

The Center Page

**Newsletter for the Center for
Behavioral Health**

**Volume 7, Issue 1
Spring/Summer 2004**



Corporate Restructuring

by Dr. Dennis Morrison, CEO

In 1969 the Center for Behavioral Health was founded as South Central Community Mental Health Centers, Inc. At that time the government funding system was very different than it is today. Back then, our funding relationship was directly with the federal government and one of our primary missions was to provide services to those who had little or no resources. We did this by offering “sliding fee scales” that would provide discounted services to clients based on their ability to pay. When we did so, the federal government would reimburse us for whatever was discounted to the client. For example, if a client needed a service costing \$100 and we determined they could only pay \$10, the federal government would pay us the remaining \$90. That is no longer the case.

In the 1980’s the funding shifted from direct reimbursement from the federal government to federal block grants given to states after decreasing the amounts by about 25%. The States would then identify key populations they would help subsidize. There is no longer any way for our organization to “make up” the money that is discounted to clients based on their ability to pay.

Despite the fact that funding has not kept pace with demand, providing deeply discounted services to the people we serve has continued to be one of our core values. The communities we serve still want and need services for the underserved. To help meet this need, the board of directors of the Center for Behavioral Health voted to become owned by a holding company called CenterPoint, Inc., a not-for-profit company. CenterPoint was developed by Center for Behavioral Health and its board members. This was done primarily so that we could have the flexibility to better serve the community than we could as a stand-alone community mental health center.

As a community mental health center, the majority of our funding comes from Medicaid and the Department of Mental Health and Addictions (DMHA). As a community mental health center, we are required to be certified by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Department of Mental Health and Addictions (DMHA). These certification processes create significant administrative overhead. By creating a broader not-for-profit (NFP) corporate structure we have additional opportunities to successfully diversify funds, making us a stronger organization—better able to continue our mission to serve all members of our communities with behavioral healthcare services.

Since 1987 we have increased the number of clients served per year from approximately 3,000 to over 8,000, yet funding per client from federal, state and county sources has decreased 91%, 31%, and 37% respectively. In addition, it has been over 10 years since we have received a rate increase from Medicaid.

(Continued on page 2.)

In this issue...

CBH Board	2
Behavioral Pathways ... Systems	3
Youth Service Bureau... ..	4
Dual Diagnosis... ..	6
Web Sites of Interest... ..	9
Profile: Linda	11
Grove-Paul	
Social Phobia	12
PATH Program on	14
Homelessness	
Long-term Service	15
of Employees	
BLS Schedule	16



Board of Directors

Chair,
Tim Puro
CTFA
Monroe Bank

Vice Chair,
Janda Troxel
1st American Trust

Secretary,
Cathy Korinek
Consumer Representative

Treasurer,
Doug Bennett
Financial Consultant
OnTrak Performance Solutions

Jeff Ellington
Monroe County Council,
JR Ellington Tree Experts

Gerardo Gonzalez
Dean
IU School of Education

Philippa Guthrie
General Counsel
IU Foundation

Liz Kalina
Private Business Owner

John Maloy
Superintendent
Monroe County Schools

Marc Smith
Dentist

Linda Trader
Owner
Medical Accounts Services

Richard J. Viken
Associate Professor
Department of Psychology, I.U.

John Whikehart
Chancellor, Ivy Tech State College

(“Corporate Restructuring”...continued.)



Despite this the Center for Behavioral Health will continue to provide our core services for community mental health but we have also identified the need for other services. The Center for Behavioral Health has for the past nine years pursued an entrepreneurial orientation towards the delivery of healthcare services in our community. In doing so, we have developed several business lines that are not aligned with our core business of providing mental health and substance abuse treatment.

Our plan is to spin off those business units to a sister corporation called VantagePoint. Through VantagePoint we will be able to run our SouthPoint Psychological Group, Behavioral Pathways Systems, and other non-core businesses more efficiently and competitively.

As noted above, the public funding has not only changed but has diminished or remained stagnant. Like many not-for-profits, we have had to learn how to do more with less and are rapidly coming to the point where there are no more efficiencies to be had. We believe it is critical to strengthen our financial viability through a diversification strategy which we have pursued through the development of CenterPoint.

We also believe there are opportunities such as developing a foundation for fundraising, offering management contracts for other not-for-profits, expanding our outcome measurement and consultation lines of business, and possibly developing affirmative business ventures that are operated by our clients.

All of this is being considered to help meet our original vision of community mental health as services for the whole community, not just those that the state chooses to reimburse. We believe that those who do not have means should have services made available to them regardless of their ability to pay, but to meet this goal we must find new sources of funding to subsidize that which is unpaid. We believe that this new corporate structure will allow us to meet these goals as well as others. The old structure of a stand-alone, not-for-profit corporation served us well but it is time for us to think differently if we are to succeed in the future. If we do not do this, we will not be here to help anyone.



Behavioral Pathways Systems Pursues New Direction

By Paul M. Lefkovitz, Ph.D.
President, Behavioral Pathway Systems

Behavioral Pathway Systems (BPS) is a component of Vantage Point, an entity established by the Center for Behavioral Health. The purpose of Vantage Point is to house entrepreneurial and other services that would generally not be found within a community-based mental health agency. Behavioral Pathway Systems, however, has actually been in existence since 1998. It was created as a collaborative venture between several Indiana community mental health centers to provide outcome measurement and regulatory reporting services. Since that time, it has functioned as a listed system within JCAHO's ORYX reporting program. It is now wholly owned by the Center for Behavioral Health.

In the summer of 2003, a formalized strategic assessment of the vision and mission of Behavioral Pathway Systems was carried out. The decision was made to augment the organization's traditional roles with a bold new direction: ***behavioral health benchmarking***.

What is benchmarking? Benchmarking allows an organization to compare itself with other organizations in a manner that can be quantified. Any dimension of performance that can be measured can be benchmarked. H. James Harrington first introduced benchmarking as a management tool in the late 1960's and explained its rationale thusly: "We are all in an automobile race of sorts, but most organizational drivers don't know, and many don't care about, where they are positioned in the track. They look around and see a competitor in the race car behind them and take comfort in believing they are in the lead, not realizing the competitor is about to lap them." Benchmarking has been widely used in the global world of business and industry. Like other management tools, however, application to health care has come more slowly. Particularly in behavioral health, many organizations measure their outcomes, but very few know how they compare to others. An industry-wide resource for benchmarking in behavioral health did not exist prior to the involvement of BPS in this vital realm.

Benchmarking can help an organization become less isolated as it examines its performance. For example, one organization was very concerned about its measured frequency of pharmacy errors. The organization put a good deal of resources into reducing its rates. However, when they were able to acquire relevant benchmarks, they learned that the occurrence of their pharmacy errors was, in fact, significantly lower than that of other organizations. At the same time, they discovered other issues that were far more deserving of their time and resources. They never would have arrived at these realizations without an external frame of reference.

Behavioral Pathway Systems set out to establish collaborative agreements with organizations that have conducted benchmarking work. In addition, it created its own benchmarking surveys. Agreements have been established with several national and regional organizations including the Mental Health Corporations of America (MHCA), the Association for Ambulatory Behavioral Healthcare (AABH), the SASSI Institute, the Ohio Ambulatory Behavioral Healthcare Association, and CarePaths. Through some of these agreements, BPS offers benchmarking data to the behavioral health industry that had previously been restricted to members of certain associations. In other instances, collaborative benchmarking surveys will be carried out with these organizations.



(Continued on page 11.)

CBH Partners with Youth Service Bureau

by Elaine Meyer, L.C.S.W.
Youth Service Bureau Project Liaison



The Center for Behavioral Health (CBH) has a strong history of collaboration to assist in meeting community needs. A new partnership with the Youth Services Bureau of Monroe County (YSB) continues this tradition.

Since 1972, the YSB has been providing services in an effort to strengthen families, divert youth from the juvenile justice system, and foster positive youth development. Over time services have grown to meet the needs of youth in crisis. Recent changes in funding, however, placed the future of their counseling services at risk.



The Youth Shelter is only one program currently being provided by the Youth Services Bureau. The Youth Shelter was initially established through the joint cooperation of Monroe County, the City of Bloomington, and Indiana University. Since November of 1977, the Shelter has been providing emergency services for youth from not only Monroe County, but other counties and states. Before this program's establishment, there was no emergency shelter care facility in south central Indiana. This meant some youths would find themselves placed in jail as a more appropriate setting was not available.



YSB emergency services include crisis counseling, residential services, home-based counseling, and follow-up care to runaways and other youngsters in need of such services. Referrals are accepted from all agencies, organizations or individuals, as are self-referrals. YSB previously funded these services through various sources—including federal grants.



In 2003, YSB received word that the federal grant that provided a fifth of their operating budget would not be renewed. Monroe County Commissioners and the County Council provided temporary assistance, but it was clear that a long-term plan and other funding sources were required to maintain the services currently provided. In January of 2004 the Center for Behavioral Health (CBH), the YSB, and the Monroe County Commissioners developed a plan. To maintain services the YSB would transfer the employment of several YSB counselors to CBH. In other words, YSB counselors would continue to provide services at YSB, but as CBH employees. This action allowed YSB counseling services to be financially supported (as are similar services provided by other mental health or medical agencies) with reimbursement from Medicaid.



YSB provides a unique resource to children in crisis. Any child/teen between the ages of 8 and 17 who needs emergency shelter and can function in an open setting is eligible for referral to the Youth Shelter. The Shelter cannot, however, accept young people who are suicidal or intoxicated. If needed, appropriate recommendations are made for more intensive services such as hospitalization. Before an admission decision is made, individuals are carefully evaluated, especially if there is a history of sexual offense, chemical dependency, or dangerous behavior problems.

Requests for admission are assessed by telephone or in person by the agency counselor, on-call staff, or the residential coordinator on duty. A youngster can be admitted as soon as the assessment indicates s/he is an appropriate candidate. There are some exceptions to admission such as census limitations or recommendations

due to prior admissions, and referring parents are encouraged to meet with the agency counselor before admission.

When a referral is received an assessment interview is conducted and pertinent information gathered, such as presenting problem, involvement in Juvenile Justice, behavior history (including self-harm), and current health condition. Youngsters accepted at the shelter are given a temporary safe place to stay and resources to assist them address their current and future needs.



Once admitted to the shelter, a young person may stay there, yet continue on with other aspects of everyday life, dependent upon the conditions of their temporary placement at the Shelter. Some residents are able to continue to attend school, go to work, or visit with family while the presenting problem is addressed, allowing them to maintain a sense of normalcy during the crisis.

In 2003, YSB had 498 admissions and a daily average of ten youths residing and receiving services at the Shelter. YSP provided assistance for a total of 334 families; 164 of the 498 admissions were recidivists (youngsters returning to the shelter for services after a previous admission). The average length of stay for a client was one week. Approximately 7.8 % of those were self-referred or entered through the Safe Place Program. Sixty-two percent were parental referrals. Probation referred 20.3% of the residents; the Division of Family and Children referred 5.4%; and 4.4% were police holdovers.

According to YSB, 59.4% of all shelter admissions during 2003 were kids using shelter services for their first and only time. The organization reports that their intervention improved the ability of affected families to cope in a crisis and reduced the need for more formalized services as might be administered through Juvenile Justice or the Division of Family and Children.

Although the concept of moving employer responsibilities from one agency to another is simple enough, the actual transition required a combined effort on the part of both CBH and YSB. The action, although still in the early stages, has meant several changes. YSB clinicians completed various trainings, including several days of instruction on CBH's electronic record system, as do most new CBH employees. These former YSB clinicians are now members of the CBH Child and Adolescent Treatment Team with direct access to CBH resources, yet they continue to maintain a close working relationship on site at YSB. They also continue to provide services as they have in the past to young people who enter the Youth Services Shelter and to those in the community for whom they provide home-based services.

CBH counselors at YSB continue to offer access to intensive counseling and case management services to youth in crisis. In doing so they provide a vital resource to the community, which is now maintained through the joint efforts of CBH, YSB, and the Monroe County Commissioners.

(Additional information about YSB can be found at www.youthservicebureau.net. Information was compiled for this article from press releases from CBH and YSB, information from the YSB on-call manual, and YSB statistics provided by Robin Donaldson, M.A., L.M.H.C.; Assistant Director at YSB.)



Dual Diagnosis--Substance Abuse and Emotional/Psychiatric Problems

Linda Grove-Paul, M.S.W., L.C.S.W., M.P.A.
Assistant Manager, Adult Outpatient Services

Dual diagnosis refers to an individual who has both an alcohol and/or drug problem and an emotional or psychiatric problem. This term can be somewhat confusing because it can also describe a person with physical/mental disability coupled with an emotional/psychiatric disability. For the purpose of this article, the term dual diagnosis will be used to describe individuals who suffer with a substance problem combined with an emotional/psychiatric problem. Research indicates that as many as six out of ten individuals who abuse drugs and alcohol also suffer from a mental illness. Further, research indicates that the lack of appropriate diagnosis and treatment of these individuals contributes to some of our most challenging social and economic problems.

Though research has found that any mental disorder might coexist with a substance disorder, certain disorders are more likely to cluster with substance use disorders.

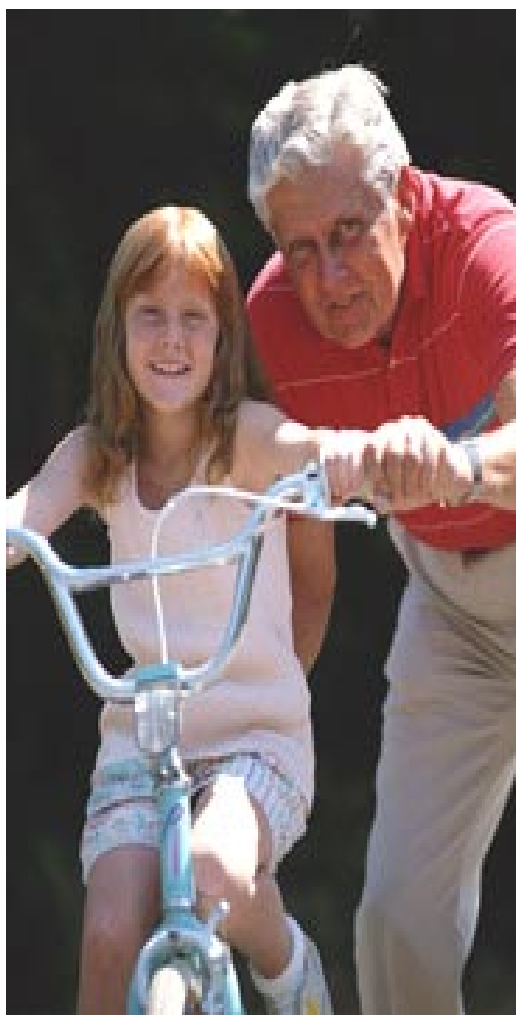
The psychiatric disorders most likely to co-exist with a substance use disorder are the mood disorders—especially bi-polar, major depression; psychotic disorders—particularly schizophrenia; the anxiety disorders of agoraphobia and social phobia, obsessive-compulsive disorder, and posttraumatic stress disorder; and anti-social and borderline personality disorders.

Individuals who are diagnosed with certain mental illnesses are much more likely to develop a problem with substances. A National Institute of Mental Health study indicates that a person diagnosed with antisocial personality disorder is 15.5 times more likely to develop a problem with substances, while an individual diagnosed with schizophrenia's risk is 10.1 times greater than that of the general population. An individual with panic disorder is 4.3 times more likely, and a person who has had a major depressive episode is 4.1 times more likely to develop substance problems.

Sorting out which comes first, the psychiatric problem or the substance problem, is difficult. Research indicates that individuals who use substances earlier are more likely to develop a psychiatric disorder later in life. Research also indicates that individuals with certain disorders are much more likely to develop a substance disorder as a co-occurring condition. In other words, some individuals begin to use drugs and alcohol for recreational use and continue for various reasons (social, physical, environmental). It is theorized that many continue to use as a misguided attempt to treat symptoms of the illness or to cope with side affects of their medications. They find that they can reduce, for example, their anxiety or depression—at least short term.

Individuals who experience a dual diagnosis often face a wide range of psychosocial issues and experience multiple symptoms that can interact or interfere with one another. Both illnesses may affect the individual physically, psychologically and socially. Each illness has symptoms that interfere with the person's ability to function and relate to themselves and others. Not only is the individual affected by two (or more) separate illnesses, both illnesses may exacerbate each other, which can lead symptoms that make the other illness more difficult to cope with. Often symptoms overlap and even mask the other making appropriate diagnosis and treatment more difficult. Frequently symptoms of both the substance abuse and the mental illness alienate the individual from available positive support.

People with mental illness often suffer from what has been referred to as "downward drift." This means that as a consequence of their illness, individuals find themselves living in marginalized neighborhoods where



drug use prevails. Having difficulty establishing social relationships, many find themselves more easily accepted by groups whose social activity is based on substance use. Many may believe that an identity based on drug use is more socially acceptable than that of mental illness.

Dual diagnosis is a major contributor to problems related to our criminal justice system. A National Institute of Mental Health (NIMH) study estimated that 90% of inmates who were diagnosed with a mental disorder also had a substance disorder. Since the mid-1960's, when the deinstitutionalization (closing of inpatient psychiatric units for individuals with mental illness) process began, the number of individuals in the criminal justice system has been on the rise. Many people with untreated dual disorders end up in the correctional system and continue to return due to the lack of treatment for their dual disorder. It is estimated that in 1972 the total number of jail and prison beds was 196,000, whereas by 1990 the number of beds had increased 750% to 1.5 million beds in operation. A significant contributing factor in the involvement of this population in the criminal justice system is untreated dual disorders.

The interaction between mental illness and alcohol and drugs greatly increases psychiatric symptoms and disinhibits behavioral controls. This explosive mixture often results in behavior that is disruptive and dangerous to the community such as disorderly conduct, assaultiveness, trespassing, and shoplifting. Research indicates that it is critical for those who work with this population to understand how substance abuse, mental illness and criminal behavior interact.

Traditionally substance abuse and mental health issues have been dealt with separately. Typical services consisted of treatment for mental health in one agency and treatment for substance abuse in another. Clients in this situation are referred back and forth between agencies and providers in what some have called "ping pong" therapy. In addition, many substance treatment programs are not recommended for people with mental illness because they tend to be heavily confrontive, coercive, with intense emotional jolting which can lead to high levels of stress that may worsen symptoms, lead to relapse or high client drop out rates. What are needed are "hybrid" programs that integrate treatment needs and address both illnesses together.

Hybrid programs, or comprehensive mental health programs, are critical for the successful treatment of dual diagnosis, particularly because a dual diagnosis should be considered as an expectation, not the exception. Interventions for this population must address various levels of severity, disability, as well as various levels of motivation and readiness. Treatment success involves the formation of empathic, hopeful, integrated treatment relationships. Integrated treatment does not imply a single type of intervention but individualized interventions that provide disease management for both (all) disorders. This treatment should be applied continuously, across multiple treatment episodes while balancing case management support (i.e. assistance with accessing local resources, housing, working with family members).

The quality of any integrated intervention depends on the accuracy of the diagnosis and the quality of intervention for each disorder being treated. It is critical that integrated treatment interventions apply evidenced-based best practices (for pharmacology as well as other interventions) for each separate primary disorder addressed. Interventions need to be matched not only by diagnosis, but also to phase of recovery, stage of treatment and stage of change. As indicated above, the research is clear that there are some forms of treatment that are effective and some that aren't. Traditional substance treatment has been very confrontive ("you are in denial") and emotional. This form of treatment has been found to be ineffective with the dually diagnosed. Treatment for those with dual disorders should begin by assessing the client's readiness to engage in treatment. The objective in the engagement phase is to develop comfortable and trusting relationships and if possible expose the client to information about his/her illness in an empathic and educational manner. The value of stage wise (engagement, persuasion, active treatment,



(Continued on page 8.)

Center for Behavioral Health

(“Dual Diagnosis”...continued.)

relapse prevention) treatment has been well documented, as well as stage-specific treatment (providing certain kinds of treatment based on how ready and willing the client is—“stage of change”—to engage in treatment). Motivational interviewing strategies (Miller and Rollnick) correlate client’s readiness based on the stages of change theory (Prochaska and DiClemente). This approach is non-threatening, respectful, and hopes to provide a safe atmosphere for the examination of self and change.

Interventions need to be matched according to level of care and service intensity requirements. For example, Center for Behavioral Health provides a continuum of care for dually diagnosed individuals. An example of the most intensive treatment on the continuum of care would be in the community support services program (program for the severely and chronically disabled). This service is currently providing an empirically based pilot program of intensive, integrated case management for those who are identified as severely and persistently mentally ill and have a significant substance use problem. This program provides stabilization, motivational interviewing, harm reduction interventions, support, active treatment (medication, therapy), psychosocial rehabilitation, housing support, case management, integrated treatment for other problem areas etc.), and relapse prevention treatment.

There is neither a single correct dual diagnosis intervention nor a single correct program. For each individual, at any point in time, the correct intervention must be individualized according to diagnosis (i.e. specialized, empirically based treatment for PTSD, anxiety, depression, personality disorders), stage of treatment or stage of change, phase of recovery, need for continuity, extent of disability, availability of external contingencies (e.g. legal, child protective services), and level of care assessment.

The empirically based model of comprehensive care is the model for the new millennium. This model represents “inclusion” and the idea of comprehensive, cohesive services rather than the “exclusionary” models (tackling one diagnosis at a time) that have resulted in serious casualties among persons who suffer with singular, dual or multiple disorders.



-
- Brown, V.B., Ridgely, M.S. Pepper, B., Levine, I.S. & Ryglewicz. The Dual Crisis: Mental Illness and Substance Use, *American Psychologist*, 44, 565-560.
- Evans, K. & Sullivan, J.M. (1990) *Dual Diagnosis: Counseling the Mentally Ill Substance Abuser*, New York: Guilford Press.
- Hatfield, Agnes B, (1993) *Dual Diagnosis: Substance Abuse and Mental Illness*, National Alliance for the Mentally Ill.
- Minkoff, Kenneth (2001) *Behavioral Health Recovery Management Service Planning Guidelines Co-Occurring Psychiatric and Substance Disorders*.
- Minkoff, K. & Drake, R. (1991) *Dual Diagnosis of Major Mental Illness and Substance Disorder*, New Directions for Mental Health Services No. 50, Jossey Bass: San Francisco.
- National Mental Health Association factsheet: *Substance Abuse – Dual Diagnosis*.
- Sciacca, K. (1997) *Removing Barriers: Dual Diagnosis and Motivational Interviewing*. *Professional Counselor* 12(1): 41-46.
- Sciacca, K. (1997) *Program Development and Integrated Treatment Across Systems for Dual Diagnosis: Mental Illness, Drug Addiction and Alcoholism*.

For more info., contact:
National Alliance for the
Mentally Ill 1-800-950-
NAMI, Dual
Recovery Anonymous
1-877-883-2332 CBH



Behavioral Health Resources on the World Wide Web

Jennifer Cook, CBH Quality Assurance Department

#4

BEHAVIORAL HEALTHCARE FOR CHILDREN & ADOLESCENTS:

- American Academy of Child & Adolescent Psychiatry (AACAP): www.aacap.org
- Clinical Practice Parameters (AACAP):
www.aacap.org/clinical/parameters/index.htm
- *Facts for Families* (AACAP): www.aacap.org/publications/factsfam/index.htm
- *Glossary of Symptoms & Mental Illnesses Affecting Teenagers* (AACAP):
www.aacap.org/about/glossary/index.htm
- Child Development (National Library of Medicine):
www.nlm.nih.gov/medlineplus/childdevelopment.html
- Child Mental Health (National Library of Medicine):
www.nlm.nih.gov/medlineplus/childmentalhealth.html
- Teen Development (National Library of Medicine):
www.nlm.nih.gov/medlineplus/teendevelopment.html
- Teen Mental Health (National Library of Medicine):
www.nlm.nih.gov/medlineplus/teenmentalhealth.html

LOCAL RESOURCES FOR CHILDREN & ADOLESCENTS:

- *Youth and Family Services Directory* (City of Bloomington):
www.city.bloomington.in.us/cgi-bin/yfsd/toc
- Center for Behavioral Health's Child & Adolescent Services:
www.the-center.org/servicesChild.html
- The Youth Services Bureau of Monroe County: www.youthservicesbureau.net
- Big Brothers Big Sisters of South Central Indiana: www.bloomington.in.us/~bbbs
- Boys' and Girls' Club of Bloomington: www.bloomington.in.us/~bgclub/home.html

HOMELESSNESS & THE PATH PROGRAM:

- Indiana Coalition on Housing and Homeless Issues: www.ichhi.org
- The PATH Program (Projects for Assistance in Transitions from Homelessness):
www.pathprogram.samhsa.gov
- National Resource Center on Homelessness and Mental Illness: www.nrchmi.samhsa.gov
- National Coalition for the Homeless: www.nationalhomeless.org
- National Alliance to End Homelessness: www.endhomelessness.org

(Continued on next page...)

TREATMENT FOR DUAL DISORDERS:

- SAMSHA's 2002 *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*: www.samhsa.gov/news/cl_congress2002.html
- Center for Substance Abuse Treatment's (CSAT) Treatment Improvement Protocol (TIP) Series: www.treatment.org/Externals/tips.html
- TIP 9 - *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse* (CSAT): <http://ncadi.samhsa.gov/govpubs/bkd134>
- TIP 29 - *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT): <http://ncadi.samhsa.gov/govpubs/bkd288>

Links to Other Resources on Dual Disorders (CSAT): www.treatment.org/topics/dual.html

PERFORMANCE IMPROVEMENT & BEHAVIORAL HEALTH BENCHMARKING:

- Center for Behavioral Health's *Behavioral Pathway Systems* (BPS): www.bpsys.org
- *Beyond Outcomes: Benchmarking in Behavioral Healthcare* (Paul Lefkowitz, BPS President): www.bpsys.org/Beyond%20Outcomes%20BHT%20Article.pdf
[Lefkowitz, P. M. (2004). *Beyond Outcomes: Benchmarking in Behavioral Healthcare. Behavioral Healthcare Tomorrow*, 13(1), 32-37.]
- *Free Benchmarks* (BPS): www.bpsys.org/benchfree.htm

CUSTOMER COMMENTS:

"Degree of treatment is good because I am still working on it. Coming here has helped a lot."

"I look forward to my appointments. My appointments help me get through my days and weeks."

"I really enjoy bringing my son here to see his counselor for his medicine."

"(Therapist) is a unique individual, with whom I have built a strong trust. It's amazing to me how, with so few sessions, he has helped me with my life."

"I've had a few times when the doctors were at odds with me but we work things out."

"I'm pleased with the treatment my niece has received from her therapist and psychiatrist."

"I am so glad all of you are here to help me and others with problems or concerns. Thank you for all you have done."

"This place has been fantastic with all my treatment. I would recommend this place to anyone. All staff are courteous and professional."

"This is the first time I've paid attention, and it has helped me."

"If not for CBH and medication I would probably be in my grave by now."

"The groups are good; support is very positive."

"I would not be here today if not for my IOP (Intensive Outpatient Program) counselor."



(Behavioral Pathways...Continued from page 3.)

BPS developed a Web site (www.bpsys.org) featuring its new benchmarking services. The internet provides a wonderful and unique vehicle for the dissemination of benchmarking data. At this time, approximately 40 different benchmarks are available, representing a very comprehensive range of performance indices. Examples include: day's cash on hand, debt ratio, bad debt percentage, pre-certification denials, staffing patterns, staff-to-client ratios, staff retention, salaries, no-show rates, length of stay, productivity, managed care reimbursement, medication errors, seclusion and restraint, re-admissions within 30 days, suicide attempts, and many more.

BPS makes these benchmarks available on an "a la carte" basis so organizations can make decisions about their priorities. Most benchmarks cost just \$25.00. Organizations interested in benchmarking simply access them on the BPS Web site by selecting the ones they want to obtain. A customized on-line survey is created in the areas of their choice. They then enter the necessary data and electronically submit it to BPS. A report revealing their percentile rankings for each of the selected items is e-mailed to them within a few minutes. If they prefer, they can print out the survey, complete it manually, and mail it to BPS.

In addition to benchmarking, BPS continues with its ORYX reporting and outcome measurement work. Consultative assistance is also provided to organizations in these and other areas. As resources in behavioral health continue to wane, accountability and efficiency become essential. Behavioral Pathway Systems has a unique opportunity to make a meaningful contribution to the industry by helping organizations learn from one another and identify best practices. In fulfilling this role, BPS is proud to be part of the CBH family and its fine tradition of quality care and evidence-based service delivery.



Center Profile



Linda Grove Paul

CBH's Assistant Manager of Adult Outpatient Services, Linda Grove Paul, is no stranger to action. As mother in a blended family of six kids and a disabled husband she sometimes feels her car clocks more miles than Yellow Cab. Yet she's always been up to her elbows in interests. Born in Cincinnati, OH in 1964, Linda moved a lot before eventually graduating from Indiana University in Business Marketing (1987). After discovering she hated investment sales, she returned to school for a Masters in Public Administration while starting a family. Three daughters and a degree (MPA, 1992) later, she volunteered at CBH and won a Volunteer of the Year Award (1994). A keen interest in social justice and disenfranchised populations coupled with her work at CBH drove her to seek an MSW degree (I.U., 1998), while her second husband brought three more kids into the family circle. Linda has now added six years of employment at CBH to her three volunteer years here and considers the job exciting. "I love the flexibility—there are so many opportunities, so much expertise and commitment. I also love the combination of business and clinical care. Everyone gives input and sharing equalizes and informs everyone. This keeps things fresh and vital. CBH is a clinical gold-mine and I like that we *still* provide indigent, quality care." She smiled. "I guess I'm not a grass-is-greener kind of girl...I feel lucky." We do too, Linda.

“A Brief Look at Social Phobia”

Source: National Institute of Mental Health (NIMH)*
By Cathi Norton, Community Relations Specialist



Social Phobia, or Social Anxiety Disorder, is an anxiety disorder characterized by overwhelming anxiety and excessive self-consciousness in everyday social situations. Social phobia can be limited to only one type of situation—such as a fear of speaking in formal or informal situations, or eating or drinking in front of others. In its most severe form, the disorder may be so broad that a person experiences symptoms almost anytime they are around other people.

Social phobia affects about 5.3 million adult Americans—3.7% of the U.S. population, ages 18–54. Women are about twice as likely to develop this disorder than men, although a higher proportion of men seek help. The illness usually begins in childhood or early adolescence, and there is some evidence that genetic factors are involved. Individuals with this phobia have a persistent, intense, and chronic fear of being watched and judged by others and being embarrassed or humiliated by their own actions. Physical symptoms often accompany intense anxiety and include blushing, profuse sweating, trembling, nausea, difficulty talking, and even stomach discomfort. These visible symptoms heighten the fear of disapproval and the symptoms themselves can become an additional focus of fear. Fear of symptoms can create a vicious cycle: as people worry about experiencing the symptoms, the chances of developing them becomes greater. While many people with social phobia recognize that their fear of being around people may be excessive or unreasonable, they are unable to overcome it. They often worry for days or weeks in advance of a dreaded situation. Many people with this illness have a hard time making and keeping friends. Social phobia often runs in families and may be accompanied by depression or alcohol dependence.

While social phobia research is on-going, two treatments are currently deemed effective. One approach involves certain medications—antidepressants such as selective serotonin reuptake inhibitors (SSRIs) and monoamine oxidase inhibitors (MAOIs), as well as drugs known as high-potency benzodiazepenes, and in certain cases, beta-blockers. The other treatment, thought to be very useful in treating social phobia, is short-term, cognitive-behavioral psychotherapy. The central component of this approach is exposure therapy, which involves helping patients gradually become more comfortable with situations that frighten them. The exposure process often involves three stages. The first involves introducing people to the feared situation. The second stage is to increase the risk for disapproval in that situation so people build confidence that they can handle rejection or criticism, and the third stage involves teaching people

techniques to cope with disapproval. In this stage, people imagine their worst fear and are encouraged to develop constructive responses to it and perceived disapproval.

Cognitive behavior therapy for social phobia also includes anxiety management training. For example, individuals are taught techniques such as deep breathing to control their anxiety level. Another important aspect of treatment is called cognitive restructuring, which involves helping them identify their misjudgments and develop more realistic expectations of the likelihood of danger in social





(“Social Phobia”...continued.)

situations. Supportive therapy such as group therapy, or couples or family therapy to educate significant others about the disorder, is also helpful. Sometimes people with social phobia also benefit from social skills training.

Social phobia can cause lowered self-esteem and depression. To try to reduce anxiety and alleviate depression, affected persons may use alcohol or other drugs which can lead to addiction. Some people with social phobia may also have other anxiety disorders, such as panic disorder or obsessive-compulsive disorder.

As is the case with many other anxiety disorders, individuals seeking help for social phobia can quite reasonably look forward to effective treatment and an enhanced quality of life.



“In any social situation, I felt fear. I would be anxious even before I left the house and it would escalate as I got closer to class, a party, or whatever. My heart would pound, my palms would get sweaty, and I would get this feeling of being removed from myself and from everybody else.”

*National Institute of Mental Health, Bethesda, MD,
US Dept. of Health and Human Services, <http://www.nimh.nih.gov>



Pathways from Homelessness

By Stephanie LaFontaine, M.A., L.M.H.C.

What do we know about homeless persons with serious mental illness?

- While only four percent of the U.S. population has a serious mental illness, five to six times as many people who are homeless (20-25%) have serious mental illnesses.
- Their diagnoses include the most personally disruptive and serious mental illnesses, including severe, chronic depression; bipolar disorder; schizophrenia schizo-affective disorders and severe personality disorders.
- People with serious mental illnesses have greater difficulty exiting homelessness than other people. They are homeless more often and for longer periods of time than other homeless persons.
- Up to 50% have co-occurring mental illnesses and substance use disorders.
- Their symptoms are often active and untreated, making it extremely difficult for them to negotiate meeting basic needs for food, shelter and safety and causing distress to those who observe them.
- They are impoverished, and many are not receiving benefits for which they may be eligible.
- The majority have had prior contact with the mental health system, either as inpatients or outpatients.
- They typically are long-term citizens of the communities in which they are homeless.
- Their social support and family networks are usually unraveled. Family members often have lost regular contact with their relatives or are no longer equipped to be primary caregivers.
- They are twice as likely as other people who are homeless to be arrested or jailed, mostly for misdemeanors. They are often good candidates for diversion from jail to more appropriate treatment, support, and housing.

What can be done?

The Stewart B. McKinney Homeless Assistance Amendments Act of 1990 authorized a Federal grant program to deal with the needs of people who are homeless and have serious mental illnesses. The program is known as **PATH** (Projects for Assistance in Transition from Homelessness). Center for Behavioral Health established a PATH program less than three years ago. Since its start-up, PATH has transitioned 64 homeless mentally ill persons into mental health services and housing. In the past eight months, PATH has had 287 outreach contacts with homeless persons in our community, providing mental health screening, and has enrolled 17 individuals identified as having mental illness in services. The PATH homeless outreach program positively impacts the community by providing outreach, mental health screening and case management to at-risk and



Center for Behavioral Health

homeless persons who are unsheltered, staying at homeless shelters, precariously housed, or in jail. A full-time seasoned case manager, Andy Matthews, staffs PATH. Andy assists in identifying homeless, mentally ill persons in the community; visits them regularly wherever they may be staying to establish trust; and then strives to transition them into receiving mental health services, applying for mainstream benefits, and moving into stable housing. As a result the program has a ripple effect—positively impacting the community corrections system, healthcare, and the community image.

PATH Works

Results of PATH are heartening. (The following names have been changed to protect confidentiality.) “Rob” was homeless for eight-to-nine years and transient in three different states. Prior to his homelessness, he was in and out of the correctional system and various mental health programs. The main factor in his continued homelessness was his inability to comply with traditional mental health models that required him to make appointments and come to the mental health center to receive services. Through the PATH component of our program, outreach staff went out into the community and visited Rob wherever he was that day. Through these extensive outreach efforts he learned to trust and overcome his reluctance to participate in treatment. Rob is now receiving services, consistently takes his medications to manage his mental illness, has not been arrested or hospitalized, and has maintained his apartment for over one year. Similarly, “John” spent four years homeless and transient throughout Southern Indiana. During this time he lived outdoors and in hotels for brief periods until he was evicted or arrested. During that four-year period he was arrested 63 times for crimes ranging from assault and public intoxication to arson. When he came to Bloomington, PATH outreach worked with him. He has now lived in our supportive housing for over 18 months, receives intensive treatment services, attends group activities to help him with social skills and further integration into the community, and has had no further criminal charges filed against him.



Center for Behavioral Health would like to thank all employees who celebrate a work-anniversary of over five years! Of our 210 full-time, and 58 part-time employees, the following staff have such anniversaries that fell/falls in the first six months of 2004:

Thank you!

<u>Years</u>	<u>Staff</u>	<u>Years</u>	<u>Staff</u>	<u>Years</u>	<u>Staff</u>
32	Gordon Gibson	9	Andy Matthews	5	Darlene Monroe
29	Denise Jackson	9	Dennis Morrison	5	Nick Quagliara
25	David Carrico	8	Sally Caldwell	5	Cindy Rhodenbaugh
23	Judith Hack	8	Ursula McCormick	5	Lee Sanders
23	Donna Nicholas	7	Jennifer Cook	5	Veronica Sansone
21	Tom Sullivan	7	Renee Doss	5	Debra Schoolcraft
20	Greg Clark	7	Jennifer Poe	5	Derek Talkington
17	Cindy Houston	6	Michael Campbell	5	Floyd Waldrip
16	Deborah Acito	6	Linda Grove-Paul	5	Melissa Wickens
15	Michelle Sears	6	Gina Thomas		
15	Mary Schreiber-Dooley	5	Carla Baumstark		
14	Beverly Terry	5	Nancy Clark		
13	Laura Crum	5	Amanda Cross		
13	Julie Matthews	5	Sherry Hardesty		
13	Michael Wagner	5	Andi Haynes		
11	Carol Ketchem	5	Edward Hopkins		
10	Sherry Dickey	5	Deb Mishler		



South Central Community
Mental Health Center, DBA

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

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 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) or **visit the CBH web site at www.the-center.org. Our fall schedule will soon be posted there.**

Final Spring/Summer events include:

May 21, 2004	“Psychopharmacology Update”	Bethany Murray, MSN, RN, CS
June 18, 2004	“Families Coping With Life-Threatening Illnesses”	Michelle Katz, MA