuals in need of extra support, or in danger of decompensation, is a vital bridge to maintaining the continuity of care that enhances our clients' treatment and lives.



Behavioral Health Resources on the World Wide Web

Jennifer Cook, CBH Research Department

#1

EFFECTIVE BEHAVIORAL HEALTH TREATMENTS:

Effective Treatments: Descriptions, Practice Parameters, & Guidelines

Mental Health: A Report of the Surgeon General (1999): www.osophs.dhhs.gov/library/mentalhealth/home.html

Empirically Supported Treatments (APA, Clinical Psychology): www.apa.org/divisions/div12/rev_est/index.shtml

Practice Parameters (American Academy of Child & Adolescent Psychiatry): www.aacap.org/clinical/Summ-1.htm

Practice Guidelines (American Psychiatric Association): www.psych.org/clin_res/prac_guide.cfm
Expert Consensus Guidelines: www.psychguides.com

Behavioral Healthcare for Culturally Diverse Consumers: Resources from the Surgeon General

Culture, Race & Ethnicity (2001 supplement to 1999 Surgeon General report):
www.mentalhealth.org/cre/toc.asp

Mental Health Care for African Americans (chapter of 2001 report): www.mentalhealth.org/cre/ch3.asp

Mental Health Care for American Indians & Alaska Natives (chapter): www.mentalhealth.org/cre/ch4.asp

Mental Health Care for Asian Americans & Pacific Islanders (chapter):
www.mentalhealth.org/cre/ch5.asp

Mental Health Care for Hispanic Americans (chapter): www.mentalhealth.org/cre/ch6.asp

Culturally Specific Mental Health Resources: www.mentalhealth.org/cre/resources.asp

Fact Sheets: www.mentalhealth.org/cre/factsheet.asp

Medication Information:

MEDLINE plus Health Info (Nat Lib Med/Nat Instit Health): www.nlm.nih.gov/medlineplus/druginformation.html

Research Databases (free access to article abstracts & many full-text articles):

INSPIRE (Indiana Spectrum of Information Resources): www.inspire.net/index.html

PubMed (National Library of Medicine): www.ncbi.nlm.nih.gov/entrez/query.fcgi

RESOURCE LISTS, FACT SHEETS, & GUIDES:

Resource Lists (provide links to multiple resources):

For Practitioners (National Institute of Mental Health): www.nimh.nih.gov/practitioners/index.cfm

For the Public (National Institute of Mental Health): www.nimh.nih.gov/publicat/index.cfm

Info on Illnesses & Treatments (National Alliance for the Mentally Ill): <http://ocd.nami.org/illness/index.html>

Mental Health/Behavior Topics (Nat Library of Med): www.nlm.nih.gov/medlineplus/mentalhealthandbehavior.html

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RESOURCE LISTS, FACT SHEETS, & GUIDES: (CONTINUED)

Fact Sheets:

- Mental Health Info Fact Sheets (National Mental Health Assoc): www.nmha.org/infoctr/factsheets/index.cfm
- Fact Sheet Series (Amer Psychiatric Assoc): www.psych.org/public_info/dpa_fact.cfm
- Let's Talk Facts (Amer Psychiatric Assoc): www.psych.org/public_info/talk_facts.cfm
- Get the Facts (Amer Psychological Assoc): http://helping.apa.org/get_the_facts.html
- Alcohol & Drug Facts (National Clearinghouse of Alcohol & Drug Info): www.health.org/catalog
- Facts for Families (Amer Acad of Child & Adoles Psychiatry): www.aacap.org/publications/factsfam/index.htm
- Families & Health (Amer Assoc of Marriage & Family Therapy): www.aamft.org/families/index_nm.asp

Treatment Guides:

- Expert Consensus Guidelines: Guides for Patients: www.psychguides.com/patient_family_guides.html
- Patient and Family Guides (Amer Psychiatric Assoc): www.psych.org/clin_res/prac_guide.cfm

NATIONAL ORGANIZATIONS:

Professional Associations:

- American Counseling Association (ACA): www.counseling.org
- American Association of Marriage and Family Therapy (AAMFT): www.aamft.org
- American Psychiatric Association (APA): www.psych.org
- American Psychological Association (APA): www.apa.org
- National Association of Social Workers (NASW): www.socialworkers.org

Other Organizations:

- American Academy of Child and Adolescent Psychiatry: www.aacap.org
- Anxiety Disorders Association of America: www.adaa.org
- Children and Adults With Attention-Deficit/Hyperactivity Disorder: www.chadd.org
- Depression & Bipolar Support Alliance: www.ndmda.org/index.asp
- National Alliance for the Mentally Ill: <http://ocd.nami.org>
- National Aging Information Center: www.aoa.dhhs.gov/NAIC
- National Center for Posttraumatic Stress Disorder: www.ncptsd.org
- National Clearinghouse for Alcohol/Drug Info: www.samhsa.gov/centers/clearinghouse/clearinghouses.html
- National Eating Disorders Association: www.nationaleatingdisorders.org
- National Institute of Mental Health: www.nimh.nih.gov
- National Mental Health Association: www.nmha.org
- Obsessive-Compulsive Foundation: www.ocfoundation.org
- Substance Abuse & Mental Health Services Administration: www.samhsa.gov/
- World Fellowship for Schizophrenia & Allied Disorders: www.world-schizophrenia.org

CONTINUING EDUCATION OPPORTUNITIES:

- American Counseling Association's CE Options: www.counseling.org/resources/practice.htm
- American Psychiatric Association's CE Options: www.psych.org/pract_of_psych/cme.cfm
- American Psychological Association's CE Options: www.apa.org/ce/menu.html
- CBH's Breakfast Learning Series: www.the-center.org/events/BreakfastLearning.html
- National Association of Social Workers' CE Options: www.socialworkers.org/ce/default.asp





Tornado in Martinsville

Linda Groce, RNC

Shortly after lunch on Friday, September 20th, the radio alerted us that a tornado had touched down in Ellettsville and was en route to us! Sirens sounded, but there was an odd silence outside. The power went out and staff and clients gathered in the center of the building, still able to see the doors on the West and South sides of the building. A fierce wind blew open the doors, smashed windows, broke car windows, lifted picnic tables, and debris flew everywhere. Visibility was limited inside the funnel of the F3 tornado, but we saw debris and trees flying by the doors, horizontal to the ground. Terrifyingly, one of our case managers was nearly pulled out the front door!

As the tornado passed, we could see a semi trailer dropped sideways, blocking our driveway. Large trees were broken and uprooted. Steel utility poles and basketball goals were bent over and shingles were torn from our roof. Our park bench was thrown into a visitor's car. Damage appeared everywhere: the air conditioning units, the shed, and the building's outside lighting fixtures were twisted. A dumpster was hurled toward the pond, but stopped just short by a tree trunk.

Afterwards we emerged to see buildings across the street with roofs damaged and destroyed. We saw cars and motor homes overturned. The McDonald's sign was shattered and bent as if the "M" was in italics. With no trees left between Highway 37 and our Center (for Behavioral Health), we saw traffic stopped for over three hours. Highway 37 was closed due to downed trees, electrical lines, and debris from shattered homes. To our surprise and relief we sustained no serious injuries, only minor cuts from broken glass. Interestingly, one staff person's car window broke after the tornado, ruined by the tornado's pressure.

Our next jolt was learning that we had no access to the outside world. CBH telephones, as well as our cellular telephones, would not work. Eventually we found a pay phone still in order, so we called 911 to let them know we had been hit by the tornado, but had no serious injuries. When the 911 operator was told that we had been in the direct path of the tornado, she responded, "Yup."

Loren Kimsey and the CBH Facilities Department showed courage and dedication in their efforts to reach us—traveling circuitously on backroads and immediately springing into action to deal with the many damages and consequences of the tornado.

We were able to open for services the following Monday, with electricity and telephone service restored. Still unable to drink the water, we managed to provide service to our clients despite the disturbance added by the much-appreciated re-roofing of the building.

Our concerns now focus on helping staff and clients cope with trauma and losses. We were already deeply aware of this month's recent 9/11 anniversary, and the sudden tornado experience seemed to amplify them, and our gratitude!

Martinsville CBH staff were courageous and professional in their responses to the tornado. Like 9/11, good things often come from bad. It is touching to see the caring and compassion shared amongst our staff and the people of Martinsville.



Center Profile



Kellie Lewis

Kellie Lewis, new CBH Assistant Manager for Child & Adolescent Services, is an Aussie! Born in Perth, Australia, Kellie obtained her BS in Psychology at Edith Cowan University in Perth (1996) and her M.S. in Psychology at U. of Queensland in Brisbane (1998). She and husband Chris Smethurst, moved to IU-Bloomington in pursuit of his research interest in the field of Infant Motor Development—an appropriate subject, because this year the couple welcomed a son into the family: Indiana Sam Smethurst. Initially very homesick, the couple now loves Bloomington. "It's easy here," Kellie said, "but the main thing for us is the people—really friendly and just nice. We want to always maintain a connection here, where our son was conceived and born, so we named him Indy."

Kellie also appreciates her job. "The Center presents me with opportunities to develop my skills as a psychologist, and I love being a manager. To be a leader of such a phenomenal team of people is just fantastic—an opportunity I don't think I would be afforded (at my age) if I weren't in the 'land of opportunity,'" she smiled. She views CBH as a special place with "faith in one's ability to grow and develop. They allowed me to show my potential."

Kellie and her family hope one distant day to return to Australia, but for now she brings her heritage along with her: I laughed when after thanking her she instantly chirped, "No worries!"

Welcome Kellie!

http://www.the-center.org
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812-339-1691
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PERMIT NO. 45

CBH Breakfast Learning Series

The Center for Behavioral Health continues to offer its free monthly "Breakfast Learning Series"—informative sessions on a variety of mental health topics. Each session is held on a Friday morning, from 8:00–9:30 a.m., at the Unitarian Universalist Church, 2120 N. Fee Lane (Bloomington). Attendees are eligible for 1.5 CEU credits (Category I), and no reservations are required. Breakfast is free. For more information, contact Cathi Norton (812-330-2887; cnorton@the-center.org). Upcoming topics include:

Nov. 15, 2002	"Treating Children of Addicts/Alcoholics"	Linda Grove-Paul, MSW, LCSW
Dec. 13, 2002	"Bipolar Disorder Update"	Jerry Neff, M.D.
Jan. 24, 2003	"Autism & Autistic Children"	Stine Levy, M.S.
Feb. 21, 2003	"Childhood Sexual Abuse: Recent Research on Treatment and Complicating Environmental Factors"	C. Jessica Hersch, LCSW, LMFT