



# FAMILYA *flyer...*

Summer 2007

A Newsletter of NAMI-FAMILYA - Rockland's Voice on Mental Illness  
Serving Families Through Education, Advocacy and Support

*"The unnecessary secrecy is a significant problem"*

## Keeping Patients' Details Private, Even From Kin

By Jane Gross, July 3, 2007, the New York Times

An emergency room nurse in Palos Heights, Illinois told Gerard Nussbaum he could not stay with his father-in-law while the elderly man was being treated after a stroke. Another nurse threatened Mr. Nussbaum with arrest for scanning his relative's medical chart to prove to her that she was about to administer a dangerous second round of sedatives. The nurses who threatened him with eviction and arrest both made the same claim, Mr. Nussbaum said: that access to his father-in-law and his medical information were prohibited under the Health Insurance Portability and Accountability Act or HIPAA.

Mr. Nussbaum, a health care and HIPAA consultant, knew better and stood his ground. Nothing in the law prevented his involvement. But the confrontation drove home the way HIPAA is misunderstood by medical professionals, as well as the frustration – and even peril – that comes in its wake. Government studies released in the last few months show the frustration is widespread, an unintended consequence of the 1996 law.

HIPAA was designed to allow Americans to take their health insurance coverage with them when they changed jobs, with provisions to keep medical information confidential. But new studies have found that some health care providers apply HIPAA regulations overzealously, leaving family members, caretakers, public health and law enforcement authorities stymied in their efforts to get information. Experts say many providers do not understand the law, have not trained their staff members to apply it judiciously, or are fearful of the threat of fines and jail terms – although no penalty has been levied in four years.

Some reports blame the language of the law itself, which says health care providers may share information with others unless the patient objects, but does not require them to do so. Thus, disclosures are voluntary and health care providers are left with broad discretion.

The unnecessary secrecy is a "significant problem," said Mark Rothstein, chairman of a privacy subcommittee that advises the Department of Health and Human Services (HHS), which administers HIPAA. "It's drummed into them that there are rules they have to follow without any perspective," he said about health care providers. "So surprise, surprise, they approach it in a defensive, somewhat arbitrary, and unreasonable way."

Susan McAndrew, deputy director of health information privacy at HHS, said that problems were less frequent than they once had been but that health care providers continued to hide behind the law. "Either innocently or purposefully, entities often use this as an excuse," she said. "They say 'HIPAA made me do it' when in fact, they chose for other reasons not to make the permitted disclosures." Mr. Rothstein, one of HIPAA's harshest critics, has led years of hearings across the country. Transcripts of those hearings, and accounts from hospital administrators, patient advocates, lawyers, family members, and law enforcement officials offer

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# From The Editor

By Rena Finkelstein, President

Our gala 25<sup>th</sup> anniversary celebration on June 20<sup>th</sup> marked a milestone in the history of NAMI-FAMILYA. We've come a long way since 1981 when fourteen families with loved ones suffering from mental illness met to form the Family Support Group of Rockland County. In 1982 the infant group linked up with the state and national family associations, a movement that has had an unparalleled growth in the past quarter of a century and phenomenal impact on both clinical practice and public policy.



Our centerfold includes a photo essay showing some of the highlights of the warm and wonderful evening at the beautiful View on the Hudson as we celebrated our silver anniversary and honored two very special friends of people with mental illness. The 2007 Florence Gould Gross award was presented to our Rockland Commissioner of Mental Health Mary Ann Walsh-Tozer in recognition of her enlightened policies and commitment to best practices in the treatment of individuals afflicted with mental illness. We wanted to show our deep appreciation, also of her concern, compassion and accessibility to our families. Our award to Chris Vanasse recognized her passionate dedication to providing support and education, which has made a significant difference in the lives of families of people with mental illness. Chris' energy, enthusiasm and compassion as Family-to Family teacher and co-facilitator of our family support group for the past three years have been an abiding inspiration.

During the ceremonies I traced some of the history of the family movement. Twenty-five years ago, families felt isolated, misunderstood by friends and relatives, unable to speak freely about their feelings to anyone. At best some mental health clinicians saw them as interfering, and at worst as "the cause" of their loved ones' illness. In the late 1970's several highly regarded family therapists espoused the idea that mixed or conflicting messages, primarily from the patient's mother, caused Schizophrenia. Hence, the term "schizophrenogenic mother" was coined. Perhaps most notable among those theorists was Jay Haley, who has long since recanted. Although more and more people were being discharged from psychiatric hospitals and returned to families for care and treatment, the belief that mental illness was caused by poor parenting persisted—but the idea of providing support for these families was not an integral component of community treatment planning.

Additionally, families saw a tremendous service vacuum and felt impotent to have any impact on the mental health system—and so the family movement developed nationwide and here in Rockland to fill that vacuum with education, support and grass roots advocacy - and to transform family pain and frustration into action and power.

**But what disturbing news have we been hearing recently from some of our family members?** Despite gigantic strides made in psychiatric research and clinical practice - the recognition of families as an important partner in treatment, the inclusion of families in the planning process for mental health services, the family education initiatives launched by the Office of Mental Health in concert with family advocacy organizations such as NAMI—we are still receiving reports about families being left out of the loop on the basis of "confidentiality" and HIPAA law.

HIPAA (the Health Insurance Portability and Accountability Act of 1996), jointly sponsored by Sen. Edward Kennedy (D-Mass) and Sen. Nancy Kassenbaum (R-Kan) was

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FAMILYA flyer is a publication of  
NAMI-FAMILYA  
of Rockland County, NY  
*Rockland's Voice on Mental Illness*  
Serving Families of People with  
Mental Illness through Education,  
Advocacy and Support

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NAMI-NYS-National Alliance  
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# An Interview About HIPAA With RPC's Dr. William Boyle

**W**e wondered how the HIPAA laws relating to privacy of patient information was specifically applied in the case of psychiatric patients. So we asked Dr. William Boyle, Deputy Director for Quality Assurance for Rockland Psychiatric Center (RPC) programs, to give us his reading on the HIPAA laws, how they were interpreted by RPC and how the law was implemented by RPC outpatient staff. What follows is a summary of his responses to our questions.

**Q:** Under the HIPAA law, under what conditions can you give information to family members about a patient in your outpatient programs?

**Dr. B:** Absent expressed objection by the patient, you can share information about the patient with family members.

**Q:** Do you have to have a signed consent form in order to share information with family members?

**Dr. B:** The law doesn't actually require a signed permission. As long as the patient doesn't object, the treating professional can contact the family.

**NOTE:** The HIPAA policy notice reads: *You have the right to request a restriction or limitation on the health information used or disclosed about you for the purpose of treatment, payment or health care operations. You also have the right to request that we restrict or limit health information about you that we may use or disclose to someone who is involved in your care such as a family member. For example, you could ask that we not use or disclose information about the medication you are taking to your spouse or significant other.*

**Q:** How do you implement this contact with the family in the RPC community outpatient programs?

**Dr. B:** Our staff tells the patient that we think family involvement is essential for their care, so we want to contact the family. If the patient does not express an objection, we are free to share information with his/her family member. Also, we do not need consent if it is an emergency (a threat to life). Of course, we would document in the patient's chart that he/she expressed no objection. The Federal government has the right to come in and ask what information was released and to whom it was released.

**Q:** How do you identify individuals with whom you can share information?

**Dr. B:** There are a number of areas in HIPAA that are not well-defined—for example, who is family, what about step-families, foster parents? RPC defines the family member as those individuals who are logically involved with the patient. There are some people who are legally entitled to information such as a guardian, spokesperson (which is a different level of guardianship)

**NOTE:** HIPAA Privacy practices indicate that: *If you do not object and the situation is not an emergency and disclosure is not otherwise prohibited by stricter laws, we are permitted to release your health information to individuals involved in your care, a family member, other relative, friend or other person who you have identified to be involved in your health care or payment. We may use your health information to notify a family member, a personal representative or a person responsible for your care, of your location, general condition or death.*

**Q:** What if a patient indicates that he/she does not want his/her family contacted?

**Dr. B:** In that case we would honor the patient's request but would continue to urge the patient to involve family members. We believe that family involvement is essential to the successful treatment of the patient.

**Q:** Can a treating professional share information with another professional?

**Dr. B:** Absolutely. Yes, mental health professionals can share information with other mental health professionals—as long as they are involved with the treatment of the individual, even if they are from another agency.

**Q:** What happens in the case of a deceased patient? Can mental health professionals who were involved with the patient, even if they come from different agencies, discuss the case and review their records under HIPAA?

**Dr. B:** Yes, Psychiatric autopsies are permitted under the law. All the treating professionals can be involved in this process.

**Q:** Why do you think some clinicians and agencies are so reluctant to give information to family members? Also, most absolutely require a signed release from the patient before talking to family members? Do you think it is the threat of the severe penalties under HIPAA?

**Dr. B:** This may be one of the reasons. But of course, although HIPAA does not prevent you from releasing information, it **does not require** the provider to release information. Most agencies/doctors in the community prefer to obtain a signed release at the time of intake. Many providers interpret the HIPAA regulations very narrowly. Provider policies, if more stringent, supersede the HIPAA law. Thus, although HIPAA may allow the sharing of information without a signed consent (in many instances) a particular agency may still require such.

**Q:** Are legal advisers to agencies generally familiar with the HIPAA law?

**Dr. B:** The HIPAA law and privacy practices are very

## *An Interview About HIPAA* continued from page 3

lengthy and complex. As such it is certainly possible that legal counsel who are not intimately familiar with the legislation and the many administrative “simplification” provisions, might take an unnecessarily restrictive view to cover any possible liability exposure.

**Q:** How can families convince clinicians to release information about their loved ones?

**Dr. B:** RPC staff are bound to follow HIPAA regulations. Any changes to HIPAA policy would have to come from The Health and Human Services Dept. As HIPAA policy now stands, staff are free to share information with a patient’s family unless that patient expressly objects to such sharing.

### *HIPAA Privacy Rule*

Does the HIPAA Privacy Rule permit a doctor to discuss a patient’s health status, treatment, or payment arrangements with the patient’s family and friends?

The US Department of Health & Human Services in a memo last revised April 3, 2007 states:

HIPAA Privacy Rule at 45 CFR 164.510(b) specifically permits covered entities to share information that is directly relevant to the involvement of a spouse, family members, friends, or other persons identified by a patient, in the patient’s care or payment for health care. If the patient is present, or is otherwise available prior to the disclosure, and has the capacity to make health care decisions, the covered entity may discuss this information with the family and these other persons if the patient agrees or, when give the opportunity does not object. The covered entity may also share relevant information with the family and these other persons if it can reasonably infer, based on professional judgment that the patient does not object.

Under these circumstances, for example:

- A doctor may give information about a patient’s mobility limitations to a friend driving the patient home from the hospital.
- A hospital may discuss a patient’s payment options with her adult daughter.
- A hospital may instruct a patient’s roommate about proper medicine dosage when she comes to pick up her friend from the hospital.
- A physician may discuss a patient’s treatment with the patient in the presence of a friend when the patient brings the friend to a medical appointment and asks if the friend can come into the treatment room.

Even when the patient is not present, or it is impractical because of emergency circumstances or the patient’s incapacity for the covered entity to ask the patient about discussing his/her care or payment with a family member or other person, a covered entity may share this information

with the person, when in exercising professional judgment, it determines that doing so would be in the best interest of the patient (see 45 CFR 164.510(b)). Thus, for example:

- A surgeon may, if consistent with such professional judgment, inform a patient’s spouse, who accompanied her husband to the emergency room, that the patient has suffered a heart attack and provide periodic updates on the patient’s progress and prognosis.
- A doctor may, if consistent with such professional judgment, discuss an incapacitated patients condition with a family member over the phone.

In addition, the Privacy Rule expressly permits a covered entity to use professional judgment and experience with common practice to make reasonable inferences about the patient’s best interest in allowing another person to act on behalf of the patient to pick up a filled prescription, medical supplies, X-rays, or other similar forms of protected health information. For example, when a person comes to a pharmacy requesting to pick up a prescription on behalf of an individual he identifies by name, a pharmacist, based on professional judgment and experience with common practice, may allow the person to do so.

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## *Albert Ellis, Psychotherapist and Father of Cognitive Behavior Therapy Dies*

Albert Ellis, a psychotherapist, whose methodology has been credited with providing the basis for cognitive behavior therapy (CBT) died on July 24th at the age of 93 at his home above the Institute for Rational Living (now the Albert Ellis Institute) that he founded in Manhattan. CBT has been effective for many people in treating anxiety, depression, obsessive-compulsive disorder and other psychiatric disorders. Dr. Ellis called his approach rational emotive behavior therapy, or R.E.B.T. Developed in the 1950s, it challenged the methods of Sigmund Freud, the prevailing psychotherapeutic treatment at the time.

Dr. Ellis believed in short-term therapy that called on patients to focus on what was happening in their lives at the moment and to take immediate action to change their behavior. He saw the role of therapists as intervening directly, using strategies and homework exercises to help patients first learn to accept themselves as they are (unconditional self-acceptance, he called it) and then to retrain themselves to avoid destructive emotions — to “establish new ways of being and behaving,” as he put it. His ideas defied the convention of the times, but in a 1982 survey, clinical psychologists ranked Dr. Ellis ahead of Freud when asked to name the figure who had exerted the greatest influence on modern psychology.

# Letting Your Family In On Your Therapy

By Elizabeth Bernstein, *the Wall Street Journal*, July 17, 2007

When Tony Fama worries about recurring sadness or has questions about antidepressants, he calls a psychiatrist—his wife's.

Mr. Fama's wife, Helen Kraljic, suffers from bipolar disorder, and he calls her doctor frequently if she seems to be manic or having side effects from her medication. Often, Mr. Fama sits in on his wife's therapy sessions, offering his opinions. Sometimes, he talks to the doctor about his own struggles as caregiver.

"The fact that I have an input with her doctors makes it easier to keep her disorder under control," says Mr. Fama, a 60-year-old supermarket manager in Manhattan.

Ms. Kraljic's doctor isn't breaching her confidentiality by talking to her husband. Rather, he is practicing an increasingly popular psychiatric treatment called "family-based" or "family-focused" therapy. Instead of excluding family members out of concern for patient privacy, the family-based approach seeks to expressly include spouses, parents or siblings in therapy. The practice goes beyond traditional family therapy—which typically focuses on families' dysfunction—and forges new territory on privacy and doctor-patient confidentiality issues.

Frustrated by often ineffective treatment plans that keep loved ones in the dark and blame families for problems, a growing number of therapists are turning to such methods. Family-based counselors meet regularly with the patient and family members. Certain loved ones, most often a spouse or parents, but sometimes siblings, as well, are designated as caregivers. Each member of the family, including the patient, agrees to the open nature of the treatment -- sometimes signing a waiver outlining what information the therapist can share with relatives. This can include details about symptoms and medication.

Family members are free to talk to the therapist about their loved one's behavior, symptoms and progress. They also talk about how their relative's illness affects them. The aim is to give each family member support and a role in the treatment.

"The focus is helping to mobilize the strengths in the family," says Joan R. Asarnow, a psychologist and professor at UCLA's Semel Institute for Neuroscience & Human Behavior, who uses the family-based approach to treat depressed and suicidal children and adolescents.

Critics of family-based therapy say that the lack of boundaries can be dangerous. Patients may be leery of sharing intimate information with a therapist because they know there is a lower bar on confidentiality. And family members may resist talking about their problems.

But proponents believe that the benefits far outweigh potential drawbacks. They point out that this approach can save money: Rather than going on indefinitely, the therapy is prescribed for a limited time, typically nine months to a year, with the idea that families will gain skills to continue on their own.

Advocates also note that spouses, parents and siblings often know the patient better than anyone else does. Indeed, research has shown that the family-based approach can reduce hospitalization and relapse rates and help patients take their medications more regularly. "What has happened in the past is mental health professionals and the public would blame families and criticize them," says Susan Gingerich, a social worker in Philadelphia who uses family-based therapy to treat people with schizophrenia. "In fact, they can be an important source of treatment."

In September, Beth Israel Medical Center in New York will open the Bipolar Family Treatment Center, an outgrowth of the hospital's Zirinsky Mood Disorders Center. The center's director, psychiatrist Igor Galynker, created an approach he calls "family-inclusive treatment."

At the bipolar center, therapists explain to patients how their families can be an early warning system for crises and how the patient and family can work together to improve behavior. The patient receives medication and psychotherapy, and both the patient and caregivers are evaluated on a quarterly basis. In addition, children of the patient are evaluated by a therapist.

Patients and family members sign consent forms that acknowledge that the doctor can share information with the family. "But we don't disclose private issues that were discussed in therapy, such as dreams or fantasies," says Dr. Galynker, who gives his cell phone number to all patients and their families.

Dr. Galynker says his approach is similar to the work of David Miklowitz, a psychologist and professor at the University of Colorado who pioneered a family-focused approach for bipolar patients.

In 2000 and 2003, Dr. Miklowitz published the results of his first randomized trials. "What those studies showed is that if you combine family-focused treatment with medications, then you get a better outcome over two years than if you just give medication or medication and equally intensive individual therapy," says Dr. Miklowitz, who has written a manual for clinicians detailing his approach, as well as a guide for families.

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## Letting Your Family In On Your Therapy

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The family-based approach may be having one of its biggest impacts in the area of eating disorders. Traditionally, eating disorders have been treated by isolating the patient from his or her family in an in-patient facility, where feeding is controlled and the patient is given psychotherapy with the goal of encouraging autonomy from the family.

Instead, the family-based treatment for eating disorders—called the Maudsley approach, after the hospital in London where it was developed—puts parents in charge of feeding and caring for the patient. Parents and siblings enter into therapy with the patient. In addition, they prepare all of the patient's food and eat all meals with him or her.

"It stands traditional therapy for anorexia on its head," says James Lock, a child psychiatrist and professor at Stanford University, who helped bring the Maudsley approach to the U.S. and developed a treatment manual with Daniel Le Grange, a psychologist at the University of Chicago.

The treatment has been spreading rapidly in the U.S. Maudsley Parents, a Web site that disseminates information about the family-based approach, listed four therapists when it was launched in 2004. Today it lists almost 60.

In a study published in 2005 in a psychiatry journal, Dr. Lock reported that of 86 anorexic subjects treated with the Maudsley approach, about 90% returned to a normal weight range by 12 months and about 70% returned to normal weight and had normal psychological parameters.

Lydia Spottswood credits the Maudsley approach with helping her daughter, Erin, finally beat anorexia. For 4½ years, the 22-year-old college student battled her eating disorder, with individual psychotherapy, family therapy and two extended stays in residential treatment centers. As her health declined—at one point she weighed about 75 pounds and was hospitalized on a cardiac ward—her parents tried to talk to her therapist. But citing ethical guidelines and privacy laws, the counselor refused to share information. "Even if they saw her deteriorating or we saw her deteriorating, we couldn't communicate," says Mrs. Spottswood, a retired nurse who lives in Kenosha, Wis.

Last year, the Spottswoods asked their daughter to try the Maudsley approach through a program at the University of Chicago. She moved back home, and her parents took control of her feeding; she and her parents attended weekly therapy sessions.

Although Miss Spottswood says it wasn't easy, she gained 15 pounds in the first two weeks. Now for the first time in nearly five years, she is at a healthy weight and is planning for the future. "It's a completely different thing knowing my parents were taking care of me," says Miss Spottswood. "If a counselor or nurse helps you, it's their job. But when my

mom and dad did it, it's because they truly love and care about me."

Write to Elizabeth Bernstein at [elizabeth.bernstein@wsj.com](mailto:elizabeth.bernstein@wsj.com)

### Commentary by Irene S. Levine, Ph.D.



*When it comes to serious mental illnesses, family-based therapy makes eminent sense. If the patient is willing and the family is supportive, the synergy of patient, therapist and family working together can only be helpful. There is great legitimacy to including spouses, siblings, parents and other relatives in the treatment of an individual for a variety of reasons:*

*1. Many patients spend far more time with their families than with any service provider. They may live with their families or depend on them for social support.*

*2. No one else knows the patient like their family. Families are the archivists of a patient's history: They can help recall which medications worked, which didn't, and what types of side effects they produced.*

*3. Service providers tend to come and go but families provide continuity in the lives of patients. They often provide financial and other logistical supports that enable treatment, rehabilitation, and recovery (e.g. transportation).*

*4. Lastly, no one else has the same vested interest in the recovery of their loved one as an individual's family.*

*Families deserve to be given the tools and supports they need to help their family member and better understand their illness and its treatment.*

## Keeping Patients' Details Private

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phone was not helpful, so Ms. Banks hit the road. Twenty-two hours later, she arrived at the hospital. But more of the same awaited her. She said her mother's nurse told her that "because of the HIPAA laws I can get in trouble if I tell you anything," In the morning, she could speak to the doctor, she was told.

The next day, Ms. Banks was finally informed that her mother had had heart failure and that her kidneys were shutting down. "I understand privacy laws, but this has gone too far," Ms. Banks said. "I'm her daughter. This isn't right." A hospital spokeswoman, Elena Mesa was asked if nurses were following HIPAA protocol when they denied adult children information about their parents. She could not answer the question, Ms. Mesa said, because HIPAA prevented her from such discussions with the press.

# She Finds Life, Healing By Tapping Into Love For Art

From an article in *Newsday*, June 4, 2006 by Merle English

Sitting near the entrance of a small Forest Hills restaurant, Rose-Ellen Rinsler, 50, shows a visitor a small album with samples of her work: greeting cards with collages and whimsical line drawings of lighthearted themes and couples in love. Hanging on a wall nearby, the faces of the Beatles dominate another collage. The art evokes pleasant feelings. "I like to do work that makes people happy," Rinsler explains.

Happiness expressed in her art is especially important for Rinsler, who had to put her drawing on hold for three decades while she battled mental illness. Diagnosed with schizophrenia and bipolar disorder as a teenager, Rinsler was hospitalized 17 times at Long Island Jewish Methodist Center. "I had it all. I was hallucinating, having delusions," she recounted in a recent interview. She was treated with antidepressants, antipsychotic drugs, and shock treatment. She once tried to commit suicide.

But three years ago Rinsler took up her art again, and her work, along with the medicine and psychotherapy, have been keys to her continuing recovery. "In the past three years I've been a happy person," she said. "I'm in touch with reality. I'm grateful and happy I have a clear mind. It's been 35 years that I've been struggling to get to this point."

"I was a very happy child," she recalled "I was doing beautifully in school. I had lots of friends, played piano, went to summer camp. Everything was great." That was until the family relocated to California when she was 15. "I became very depressed because I missed my friends, my school. My father couldn't find a job," Rinsler said. The family, including an older brother, returned to Forest Hills and six months later Rinsler began to show serious signs of depression.

"Sadness, fear, anxiety. I was pacing back and forth in my home. I had to stay home from school. I couldn't relate to the other kids. I couldn't go to the supermarket and shop. I'd be lying in bed watching TV, thinking that the radio and TV were talking directly to me, sending me messages, and I thought I could send messages to other people through my thoughts. "There was a time when I thought I would never be able to make it through life, be part of society," she added. "I told my mother I didn't want to live anymore."

Doctors advised Rinsler, to get full or part-time work, but she found work stressful, she said. "I was scared to be on a bus or train. I would have a panic attack and had to be put in the hospital." Then a psychiatrist convinced her that her art could be her work.

Rinsler, a former member of the Alliance of Queens Artists in Forest Hills, showed an early talent for art. When she was

5, she said, her mother gave her crayons and magic markers and told her, "Sit down and create." She now sells her work at a Long Island City restaurant and a boutique in Jamaica under the legend: "Rosie's Originals, With Love."

"This woman is a miracle," says Barbara Cosentino of Forest Hills, Rinsler's psychotherapist. "She's had a very serious mental illness, but has found a way to lead a rich and fulfilling life. Having a passion helps people get well and stay well. The illness sometimes kills all the joy, but she managed to hold onto the joy."

Rinsler exudes that joy. "Only recently have I been able to say I'm an artist, a musician ... not just a person with mental illness," she said. "There's always hope."

## Breaking The Silence Through Art Wednesday, October 17, 2007



You won't want to miss this special program celebrating how art expressions transcend the challenges of mental illness. Come at 6:30 PM for refreshments and an exciting exhibit of visual art. Also, enjoy some musical performances, all

in the Fire Training Center at Firemen's Memorial Park Drive in Pomona. Then join us in the auditorium for a public forum on the Arts and Healing, featuring a talk and performance by Composer and musical artist Barry Call and visual artist and motivational speaker Nancy Gross. See you there!!

Watch for your registration form. Seating is limited, so be sure to reserve your seat in advance.



*Serving up the delectable desserts at our Annual Theatre party benefit are (L-R) Joan Pollner, Chair, with Gloria Pesce and friend Jeanette Squitieri*

# NAMI-FAMILYA's 25<sup>th</sup> Anniversary



*Joseph Holland, former Social Services Commissioner, takes time from conversing with wife Sally and Eileen Murphy for a photo op. (The Hollands are former Florence Gould Gross award recipients)*



*The Hon. C. Scott Vanderhoef, County Executive, lets us in on some personal memories and anecdotes of high school days with Mary Ann Walsh-Tozer and husband Joel.*

NAMI-FAMILYA's 25<sup>th</sup> Anniversary Celebration and Awards Night drew a banner crowd of 180 friends, dignitaries, families and consumers. We bring you photos of some of the individuals who joined us for that memorable occasion.



*Honorees Commissioner Mary Ann Walsh Tozer and Chris Vanasse pose for an "official photograph."*



*Guests enjoy mingling during the reception prior to dinner. (L to R) Joel Tozer chit-chats with Jocelyn Youngblood of RCDMH while Fran Aquino and Beverly Feuer (back to camera) of the Mental Health Coalition enjoy a laugh with Dr. Irene Levine of the Nathan Kline Institute.*



*Keynote speaker Sylvia Nasar, award winning biographer, economist and journalist, gives some fascinating behind-the-scene insights into the life of John Forbes Nash. Her biography, "A Beautiful Mind," examines the life of this Nobel laureate, who suffered from schizophrenia. Adapted for the screen in 2001 the book and film raised public consciousness about mental illness.*



*Sylvia Nasar and Rockland Psychiatric Center Executive Director Jim Bopp exchange reminiscences when they discover that they both attended Antioch College.*

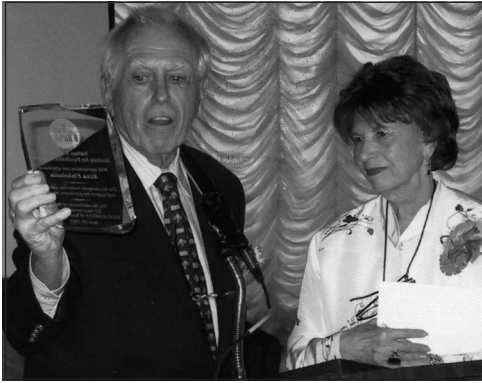


*Sidney Paul, former Executive Director of the Mental Health Association of Rockland County and wife Cyrille join us for our special evening. (We partnered in many joint ventures under Sid's tenure)*



*Rich Stolfi and Roz Stoller pause*

# Celebration and Awards Night



*Rena is surprised by Dr. Jerome Levine, Deputy Director of the Nathan Kline Institute with an award for her "energetic leadership advocacy and support for psychiatric research."*



*Sherry Glickman, Director of Children's Services for the Rockland County Dept. of Mental Health, shares stories about Mary Ann's early days with the Department.*



*FAMILYA Board member Jim Scaringe and wife Angie enjoy some hors d'oeuvres at the reception.*



*Sherry Muth (Jawonio), Tom Zimmerman (Loeb House) and Donna Pauldine (Rockland County Department of Mental Health) get together to compare notes during the reception.*



*President Rena Finkelstein catches up with Ellen Fein, one of the founding members of NAMI-FAMILYA, as they enjoy the video "Back to the Future" dedicated to our volunteers, friends and families.*



*Commissioner Walsh-Tozer stops to chat with County Legislator John Murphy.*



*...e to greet a friend.*



*Diana Siegel, Barbara Murphy, Joan Higgins and Peggy Moran register attendees as FAMILYA staff members Marlene Becker and Anne Arias look on.*



*Chris Vanasse's brother Bruce Hansen and mother Otilie Hansen, NKI Coordinator of outpatient research recruitment Melissa Benedict, and research assistant Alexis Morena check in at The View.*

## Study Cites Cost Savings Of Mental Health Courts

Special courts that sentence people with mental illness who are convicted of misdemeanors and low-level felonies to treatment instead of jail have the potential to save taxpayers money, according to a RAND Corporation study. The study examined costs incurred by participants in the Allegheny County Mental Health Court in Pittsburgh.

There are about 120 such courts in the United States, and the findings are likely applicable to many of them, according to M. Susan Ridgely, J.D., the lead researcher on the RAND study team.

The Council of State Governments, sponsor of the study, cites evidence that many people with mental illnesses cycle through the criminal justice system. Nearly a quarter of jail inmates who reported having a mental health problem had served three or more prior jail terms, according to 2006 figures from the U.S. Bureau of Justice Statistics. About 16% of people in jails and prisons have a serious mental illness, compared with about 5% of the U.S. population. Millions of dollars are spent each year incarcerating people with mental illness, many of whom engage in relatively minor offenses, such as trespassing and disorderly conduct.

Mental health courts offer defendants the opportunity to participate in court-supervised, community-based treatment in lieu of typical criminal sanctions—the intervention is essentially probation with close supervision and mandated treatment. Because such courts are relatively new—in 1997 there were only four in the United States—only a handful of studies have measured their performance, and no published study has systematically examined the costs of mental health courts or, more specifically, their fiscal impact on criminal justice, mental health, and welfare systems.

The sample for the RAND study included all 365 individuals who participated in the Allegheny County Mental Health Court between its inception in June 2001 and the end of September 2004. Cost analyses were conducted for sub-samples for which comparison conditions could be constructed. To determine the fiscal impact, RAND researchers gathered information on treatment costs and costs incurred by the criminal justice, behavioral health, and welfare systems from six state and county public agencies. These costs were compared with costs that would have been incurred by the participants had they gone through the normal criminal court system and with their costs before and after an arrest in the years before entry into the mental health court.

Most participants were men (62%). They ranged in age from 18 to 72 years old; half were between the ages of 29 and 44. The sample was split between white, non-Hispanic

(55%) and African-American (41%) individuals. On average, participants were arrested twice in the two years before they entered the mental health court and had spent almost half of the two years (an average of 345 days) in jail.



Diagnoses were missing for almost one-third of the sample, but for the remainder, severe mental illnesses dominated—schizophrenia, schizoaffective, and other psychotic disorders (22%); bipolar disorder (21%); and major depression (6%). Half of the sample had evidence of alcohol or drug abuse. Although Global Assessment of Functioning scores were missing for a quarter of the participants, most had a score of less than 50, indicating a group of individuals with serious psychiatric impairment.

The findings show that entry into the mental health court program led to an increase in the use of mental treatment services in the first year as well as a decrease in jail time. The decrease in jail expenditures mostly offset the cost of the treatment services. When federal cost-sharing under Medicaid is factored in, there was a complete offset of costs for the state and county. An analysis that followed a sub-sample of participants for a longer period showed a dramatic decrease in jail costs in the second year of participation. The treatment costs returned to pre-mental health court levels in the second year. The drop in jail costs more than offset the treatment costs, suggesting that the program may help decrease total taxpayer costs over time.

Although the overall cost savings for the two years was not statistically significant, the leveling off of mental health treatment costs and the dramatic drop in jail costs yielded a large cost savings at the end of the observation period. The lower cost associated with the program in the final two quarters of observation was more than \$1,000 per quarter per person and statistically significant in both quarters. The study also found that more seriously distressed subgroups had larger estimated cost savings, although none of the savings was statistically significant in the first year of participation. Consistent with previous studies of mental health courts, no evidence was found that diverting these individuals from the criminal justice system posed any higher risk to public safety.

The 48-page report, *Justice, Treatment, and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court*, can be found at [www.rand.org](http://www.rand.org) and at [www.justicecenter.csg.org](http://www.justicecenter.csg.org).

*(Thanks to Jerome Levine, M.D., Deputy Director of the Nathan Kline Institute for Psychiatric Research for sharing this article from Psychiatric News, April 2007)*

# Good News From Albany

**W**e have received word that an agreement has been reached on legislation to ban solitary confinement for prison inmates with serious mental illness. Governor Spitzer has agreed to sign the new bill, a reversal of his position on the original bill. The compromise bill was passed unanimously by the Senate during a special session on July 14 and the Assembly is committed to its passage when it returns to Albany later this year.

The bill will provide for people with severe psychiatric disabilities to be housed in residential mental health units (RMHU's), instead of being put into solitary confinement in Special Housing units (SHU's). Individuals in RMHU's would be permitted out of their cells for five hours a day – four for therapy and one for exercise. Presently people confined to SHU's are allowed out for only one hour a day.

The Commission on Quality of Care and Advocacy for Parents with Psychiatric Disabilities would monitor the housing and treatment for prison inmates with psychiatric disabilities. The bill also calls for eight hours of training for all corrections officers, eight specialized hours for those assigned and RMHU's as well as eight hours of annual—in service training. \$9 million has been allocated in the 2008 budget specifically for the RMHU's.

Our thanks to Assemblyman Jeffrion Aubry and Senator Michael Nozzolo, the legislative sponsors who fought so tirelessly for this legislation and to Governor Spitzer for his negotiations to reach this agreement. Sen. Nozzolo called the bill a "landmark legislative measure" ... that "encourages, establishes and requires the different treatment of the mentally ill who are incarcerated." The legislation will make our prisons safer and more humane, he added.

Thanks also to the passionate efforts of the MHASC Coalition, comprised of family members, former inmates, recipients, providers, legal assistance groups and advocates, that kept the legislation alive. Kudos to all of you who joined in the battle by writing, calling, and emailing Albany legislators. Passage of this bill shows that working together, we can make a difference!

## More Good News!!

For the past decade advocates have fought for adoption of legislation that would suspend, rather than terminate Medicaid benefits during incarceration. Currently, released inmates must re-apply, a process that is costly, lengthy and has left thousands without vital health and mental health care during their re-entry to the community after completion of a prison sentence – the most difficult of times. This bill which permits an inmate in a state prison or local jail who was receiving Medicaid prior to incarceration to remain eligible for medical assistance, which will give these indi-

viduals Medicaid coverage at the time of release.

Many counties (including Rockland) provide medications expeditiously upon release of prisoners from the local jail through the Medication Grant program. Rockland County Department of Mental Health also has a transition manager as part of the behavioral health team in the jail. Presumptive eligibility will provide an added tool to facilitate quick and appropriate delivery of services to this vulnerable population. We applaud Governor Spitzer for signing this bill, which was sponsored by Assemblyman Wright and Senator Hannon

*Information derived from MHANYS Mental Health Updates, 7/19/07 and 7/23/07)*



The Nathan Kline Institute Health Sciences Library has received a generous donation of current medical books (see titles below) through a project of the Jacob and Valeria Langeloth Foundation, which is dedicated to expanding health literacy and supporting local libraries in providing health information. These books are shelved in the Library reading room, and are available for borrowing.

- American College of Physicians Complete Home Medical Guide, 2nd ed. (2003)
- American Dietetic Association Complete Food and Nutrition Guide, 3rd ed. (2006)
- Atlas of Human Anatomy, 4th ed. (2006)
- Castle Connolly Top Doctors New York Metro Area, 10th ed. (2006)
- Consumer Drug Reference (2007)
- Consumer's Guide to Dietary Supplements and Alternative Medicines (2006)
- Current Essentials of Medicine, 3rd ed. (2005)
- Current Medical Diagnosis & Treatment, 46th ed. (2007)
- Family Health, Nutrition and Fitness (2006)
- Harvard Medical School Family Health Guide (1999)
- Mosby's Pocket Dictionary of Medicine, Nursing & Health Professions, 5th ed. (2006)
- Professional Guide to Diagnostic Tests (2005)
- Professional Guide to Diseases, 8th ed. (2005)
- Professional Guide to Signs & Symptoms, 5th ed. (2007)

*For more information contact Stuart Moss, Library Director  
Nathan Kline Institute for Psychiatric Research  
140 Old Orangeburg Road, Orangeburg, NY 10962*

## Keeping Patients' Details Private *continued from page 1*

an anthology of HIPAA misinterpretations, some alarming, some annoying:

- Birthday parties in nursing homes in New York and Arizona have been canceled for fear that revealing a resident's date of birth could be a violation.
- Patients were assigned code names in doctor's waiting rooms – say “Zebra” for a child in Newton, Mass., or “Elvis” for an adult in Kansas City, Mo. – so they could be summoned without identification.
- Nurses in an emergency room at St. Elizabeth Health Center in Youngstown, Ohio, refused to telephone parents of ailing students themselves, insisting a friend do it, for fear of passing out confidential information, the hospital's patient advocate said.

State health departments throughout the country have been slowed in their efforts to create immunization registries for children, according to Dr. James J. Gibson, the director of disease control in South Carolina, because information from doctors no longer flows freely.

Teaching staff to protect records is easier than teaching them to share them, said Robert N. Swidler, general counsel for Northeast Health, a nonprofit network in Troy, N.Y. that includes several hospitals. “Over time, the staff has become a little more flexible and humane,” Mr. Swidler said. “But nurses aren't lawyers. This is a hyper-technical law and it tells them they may disclose but doesn't say they have to.” Many experts, including critics like Mr. Rothstein and proponents like Ms. McAndrew, distinguish different categories of secrecy.

There are “good faith nondisclosures,” as when a floor nurse takes a phone call from someone claiming to be family members but cannot verify that person's identity. Then there are “bad faith nondisclosures,” like using HIPAA as an excuse for not taking the time to gather records that public health officials need to help child abuse investigators try to build a case.

Most common are seat-of-the pants decisions made by employees who feel safer saying “no” than “yes” in the face of ambiguity. That seemed to be what happened to his own mother, Mr. Rothstein said, when she called her doctor's office to discuss a problem. She was told by the receptionist that the doctor was not available, Mr. Rothstein said, and then inquired if the doctor was with a patient or out of the office. “I can't tell you because of HIPAA,” came the reply. In fact the doctor was home sick, which would have been helpful information in deciding whether to wait for a call back or head for the emergency room.

The law, medical professionals and privacy experts said, has had the positive effect of making confidentiality a priority as

the nation moves toward fully computerized, cradle-to-grave medical records. But safeguarding electronic privacy required a tangle of regulations issued in 2003, followed last year by 101 pages of “administrative simplification.”

Senator Edward M. Kennedy, a sponsor of the original insurance portability law, was dismayed by the “bizarre hodge-podge” of regulations layered onto it, several staff members said, and “by the department's failure to provide adequate guidance on what is and is not barred by the law.” To that end, Mr. Kennedy, along with Senator Patrick M. Leahy, Democrat of Vermont, plans to introduce legislation creating an office within the Department of Health and Human Services dedicated to interpreting and enforcing medical privacy. “In this electronic era it is essential to safeguard the privacy of medical records while insuring our privacy laws do not stifle the flow of information fundamental to effective health care,” Mr. Kennedy said.

This spring, the department revised its website, [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa), in the interest of clarity. But HIPAA continues to baffle even the experts. Ms. McAndrew explained some of the do's and don'ts of sharing information in a telephone interview.

Medical professionals can talk freely to family and friends, unless the patient objects. No signed authorization is necessary and the person receiving the information need not have the legal standing of, say, a health care proxy or power of attorney. As for public health authorities or those investigating crimes like child abuse, HIPAA defers to state laws, which often, though not always, require such disclosure. Medical workers may not reveal confidential information about a patient or case to reporters, but they can discuss general health issues.

Ms. McAndrew said there was no way to know how often information was withheld. Of the 27,778 privacy complaints filed since 2003, the only cases investigated, she said, were complaints filed by patients who were denied access to their own information, the one unambiguous violation of the law. Complaints not investigated include the plight of adult children looking after their parents from afar. Experts say family members frequently hear, “I can't tell you that because of HIPAA,” when they call to check on the patient's condition. That is what happened to Nancy Banks, who drove from Bartlesville, Okla., to her mother's bedside at Town and Country Hospital in Tampa, Fla., last week because Ms. Banks could not find out what she needed to know over the telephone.

Her 82 year old mother had had a stroke. When Ms. Banks called her room she heard her mother “screaming and yelling and crying,” but conversation was impossible. So Ms. Banks tried the nursing station. Whoever answered the

*continued on page 6*



Our sincere thanks to the following friends and supporter for their generous contributions during the past month:

Dale Brachfeld      Barbara Murphy  
 Anna Muttath      Elliot Eichler Foundation  
 Rosina Porco

**In Honor of NAMI's work**

D. Peter Birkett, MD      Eileen Kimmelman  
 Virgen Fernandez      Barbara Murphy  
 William Goldberg      Annette & Herbert Pilelsky  
 Miriam Jaffe      Margaret Cullen

**In Honor of Mary Ann Walsh-Tozer**

Marlene Becker      Mort and Joan Pollner  
 Rena Finkelstein

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Helen Bradley      Elaine & Edward Cahill

**In Honor of Ernie Rosenfeld**

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**In Honor of Joan Pollner**

Helen Bradley      Elaine & Edward Cahill

**In Honor of Chris Vanasse**

Marlene Becker      Rena Finkelstein  
 Jeanette Kops      Dale & Jerry Brachfeld  
 Helen Bradley      Elaine & Edward Cahill  
 Joan & Mort Pollner      Jeanette Kops

**In Honor of Paul Maddox**

Barbara Maddox

**In Memory of Dr. Lewis Opler's mother Charlotte**

Drs. Irene & Jerome Levine

**In Memory of Norman Turitz**

Bea Naparstek      Dale & Jerry Brachfeld

**In Memory of Seymour Shiplacoff**

Dale & Jerry Brachfeld

**In Memory of Lee Toonkel**

Dale & Jerry Brachfeld

*If you would like to make a tax-deductible contribution to honor or memorialize a friend, colleague or family member, an acknowledgment will be sent to whomever you designate. Please indicate on your check that it is a donation. Checks should be made payable to NAMI-FAMILYA and mailed to PO Box 635, Orangeburg, NY 10962-0635.*

*State Employees can also make a direct contribution through a tax deductible payroll deduction. Just designate NAMI-FAMILYA on your pledge card for SEFA (State Employees Federated Appeal).*

# THIS & THAT

■ NAMI-FAMILYA's representatives Jim Scaringe and Rena Finkelstein joined some 300 Rockland County nurses for their luncheon and festivities at their 25<sup>th</sup> anniversary celebration on May 10. The event was held under a big white tent on the lawn of the RPC campus. We were delighted that so many nurses and nursing students stopped by our table to take brochures and talk about mental illness and FAMILYA services.

■ OMH Commissioner Michael Hogan has announced the appointment of Lloyd I. Sederer, MD, previously Executive Deputy Commissioner of Mental Hygiene in NYC from 2002 to 2007. Dr. Sederer assumed his new duties in April.

■ NAMI-FAMILYA's Anne Arias and Elliot Markowitz met in Albany with other NAMI-NYS housing advocates, representatives from the Association for Community Living (ACL) and Robert Myers, PhD, Senior Deputy Commissioner for Adult Services, along with other OMH officials in July to discuss removing obstacles to family initiated housing. Dr. Myers stated that OMH was open to the idea of participating in a work group to further develop this concept and to discuss possible solutions to any legal or other restrictions.

■ Rena Finkelstein and Diana Siegel attended a "listening forum" to explore coordination of mental health and health services in NY State. The meeting provided an opportunity for advocates to express their views on the need for greater integration of services provided by OMH (Office of Mental Health), OMRDD (Mental Retardation and Developmental Disability), OASAS (Alcohol and Substance Abuses Services), and Office of Health. They also made recommendations on ways that housing, mental and other medical health services, treatment of co-occurring disorders (dual diagnosis) could be better addressed.

■ President Rena, accompanied by Program Coordinator Anne Arias and Legislative Chair Diana Siegel, also testified at a hearing called by Commissioner Hogan on the 2006-2010 Statewide Comprehensive Plan for Mental Health Services. The New York State Office of Mental Health (OMH) presented the annual update to the Plan at the first of five scheduled forums around the state. At the morning briefing by Commissioner Hogan and his staff, there was a discussion of the strategic planning process, how the statewide plan was created and how it was updated, based on input from providers, consumers and Mental Health Directors from each county in New York State. The afternoon session provided an opportunity for stakeholders to present verbal and written testimony to a panel of OMH representatives. Rena discussed Housing as a major priority for Rockland consumers; the need for coordination of care among agencies serving consumers with

## OMH Reveals Risks Of Untreated Depression

The New York State Office of Mental Health (OMH) recently issued an advisory cautioning against the risk of no treatment for depression. Researchers Friedman and Leon write that a series of warnings, especially the most recent issued in May of 2007 by the Federal Drug Administration (FDA), may discourage depressed patients and their families and their physicians from prescribing anti depressants. The NYS OMH shares this concern, particularly since they have already observed a reduction in anti-depressant (AD) treatment for children and adolescents suffering from depression. "Since the most recent evidence suggests that anti depressants confer either no risk or are actually protective against suicidality in adults ages 25 and older, it is critical that depressed patients in this population receive them when clinically appropriate."

In October 2003, the US Food and Drug Administration (FDA) had issued a public health advisory about the risk of suicidality in pediatric patients taking selective serotonin reuptake inhibitors (SSRIs) and required a black box warning stating that ADs are associated with an increased risk of suicidal thinking, feeling and behavior in children and adolescents. Since the 2003 advisory the use of ADs for the treatment of pediatric depression has reduced significantly, without a concomitant increase in other treatments. The diagnosis of depression has likewise decreased while the rate of adolescent suicide has increased (Libby et al 2007). This latter finding furthered the belief among many experts that although antidepressant therapy may entail some risk, the risk of not receiving appropriate AD treatment may be greater (Friedman and Leon 2007) (from OMH Advisory).

On May 2, 2007, the FDA ordered that ALL antidepressant medications carry an expanded black box warning including a statement that there is an increased risk of suicidal symptoms in adults 18 to 24 years of age. This expansion was based on a meta-analysis of short term efficacy studies of many different classes of antidepressants, which also revealed no increased risk of suicidal behavior or ideation across all age groups or in persons 24-64 years of age; the risk for suicidal thinking and behavior, although NOT for actual suicide, was *slightly* numerically elevated for patients 18 to 24 years of age and finally, the risk was decreased for persons 65 years of age and older.

The OMH indicates that it is well know, though rare, that a patient experiences an increase in suicidal ideation when *started* on anti depressants in general and SSRIs in particular (Hamilton and Opler, 1992). Whether this is actually caused by the medication or is simply a consequence of the illness itself is unknown. This effect, usually seen in the first 4-6 weeks following the start of treatment, should be managed by careful clinical monitoring, counseling about risks and benefits, and joint decision making by patients and physicians. Compared to the risk of suicide in patients taking

antidepressants in the FDA analysis of the clinical trials (0.01%), the risk of suicide in untreated depression ranges from 2.2 to 15%. Thus, the risk of untreated depression is several orders of magnitude great than that of antidepressant treatment.

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### New NAMI-FAMILYA Staff Member



Welcome to Anne Arias who joined the staff of NAMI-FAMILYA in June as program coordinator/grant writer. Born in Dublin, Anne emigrated to the U.S. with her family when she was just an infant. Raised in New Jersey, Anne now lives in Highland Mills, NY with her husband and two children.

Anne earned a Bachelor of Social Work from Rutgers University and completed her Masters degree at Rutgers Graduate School of Social Work. Internships at Trenton Psychiatric Children's Hospital, the State Training School for Boys at Jamesburg (a detention center for youth) and the Somerset Youth Shelter laid the foundation for a desire to give a voice to those who cannot speak for themselves.

Anne was the first case manager for a community-based organization serving people with AIDS in the late 1980's. In 1993 she was honored with the Jersey Journal's "Everyday Hero" award for service to People with AIDS. After working with homeless individuals and families living with AIDS, chemical dependence, and mental illness for ten years, she was appointed Director of Corpus Christi Ministries, a permanent supportive housing program serving these individuals. An ardent advocate, she brought consumers to meet with state and federal legislators to share their stories. Her grant-writing efforts led to expansion of the housing program to provide services to homeless individuals and families with a variety of disabilities.

Before joining FAMILYA, Anne worked for Elant Corp. for two years, first in fundraising and later as Assistant Administrator of an Adult Home.

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### *This & That* continued from page 13

mental illness, alcohol and substance abuse and mental retardation and developmental disabilities; the need for more in-patient beds for Rockland residents; and she requested support from OMH and the state for the creation of a Mental Health Court for individuals with serious mental illness who are involved in the criminal justice system in Rockland County. This testimony will eventually be posted on the OMH website for public viewing.

**From the Editor** *continued from page 2*

approved virtually unanimously by the US Congress and Senate and signed into law on August 21, 1996. According to a Health and Human Services Press release (8/21/96), the law was designed to "improve the availability of health insurance to working families and their children." It included "new protections for an estimated 25 million Americans (approximately 1 in 10) who move from one job to another, are self-employed, or who have pre-existing medical conditions."

An unintended and unexpected consequence of the law, however, has been that families are once again encountering barriers to the exchange of information about their loved ones and inclusion in the treatment process, based on a narrow interpretation of the HIPAA law. In this issue we will attempt to shed some light upon what can and cannot be shared with families under HIPAA law.

It appears that HIPAA laws have negatively impacted on many families, not just those with members with psychiatric disorders, but with all kinds of health-related problems. Our cover story reprinted from the *NY Times* July 3rd article deals with some of the seemingly ludicrous obstacles that some of these families have encountered. On Page 3, you will find an interview with Dr. William Boyle, who is the Deputy Director for Quality Assurance and responsible for QA issues in the outpatient programs of Rockland Psychiatric Center (RPC). At our request Dr. Boyle addressed this issue at a recent RPC Family advisory committee meeting.

"On the other hand," as stated by Tevye in the superb production of *Fiddler on the Roof* that so many of us enjoyed at our FAMILYA theatre party at the Antrim Playhouse in April, there are some exciting and innovative developments involving families in therapy. On Page 5 of our *flyer* you'll find an article that appeared recently in *The Wall Street Journal* about a new approach incorporating family members in the treatment of their relatives. The positive values of "family focused therapy" do not come as a surprise to family members who have acted as chief caregivers for their loved ones for years. We've included a commentary on this methodology by Psychologist and researcher Dr. Irene S. Levine, who also serves as family liaison at the Nathan Kline Institute for Psychiatric Research.

We hope you are enjoying a relatively stress-free and relaxing summer. In the interim, your NAMI-FAMILYA President, Board members, and staff, have been busy "holding down the fort." We have attended several hearings conducted by the New York State Office of Mental Health and Commissioner Hogan, as well as local mental health planning meetings. We have some exciting and informative programs planned for the fall, so please check out our schedule and be sure to mark the dates on your calendar. We look forward to seeing you in September. Until then, we remain,

Your voice on mental illness, striving to ensure a better life for all of our loved ones.

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**Join NAMI-FAMILYA Now! 2007-2008 Membership Form**

Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone/Day \_\_\_\_\_ Phone/Eve \_\_\_\_\_

Fax \_\_\_\_\_ Email \_\_\_\_\_ (Your email address will help us keep you advised of legislative issues)

Individual/Family Membership \$35.  Professional Affiliate \$35.

NOTE: A reduced membership fee is available to individuals, families or consumers with limited means

Voluntary Gift \$\_\_\_\_\_ I have included an additional contribution to help support NAMI-FAMILYA's educational and advocacy programs in Memory/Honor of : \_\_\_\_\_

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Please make your checks payable to NAMI-FAMILYA and mail with form to: PO Box 635, Orangeburg NY 10962-0635  
For more information call (845)359-8787

NOTE: A portion of your local membership fee is remitted to NAMI National and NAMI-NYS.

**Your membership fees and contributions are tax deductible**

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Our full schedule of programs and special events through 2007 follows. Please be sure to mark these dates on your calendar.

NAMI-FAMILYA meetings are held on the first and third Wednesdays of the month. Location is the Dr. Robert L. Yeager Health Center, Bldg. F, Room 119, Sanatorium Road Pomona beginning at 7:30 PM unless otherwise noted.

**WEDNESDAY, SEPTEMBER 5**

Family Support Session (RAP)

**WEDNESDAY, SEPTEMBER 19**

**Meeting the Housing Needs of People with Mental Illness**

A Panel Discussion moderated by Marie Lombardo, co-chair Friends of FAMILYA Housing

- Jennifer Clark, LCSW, Coordinator of Planning, SPOA, Rockland County Dept. of Mental Health
- Elliot Markowitz, LCSW, Operator & Administrator L'Dor, co-chair Friends of FAMILYA Housing
- Melissa Miller, LCSW, Division Director, Home to Stay, Orange County MHA
- Tom Zimmerman, Executive Director, Loeb House, Inc
- Sybil Schwartzman, NAMI-FAMILYA Board member

**OCTOBER 7 - 13**

We celebrate Mental Illness Awareness Week – keep posted for more activities

**WEDNESDAY, OCTOBER 3**

Family Support Session (RAP)

**WEDNESDAY EVENING, OCTOBER 17**

**Breaking the Silence Through Art – Exhibit of Visual & Performing Art and Public Forum on the Arts and Healing**

NAMI-FAMILYA is proud to be a co-sponsor of this special event in conjunction with the Mental Health Coalition of Rockland County.

Fire Training Center, Pomona, NY at 6:30 PM

(See Page 7 for more information)

**WEDNESDAY, NOVEMBER 7**

Family Support Session (RAP)

**WEDNESDAY, NOVEMBER 21**

**Everything You Wanted to Know About Case Management & Were Afraid to Ask**

Rockland County Department of Mental Health Staff

**WEDNESDAY, DECEMBER 5**

Family Support Session (RAP)

**WEDNESDAY, DECEMBER 19**

Holiday Celebration with Inspirational Speaker



*FAMILYA flyer Summer 2007*

NAMI-FAMILYA of Rockland County NY is affiliated with NAMI-NYS and NAMI (National Alliance on Mental Illness)

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