



Stigma a Hurdle in Mental Health Care

Cathi Norton and Stephanie LaFontaine, Business Development

May is Mental Health Month, and once again, time to take stock of where we are in terms of demystifying behavioral healthcare. Surgeon General David Satcher’s *Report on Mental Health* called attention to the intertwined relationship between mental and physical health, and urged prompt action to break down barriers to effective treatments—like stigma, misunderstanding, limited-or-no insurance coverage, and fear. These are formidable barriers, but we can best make progress on all of them through education and the slow-but-sure eradication of the social stigma surrounding mental health disorders.

Mental illness is a disease or disturbance in thinking, feeling, and/or behavior that might impair a person’s ability to cope with life’s ordinary demands and routines. Just as with other health problems, mental illnesses vary greatly in type and severity. Twenty-three percent of American adults (ages 18 and older) suffer from a diagnosable mental disorder in a given year, but nearly two-thirds of those affected do not seek treatment due to stigma or inability to pay. Stigma is not just the use of a wrong word or action, but is about the use of negative labels that result in fear, mistrust, and violence against people with an illness. It discourages people from getting the help they need for fear of being discriminated against. For instance, people who wouldn’t dream of *blaming* parents for a child’s diabetes might not hesitate to blame bad parenting for a child’s hyperactivity, depression, or phobia. Parents may even blame children, believing their kids are just “bad.” We must challenge each other to understand that brain disorders are no one’s fault and that early assessment, intervention, and treatment can provide hope for a bright future. “People with mental illnesses come from all backgrounds and walks of life and are not only **like** ‘us,’ but they **are** ‘us,’” says Dr. Otto Wahl.

Stigma persists for a variety of reasons. Newspapers often stress a history of mental illness in the backgrounds of people who commit crimes of violence when research has shown that people with mental illness are more often the victims of crime than the perpetrators of it. Television programs frequently sensationalize crimes where persons with mental illnesses are involved. National advertisers use stigmatizing images as promotional gimmicks to sell products, and movies like the much-discussed, Jim Carrey vehicle, *Me, Myself, and Irene*, incorrectly portray individuals with mental disorders as laughable, pitiful, or dangerous. In a 1998 Screen Actor’s Guild report, it was found that mentally ill characters in American prime time TV are portrayed as the most dangerous of all demographic groups, with 60% shown to be involved in crime or violence—three times the average rate.

Education can destroy common myths like, “A mentally ill person can never be normal.” In fact people with mental illnesses can recover and resume normal activities. A good example is Mike Wallace of *60 Minutes* who has clinical depression, yet leads an enriched and accomplished life. Another myth: “People who need psychiatric care should be locked up.” Actually most people lead productive lives thanks to a variety of supports, programs, and medications.

Affordable behavioral healthcare certainly remains a large challenge in our society, but perhaps even more daunting is overcoming the stigma—false assumptions and outdated beliefs—about the nature of mental illnesses/disorders.



In this issue...

CBH C & A Programs	2
Senior Citizens & Responsible Medication Use	4
Center Profile: Ron Bricker	5
Working Within The Deaf Culture	6
Behavioral Pathways Systems	7
This County Named Lawrence	8
Computer Sites	9
Harvest Employment	10
Mental Health Trends	11

Board of Directors



Chair, Stephen Pritchard, DDS

Vice Chair, Patricia G. Dybel, Indiana University School of Nursing

Treasurer, Kenneth E. Shidler, Community Branches Director, Consumer Credit Counseling Service

Secretary, Richard J. Viken, Associate Professor, Indiana University Department of Psychology

Assistant Secretary, Janda Troxel, Account Executive, US XCHANGE

John Haury, Attorney at Law

Rob Hunter, R&D Computers, Hardware Consultant

Cathy Korinek, National Association for the Mentally Ill (NAMI)

Tim Puro, Monroe County Bank

Mary Helen Rippey, Retired, Bedford Regional Medical Center

Terry Tackett, Insurance Agent

CBH Child & Adolescent Programs

Deb Mishler, MSW



Noncompliance, or resistance to parental authority, is a growing home stressor as well as a prevalent predictor for the development of conduct problems. Conduct problems are one of the most frequently occurring childhood behavior disorders. Research reflects a growing trend for aggression in children, which is a community concern because of the potential for out-of-home placements and safety. People with early onset patterns of noncompliance, conduct problems, and aggression are at higher risk for substance abuse, depression, juvenile delinquency, and are more likely to commit violent crimes.

In response to alarming statistics and community needs, children's services are in a state of metamorphosis and program development. This includes development of appropriate treatment models and an ongoing assessment of the needs of the families we serve. Ineffective parenting skills are one of the most significant factors for influencing child behavior outcomes, as negative styles of parental interactions increase the rates and intensity of aggressive behaviors. It is a crucial requirement that growth and development of family resource programs provide families with support and knowledge as strengthened families enhance the ability of family systems to function in the community life.

Treatment Models

CBH has developed a coordinated response system that features more open communications with other providers and demonstrates respect for the expertise and resources of other agencies/professionals. Child & Adolescent (C&A) Services has a team specializing in court-ordered clients. It includes a liaison with Child Protective Services (who is a member of the Child Protection Team and the Indiana Coalition for Family Based Services); consults with an expert from the Child Advocacy Clinic; and shares cases collaboratively with other agencies and inter-departmental providers.

Models for Family Preservation and Reunification Services were researched to enhance service delivery and develop a protocol. The development and understanding of written protocols is a major focus, as is understanding and developing the ability to collaborate with other agencies to define the common goals and delivery of services to struggling families. Defining common goals is critical to preventing a family system from becoming overwhelmed/burdened by too many goals, too many providers, or an unnecessary duplication of services. This involves coordination with referral sources and community experts in a manner that focuses on the roles and responsibilities of each professional involved with the family during regular case conferences. The current model for delivering Family Reunification and Family Preservations Services includes a Home-based Counseling Program and Home-based Services. Key components are: contact with the family within 24 hours of the crisis, small caseload sizes, intensive staff availability up to 20 hours per week, skills training, removal of barriers that keep families from accessing services, working in the family's environment, and tailoring the treatment to fit the problems rather than the reverse.

In keeping with CBH's philosophy of providing empirically supported, state-of-the-art care, the "Multisystemic Treatment, (MST)" approach is being given intensive scrutiny as it shows the most promise for positive outcomes. MST focuses on the child's environment and promotes family strengths, resiliences, and positive social network development. It is different from other models in that it recognizes that violence and substance abuse must be addressed before parent training, instrumental support, and cognitive therapy have a chance. One study of youths receiving MST had a 22% recidivism rate compared to 72% for youths who received individual counseling. Three months of treatment with MST costs approximately \$3,500 as compared to \$18,000 for out-of-home placement.

New Family Resource Programs

Two examples of newly developed family resource programs are CBH-based groups with prevention components. They include personal safety planning and equip the parents and children with skills, knowledge, and information needed to protect, cope, and make sound decisions.

CBH C & A Programs, *continued...*

Parent Support Group. Social isolation, economic struggles, single-parent stress, and maternal depression are correlated with child neglect and unhealthy family practices. Through the C&A services department CBH now offers supportive counseling in a group format for parental management of family stressors. Currently the group serves as an ongoing single-parent group for women that meets 90 minutes weekly in the living room of Elder House. Topics include: role-reversals, assertiveness vs. aggression, self-esteem and the parental role, communications, healthy and unhealthy boundaries, self-care, setting limits, discipline, giving directives and consequences, prioritizing roles to prevent risk and protect children, child development and needs, and employment. Guest speakers are sometimes invited to share information.

Group Life Skills for Adolescents. Using the protocol “*Teenagers & Tough Decisions*,” the C&A Services department of CBH offers a two-hour weekly teen group to teach/promote self management. Expanded and run by the Home-based Providers, this group offers support to teens on subjects they struggle with daily. Additional program structure has been added to the protocol and several guest speakers volunteer to discuss teen pregnancy, substance abuse recovery, and the realities of independence from the family system. Topics include: peer pressure, safe sex, employment, life goals, teen pregnancy, and coping with family stressors. Currently the group is in its seventh week and the teen team has demonstrated a positive response. Several participants have built a support system during the group experience and now request ongoing group therapy services upon graduation from this project.

Parenting 101. The Home-based Providers have also utilized a protocol to implement home-based parent training to parents of younger children. Parents are introduced to a behavior modification system and loaned a book or video demonstrating the techniques. Over several weeks the material is reviewed during family support meetings; role-modeled to parents; and family support is provided for implementing and trouble-shooting the use of this approach to managing young children. Parents are encouraged to develop a predictable home structure that motivates and appropriately disciplines young children.

New Group Development

Anger Management. Utilizing a cognitive-behavioral approach, both individual and family therapy for anger management are offered for approximately one year. Expanding this format to fit a group is ongoing. Currently all CBH locations are developing groups to provide interventions utilizing anger management protocols.

The Incredible Years Training Series. Two 12-week series are available for Center-wide implementation. A “*Basic Parent Training Program*,” targets children ages 5- to 12-years old. This series is designed to reduce, prevent, and treat children with behavioral problems by use of group parent training programs. In a collaborative, non-blaming format, the leader is a collaborator and this approach can utilize the problem-solving experiences from a variety of family situations. The “*Advance*” program targets problem-solving, marital discord, reduction of maternal depression, and increasing children’s problem-solving and social skills. After implementing the parenting skills, this program teaches parents to manage their anger and become teachers for their children in learning anger management strategies. This series is recommended by the American Psychological Association Task Force as meeting the “*Chambless criteria*” for empirically supported interventions. It has also been selected by the U.S. Office of Juvenile Justice and Delinquency Prevention as “exemplary,” as a “*Blueprints*” program for best practice, and as a “*model*” program by the Center for Substance Abuse Prevention.

These programs are based on research demonstrating that coercion and negative reinforcement develops and maintains deviant behaviors in children. Consequently, parental and teacher behaviors must be altered so that children’s behaviors can be changed. The limitations for these programs are the willingness of the client to participate in a manner conducive to learning, and the ability of participants to practice the various strategies for the duration of the programs.

Conclusion

Combined with the challenging MST philosophy—that the provider is accountable for engaging the client and for treatment outcomes—the goals of reducing noncompliance and ameliorating conduct disorders might become attainable for more families. Other challenges ahead include: continued commitment to children and their families by responding to the many unmet needs for services and groups. CBH will endeavor to promote: parent and child; competencies necessary to accomplish the short-term goal of strengthening families; and long-term goals of reducing violence, drug abuse, child abuse, child neglect, and delinquency in later years.

-----References:-----

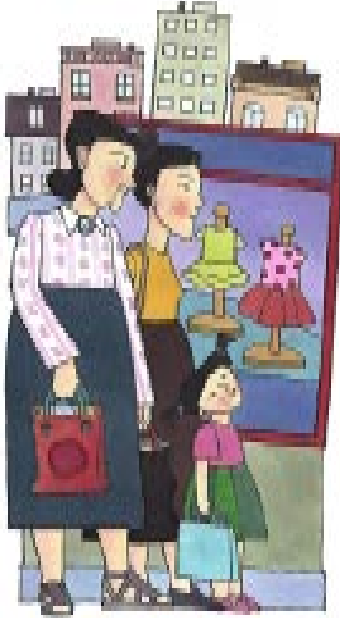
- Clay, Rebecca A. (1996) At-home programs help problem children thrive. *APA Monitor*.
- Cunningham, Phillippe B., Henggeler, Scott W. (1999) Engaging multiproblem families in treatment: Lessons learned throughout the development of multi-systemic therapy. *Family Process*. 38(3): 265-286.
- Henggeler, Scott W., Schoenwald, Sonja K., Borduin, Charles M., Rowland, Melissa D., Cunningham, Phillippe B. (1998) Multisystem Treatment of Antisocial Behavior in Children and Adolescents.
- Incredible Years Parents, Teachers and Children Series (2000) www.incredibleyears.com
- Mash & Barkley, Editors (1998) Treatment of Childhood Disorders, 2nd Edition.
- U.S. Department of Health and Human Services (1995) A Review of Family Preservation and Family Reunification Programs.
- Wilson, John J. (2000) Family Strengthening Series: The Incredible Years Training Series. *Juvenile Justice Bulletin*.



Senior Citizens and Responsible Medication Use



Bethany Murray, MSN, RN, CNS



Individuals over age 65 comprise more than 10% of the population in the United States, but use up to 25% of all prescriptions written. The number of American citizens classified as “senior” is growing each year as a result of better health care and improved nutrition. One can reasonably expect that medication usage will increase dramatically over the next quarter-century as well.

Social norms impact on the usage rates of medications, both prescribed and over-the-counter (OTC). We live in a world that is intolerant of pain, weakness, sadness, nervousness, insomnia or other unpleasant physical and emotional states. We are “problem-solvers” and as such, seek out remedies to alleviate discomfort as rapidly as possible. With the availability of such numerous and effective medical treatments, health care professionals have a tendency to address aches, pains and emotional disturbances through prescriptions. Non-medication treatments (such as relaxation training, heating pads, and herbal supplements) may be discounted or considered too minor to be of any real significance.

Over-the-counter (OTC) medications are used extensively in this country. In most homes, various preparations to treat minor aches and pains, indigestion, constipation or diarrhea, hemorrhoids, skin rashes, and head colds (viral illnesses) can be readily found. Also found are numerous vitamin supplements, popular herbal extracts, and old (partially used) prescriptions such as antibiotics or painkillers. Perhaps the greatest danger of this proliferation of self-medicating is the erroneous belief that OTC agents are relatively innocuous, or low in risks related to potential benefits. In fact, OTC preparations can have pronounced interactions when used in combination with prescription medications, alcohol, or even with other OTC medications.

Drug interactions can be loosely defined as the unexpected and unwanted results of combining two or more medications. Drug interactions can range from very minor to life-threatening. Interactions occur when the metabolism (or breakdown process) of one agent is interfered with by another agent. Most people know that mixing alcohol and sedatives can be very dangerous, but how many people realize that certain antibiotics may reduce the effectiveness of birth control pills and increase the risk for pregnancy? Or that some antidepressants can reduce the effectiveness of common blood pressure medications? Even herbal supplements may interact negatively with certain prescription medications. The herb Ginkgo biloba is used to increase brain circulation and improve memory but it can have blood thinning effects similar to aspirin. Additionally, there have been case reports of negative reactions between St. John’s Wort, an herb used for mild depression, and prescription antidepressants. OTC cold and flu preparations can cause jitteriness or sleepiness, which is compounded by antidepressants or sedatives. One such medication, phenylpropanolamine, was finally determined problematic to the extent that it was recently recalled by the Food and Drug Administration and is no longer available for OTC purchase. Cimetidine, a common antacid now sold over-the-counter, has numerous negative drug interactions as well. Even a bulk laxative such as that found in Metamucil® can expand in the intestines and trap any undissolved medications that may have been taken at the same time.

A simple case study will help to illustrate the inherent risks of drug interactions. (Note: this is purely a fictional account and not based on any real persons known to the author.)

“Mary is a 68 year old woman who has been relatively healthy throughout her life. She has recently developed high blood pressure and her health care provider has put her on a diuretic for excess fluid buildup, and an antihypertensive to lower her blood pressure. One of the side effects of her blood pressure medication is jitteriness. Mary notices that she feels anxious and a little shaky, but attributes these feelings to “nerves” as she and her husband of 40 years are moving into a new retirement community. A few months after the move, Mary’s husband has a sudden stroke and is partially paralyzed. She can no longer care for him at home, so he is moved to an extended care facility nearby. Mary starts to have crying spells, back pain, hand shakes, and feels “too nervous to eat.” She reports

Most people know that mixing alcohol and sedatives can be very dangerous, but how many people realize that certain antibiotics may reduce the effectiveness of birth control pills and increase the risk for pregnancy?

Using Medications Wisely, *continued...*

these symptoms to her family health care provider, and he puts her on an anti-anxiety agent. Mary treats her back pain with OTC ibuprofen. Mary's symptoms don't improve so her care provider adds an antidepressant. Soon, Mary finds herself falling asleep in the middle of the day, stumbling and having dizzy spells. Her care provider (fearing a stroke) orders a number of tests and x-rays. Mary is so anxious over what may be wrong with her that she starts to feel nauseated. She buys an OTC antacid to take three or four times a day. On Sunday morning, Mary's friends worry when she doesn't show up for church. They contact her daughter who goes to Mary's home only to find her still in bed, confused, wet with urine, and bruised from falling during the night. An ambulance is called and Mary is admitted to the hospital for a possible stroke. All of the tests, however, are normal. After five days in the hospital, and no medications but a single (newer) antihypertensive, Mary is discharged to home weak but alert and oriented to her surroundings. This hospitalization was unnecessary and could've been avoided had Mary been better educated to the importance of understanding her medications.

A significant portion of hospital admissions of senior citizens can be directly correlated with drug interactions. Medicines may act differently in older adults than in younger people due to normal effects of aging. These include a slower absorption rate in the gastrointestinal tract, slowed liver and enzymatic metabolism, higher fat-to-muscle ratio in the body tissues, and changes in kidney elimination rates.

Alcoholism in the elderly remains an under-reported and often hidden problem. This can lead to several health care concerns. The alcohol itself can interact with medications and cause serious reactions. Also, the senior adult may be ashamed of his or her alcohol intake and hide it from health care providers. Withdrawal symptoms mimic anxiety and can be very dangerous, even lethal. Alcohol use or dependence causes liver impairment, aspiration pneumonia, gastric bleeding, and a host of other medical conditions.

Senior citizens need to be responsible consumers of health care. Encourage your clients and family members to ask questions about side effects and possible drug interactions. Keep an up-to-date list of all the medications being taken in the home and in the pocketbook or wallet. Ask for printouts from the pharmacist. Don't take any OTC products or herbal preparations without discussing it with the pharmacist or a health care provider. Don't take medications prescribed for other people. Don't double up doses to "make it work faster." Lastly, counsel your clients not to mix alcohol and medications.

For more information, visit the website of the National Institute on Aging at www.nih.gov/nia/health.



Center Profile



Ron Bricker, MS, EdD

Ron Bricker, new manager of CBH's Lawrence County Clinic, is a Hoosier by birth and grew up in Lawrence County before working in Illinois and then moving to Sedona, Arizona. There he took a position as director of a tiny mental health clinic (seven employees), and built it, over a period of 21 years, into a newly JCAHO-accredited facility with 60 employees and an expansive new building.

The desire to be closer to his elderly relatives brought Bricker and his wife back to Bedford, where he is delighted with the challenges ahead—developing CBH's role in the community to a prevalent one.

He'll probably miss one of his favorite recreational pastimes—prospecting. "I'd spend \$10 in gas money to find a dime's worth of gold," he laughs. Yet in addition to his youthful memories of an Indiana replete with basketball, he and his wife are delighted to discover his home state also has rich architecture and history to be explored.

Meanwhile, he balances a commitment to his work with a healthy doses of family time. "There are times when work takes priority, but other times you want to take your wife out to see the sunset. It takes both things."

Ron goal in Lawrence county includes developing more programs for children and raising the clinic's visibility in the public eye. "I have a lot of different ideas," he smiled. "I want to plant seeds and see what grows."

Working Within The Deaf Culture



Andrea Wohl, MA, LMHC

What would you do if you needed, or wanted, mental health treatment and when you went to seek it, no one spoke your language or understood what you wanted? What if you didn't know how to write, and somehow every effort to make to make people understand went crazily awry somehow and you soon found yourself confined in a locked facility?

Similar things happen everyday to deaf* individuals in our culture and in our behavioral and medical healthcare system. The Deaf Network at the Center for Behavioral Health (CBH) was set up in 1997 to help this underserved population. What makes the CBH's Deaf Network special is that we employ clinicians who have specialized training, "sign" in American Sign Language and other sign systems. (For more information on the distinction between American Sign Language and sign language systems, see *The Mask of Benevolence*, Harlan Lane, 1992). Clinicians try to educate themselves and our communities as to what it really means to *treat* a deaf person.

We work within the Deaf community to help them become better consumers of behavioral health care. For instance, deaf consumers will often state that they don't need our help because they would never trust a psychologist, counselor, or psychiatrist since too many deaf people get locked away. How do we convince them to trust us? How do we educate ourselves to provide culturally and linguistically appropriate services to this population? To truly treat a deaf client, we must take away all the barriers. We must know and understand the language our clients are using and familiarize ourselves with the cultural context within which our clients live. We must be sensitive to issues of oppression.

To do so, we only have to listen to the myriad histories of clients. "I went to a local agency for help; they gave me medication. I didn't take it because I only needed help filling out a form." "I wanted to go to the women's shelter, but they didn't have an interpreter and I don't know how to write." "I never had an interpreter in school; I just passed to the next grade without learning anything." "No one told me there was a Deaf community; I've never met a therapist who could sign." "You mean I have RIGHTS as a Deaf person?!" How many Deaf and Hard of Hearing clients get misdiagnosed, mistreated, and misrepresented?

Another example is a case referred to me from a local hospital. The client is deaf and showed signs of a psychotic disorder. I visited the client who was so drugged it was impossible to make a diagnosis. After a few months of treatment without medications, we realized he didn't have a psychotic disorder, but was severely under-socialized. He has minimal education and his language skills were significantly delayed due to underexposure to people who used his language (American Sign Language). There really WAS no diagnosable mental illness.

Once these familiar barriers are down, we can accomplish behavioral health treatment with a deaf client. Deaf people do not have significantly different mental health needs than the rest of the population; they just need the same respect all our clients deserve.

CBH clinicians in the Deaf Network have specialized training not only in a clinical field, but in American Deaf Language and culture. Some of us are even Deaf ourselves! However, we cannot know everything about all mental illnesses. We consult with other professionals who work in specialized programs at CBH to try to discover: whether the client really has an anxiety disorder or is just anxious about a specific event; is the delirium a result of intoxication or is there another underlying disorder, etc. Conversely, we also work with clinicians and staff at the Center to help them understand the varied communication needs of our clients. Yes, the client needs an interpreter when meeting with the doctor. No it doesn't help to talk louder; some of them cannot read so writing does not help. Clients often must make phone calls on a specialized TTY or Indiana Relay connection.

Education and compassion are major factors in the successful treatment and socialization of deaf individuals, whether they are clients or just citizens struggling to feel at one with the community. "Walking a mile in someone else's shoes" was never more apt a saying, or more necessary than it is in working within the Deaf Culture. We have a great distance to go, but each step is one more closer to helping these worthwhile members of our society functional, healthy lives.



*"Deaf" refers to someone who affiliates with Deaf Culture; "deaf" refers to anyone with a hearing loss.





Behavioral Pathways Systems

Michael Ashley, PhD, HSPP

Behavioral Pathway Systems (BPS) is an organization with the goal of helping behavioral healthcare organizations better understand their treatment process and measure treatment outcomes. How can knowing the outcome of a treatment process help an organization to better understand its treatment process? If the focus is on outcome (e.g. a success) alone, there is a tendency to repeat the same steps (treatment intervention) on everyone else in treatment. So measuring the outcome only measures the end result and not the parts of the process that either hindered or supported the movement of the patient. In 1995 these types of issues led to the collaboration of 15 community mental health centers in Indiana to research the use of critical or clinical pathways in community-based, behavioral healthcare settings.

Like their colleagues in acute care before them, mental health practitioners now must justify the requisition of their services and demonstrate the quality of care that they provide. A quick review of the literature shows a marked increase in efforts to develop and identify treatment processes that are repeatable for specific psychiatric disorders. Only recently have efforts been made to develop treatment protocols and practice guidelines for psychiatric/mental health problems. Certainly the Center for Behavioral Health is very involved in this development with their Evidenced-Based Treatment Approach (EBT). EBTs utilize well-studied and successful approaches for different disorders and organize the treatment of individuals around these findings. In its simplest form, a critical path provides a systematic process for identifying a sequence of key events in the treatment process which, performed as described, is expected to produce the most desirable outcome(s) at minimal cost. Information on the sequence of key events is based on the best-demonstrated, most cost-efficient practice patterns and clinical processes for a diagnosis/procedure.

The Critical Pathways Collaboration Project, as it came to be known, developed and tested nearly 14 diagnostic pathways that were based on utilizing best practices approaches as well as integrating this material with the reality of what a center can do. In the fall of 1996 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) implemented their ORYX Initiative with the goal of having accredited organizations submit outcome data that would support and show quality care outcomes (or lack thereof). As part of this initiative, performance measurement systems with the ability to accept and transmit data electronically were needed to act as an intermediary between JCAHO and accredited organizations. And this is where BPS enters the picture!

BPS was developed out of the Critical Pathways Collaboration Project to become a performance measurement system (PMS). In February of 1997 BPS was notified "that it has met the initial criteria for inclusion in the future accreditation process and is included on the Joint Commission's list of acceptable systems." At that time **BPS** was housed at the Grant-Blackford Mental Health Center in Marion, Indiana, and with the input of Gordon Gibson, Ph.D., at the Center for Behavioral Health and several other Indiana Centers, obtained acceptance for ORYX. However, over the past two and a half years, BPS outgrew Grant-Blackford and felt a greater need for the research and e-commerce expertise to be found in Bloomington.

As **BPS** approaches its third anniversary, its new Bloomington home marks a natural marriage between a center that has received national recognition for its research and quality improvement efforts (as marked by receipt of the coveted *JCAHO Codman Award*), and **BPS**, a performance measurement and quality improvement measurement system (*that has met the initial criteria for inclusion in the future accreditation process and is included on the Joint Commission's list of acceptable systems*). **BPS** brings additional expertise in data warehousing and the e-commerce capabilities of marketing to the Center's Evidenced-Based Treatment Planning Products. In return, **BPS** finds a home comfortable with e-commerce that recognizes the growing need for online databases and data warehousing for behavioral health organizations. Presently, **BPS** offers many different types of outcome variables that include both instrument-based indicators, as well as, "audit" type indicators such as readmission rate within 30 days for inpatient or residential settings, and medication errors. Three main databases now exist that allows comparison of Indiana facilities, Florida centers, and Ohio organizations.

At the present time, **BPS** has over 30 customers located in Indiana, Ohio, Illinois, Florida, Georgia, with others in Utah and Connecticut preparing to join. These customers include the Florida Council of Community Mental Health (FCCMH) Center—that has contracted with **BPS** to be the data warehouse behind the FCCMH performance measurement system, and the Ohio Department of Mental Health—who will use **BPS** for JCAHO purposes in several Ohio facilities. With additional collaborations with Point of View Survey Systems—a hardware vendor out of Colorado, and a cooperative arrangement with at least one other PMS, the future for the continued growth of **BPS** looks very promising!





This County Named Lawrence



Ronald H. Bricker, EdD

Lawrence County is a unique and delightful place to live. Defying the odds of probability, three astronauts were born here. Limestone harvested from Lawrence County adorns public buildings throughout the world. I've been told that 85% of all limestone buildings quarried their stone from Lawrence County.

And what beauty! In the Spring the rolling hills of Lawrence County burst forth with blossoms from Redbud and Dogwood trees; the color continues throughout the summer and reaches a crescendo around the third week of October. Few places match the beauty of Crane Naval Depot—rich maples, oak, and hickory fall foliage reflect off the lake as civilians are allowed to tour the facility.

The people of Lawrence County are by nature good folks. They enjoy visiting with family, fishing, and most of all they love to eat. Lawrence County folks have pride in who they are, where they live, and the work they do. In spite of its industry, natural beauty, and people, Lawrence County has its share of the ills that affect all humanity. Along with cancer, diabetes, and heart disease, mental illness is also present here. Good ol' boys drink far too much alcohol. Divorce, heartache, depression, and schizophrenia are just as prevalent in this little corner of Indiana as anywhere. Sometimes compounding the problem is a lack of understanding of mental disorders. It is a topic that lay people really do not feel comfortable discussing, so they make the problem worse by using terms like “crazy,” “looney bin,” and “fruit cake.”

Against the backdrop enters the community mental health clinic (CMHC) services. The Center for Behavioral Health (CBH) began providing services in Lawrence County in 1969. In the early '70s, mental health services were like a carpenter with a toolbox only half full of tools. We really wanted to do good things for people, but didn't have the knowledge and resources, especially in rural communities where there were not many psychiatrists. The chronically mentally ill were leaving state hospitals, but CMHC's did not have good models of care or the sophisticated medications (as we do today) to treat depression, anxiety, and various forms of psychosis. Behavioral models of therapy and brief therapy models were in their infancy and therapists were unclear as to when the client's treatment was finished. At times the road was bumpy. Funding for mental health services was never adequate and to this day is still not equal to that of other medical illnesses. Still, community mental health centers survived and some thrived; both treatment and medication improved. The tools needed to care for the mentally ill slowly became manifest.

Things in Lawrence County were improving too. In Fiscal Year 2000 (July 1, 1999–June 30, 2000), CBH served a record 859 people from Lawrence County. Four therapists, five case managers, three part-time psychiatrists, one part-time clinical nurse specialist, and three office professionals provided 1,082 hours of assessment and evaluation; 2,449 hours of individual therapy and medication checks; 400 hours of family therapy; 428,145 hours of group therapy and partial hospitalization services; and 3,401 hours of case management and life skills training. Fifty-three percent of all clients seen were female and forty-seven male. Problems treated included depression (21%), adjustment disorders (15%), substance abuse (13%), child & adolescent services (12%), Schizophrenia and thought disorder treatment (8%), anxiety (7%) and personality disorders (5%). The Center treated a significant number of indigent and low-income people from Lawrence County too. Forty-one percent of our clients have an annual family income of less than \$12,000.

The statistics are impressive, but there is a human side of the story. Crisis services do, in fact, save lives of suicidal patients. Apartment living is providing

***Forty-one
percent of our
client's have an
annual family
income of less
than \$12,000.***

County Named Lawrence, *continued...*

housing for the seriously mentally ill who would otherwise be homeless. Psychiatrists prescribe medications that improve the functioning of children and adults. Therapists and case managers intervene to help people live healthier, more productive lives.

But the work is just beginning. There are many unserved needs in Lawrence County. CBH is planning to expand its services to children. We are in the process of establishing relationships and agreements with First Steps, Headstart, the Office of Family & Children, Juvenile Probation, and the various schools. It is our plan to increase adult services by working with community employers to develop Employee Assistance Programs (EAPs) to treat drug and alcohol abuse, and other mental health disorders. We plan to develop stronger ties to the medical community and law enforcement services. The time has come for mental health services to become a real presence in this county named Lawrence.



***Computer
SITES***

National Association of Mental
Illness (NAMI)
www.nami.org

Anxiety Disorders Association
of America (ADAA)
www.adaa.org

American Academy of Child &
Adolescent Psychiatry
www.aacap.org

Mental Health InfoSource
www.mhsource.com/

APA Division of Psycho-
pharmacology & Substance Abuse
[www.apa.org/divisions/div28/
index.html](http://www.apa.org/divisions/div28/index.html)

Freedom from Fear
www.freedomfromfear.com

National Association of
Psychiatric Health Systems
www.naphs.org

Suicide Prevention Advocacy
Network, USA
www.spanusa.org





Harvest Employment Services Success Story—Gary Taylor



Sandy Pate
Manager of Harvest Employment Services

When Gary Taylor was 20 years old, he approached the Center for Behavioral Health's (CBH) staff to request help with finding a job. He had been living at the Center's "Hoosier House," for five months. In his words, he "needed some money." His case manager referred him to Harvest Employment Services (HES)—a CBH service that offers vocational assistance to those who have difficulty finding or keeping a job due to mental health issues.

Harvest Employment has offered vocational services since January 1995.

Vocational needs are addressed through a contractual agreement between the Center and Vocational Rehabilitation Services. I've been manager of HES since February, 1996 and am happy to say approximately 200 CBH consumers have received help with employment needs since that time. Gary and I reviewed a handbook written by HES staff and discussed how Gary's personal goals could be met as he developed his character through working.

Gary described himself as a hard worker, an honest person, and someone who could be counted on to get the job done. He wanted an opportunity to prove it. So he began meeting with Paul Dell, an employment specialist with a host of business contacts that allow CBH clients to be placed in community employment. Paul's expertise is important when one realizes that the people served by CBH are competing for the same jobs, at the same rate of pay, as other residents. Gary was in a hurry to secure employment so Paul helped him get a job as a dishwasher at the local McDonald's, but Gary soon discovered the pace was faster than he was able to maintain. "Harvest Employment gave me a second chance," he stated. "The first try wasn't a success but I came to the second try and succeeded," he said with obvious pride. Gary used skills he had learned from CBH vocational staff to secure a second job placement in the dining room at Wendy's. "Harvest Employment helped me whenever I had a problem. They helped me to work it out. They helped me fill out my taxes. He paused, "They are very friendly when they talk to you; they help you work things out. It makes you want to succeed 'cause you know you've got somebody who will help you."

Gary's comments mirror the sentiments reflected in data from a consumer survey done through the Supported Employment and Consultation Center. It ranked HES at 45.0 on **consumer satisfaction** versus 44.2 for comparison consumers from more than 20 other mental health centers. (The theoretical neutral point is 32.5.) Additionally, **employers** ranked HES at 40.0 compared to 30.0 on a scale of 8-36 with a neutral point of 22.

"Working ain't easy, but it teaches you responsibility," Gary related. "It helps you develop into a mature adult. Working gives you the responsibility that you need to know how to survive in the working world. All bosses like honest people and hard workers. That is what I determine to be even when I am having troubles getting my job done." Gary has maintained his job at Wendy's since October of 2000. He reflects, "Even when I have my downfalls, they know I am a good worker so they help me work it out. If needed, contact is made with Harvest Employment staff who help me work it out. Then we can all go back and have a great day."

One of the goals for the CBH vocational service is to help people integrate into the community through the medium of work. Great emphasis is placed on helping the Center consumer develop natural supports on the job that will be available to the employee as needed. A report from Dr. David Perkins of Ball State University compared the vocational services of mental health agencies across Indiana. It states, "The reported cost per month of all wrap-around services to HES consumers averages \$899 vs. \$1,079 for consumers from other agencies." These numbers indicate both efficiency by HES staff and a reduction in need for mental health services for those who work.

"I love to work, not because I want to make money, but because I have friends in the workforce that help me succeed," Gary stated with seriousness in his usually jovial tone. Gary's integration into the workforce is a reflection of teamwork at CBH between direct service and support staff, in addition to caring individuals throughout the business community. We salute the efforts of all those involved in Gary's success, but most of all—we admire him.





Mental Health Trends

E. Veronica Lenard

Here is a quick quiz: Who are the clients at the Center for Behavioral Health? Do you know that, during your lifetime, **YOU** may decide to get some help? The likelihood of benefitting from professional help as one goes through life's stages and challenges is quite high. An unexpected loss, a vocational setback, an illness, or accident may temporarily leave you more apprehensive or experiencing uncharacteristic moodiness that often affects your family or work life.

More than 54 million Americans have a mental disorder in any given year, although fewer than 8 million seek treatment.¹ Depression and anxiety disorders—the two most common mental illnesses—each affect 19 million American adults annually.² Up to one-half of all visits to primary care physicians are due to conditions that are caused or exacerbated by mental or emotional problems.³

The last quarter century brought many positive changes in mental health, giving reason for hope to people going through personal or psychiatric difficulties. With increasing knowledge of depression, anxiety, and the major mental illnesses, there are now many treatment options, from self-help for mild transient difficulties to effective new medications for problems of a more serious nature. As more people believe they might benefit from help, there is a new openness about admitting difficulties, first to oneself, and then to loved ones. Employers encourage this, knowing the economic cost of untreated personal problems that affect attendance rates and productivity.

Take, for example, the middle-aged, divorced woman whose children have moved away. She may dwell on regrets and disappointments, lose interest in activities, hesitate to call friends, and fear that she is no longer “good company.” How can the new mental health awareness help her?

This may be a time for her to discuss the problem with a minister, a counselor, or perhaps seek help elsewhere. If she were to come to a mental health center, she would probably be evaluated for depression and offered a variety of remedies. She might participate in a few psycho-educational sessions to set goals for improving her situation. She might be encouraged to re-contact friends, starting with one in whose support and understanding she is most confident. She may also start a simple exercise program and learn about the intimate connection between mind and body, to learn how taking care of her sleep, nutrition, and overall physical health as important parts of wellness.

The media plays a helpful role in publicizing new developments in the mental health field too, adding to the new openness about personal problems. Articles on wellness spread the word on fairly simple steps to positive mental health, such as sleep hygiene, exercise, and the building of a supportive network. This helps to reach people before their problems cause a chain reaction of secondary complications, from family to financial troubles. Just as it is in physical health, with mental health the sooner you seek to remedy a problem, the more effective the solution.

¹Surgeon General's Report on Mental Health; ²National Institute of Mental Health; ³Collaborative Family Healthcare Coalition)



**HEALTH
CENTRAL
INDIANA**

Health Central Indiana (HCI) is a community-based initiative to increase awareness and understanding of health issues and broaden the availability of health information to all ages and populations.

A millennium project of the Local Council of Women (LCW), Health Central Indiana is based on the second floor of the Monroe County Library and staffed by a health information specialist who can provide assistance through in-person service or questions by telephone and computer. Displays on current health issues are regularly offered; free materials are available; and personal help upon request, for individuals researching their health questions.

Consumer health materials cover topics such as preventive medicine, symptoms, diagnosis and treatment of disease, complementary and alternative medicine, the health care system, caregiving, and more.

Though health information is NOT a substitute for medical advice from qualified health professionals, HCI serves as a resource for citizens to learn more about any health topic.

HCI is built and sustained through volunteer efforts, charitable gifts, and grants. No single health care entity owns or controls HCI. The single vested interest of HCI is providing quality consumer health information to all members of the community, through reference help, outreach, and special events. Contact numbers are:

- Phone: (812) 349-3083
- FAX: (812) 349-3209
- E-mail: Health@monroe.lib.in.us
- Web: www.healthcentralindiana.org

http://www.the-center.org
 1-800-344-8802
 812-339-1691
 Bloomington, IN 47403
 645 South Rogers Street

**CENTER FOR
 BEHAVIORAL HEALTH**



South Central Community
 Mental Health Center, DBA

NONPROFIT ORG
 U.S. POSTAGE PAID
 BLOOMINGTON, IN
 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 First United Methodist Church, 219 E. Fourth St. (Bloomington), Rm. 318. Attendees are eligible for 1.5 CEU credits (both Category I and II) and no reservations are required. Breakfast is free. For more information, contact Cathi Norton (812-330-2887; cnorton@the-center.org). Upcoming topics include:

May 18, 2001	“Children & Medications”	Dr. James Marencik Center for Behavioral Health
June 22, 2001	“Update on the Treatment Medications & Care of the Seriously Mentally Ill”	Mark Hickman, PhD & Linda Groce, BS, RN Center for Behavioral Health
July 20, 2001	“Mental Illness/Health & Employment”	Sandy Pate, Horizons Pgm. Center for Behavioral Health
Sept. 21, 2001	“Oppositional Defiant Disorder in Children”	Deb Mishler, MSW Center for Behavioral Health