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Founded in 1957, Creative Health Services, Inc is a not for profit provider of community based behavioral health services to children, families and adults throughout Southeastern Pennsylvania. For more information, or to inquire about how we may assist you in your design and development projects, please contact Dr. Andrew Trentacoste at 484-941-0500 or visit us on the web at www.creativehs.org.
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Mental Health First Aid USA is coordinated by the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health.
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Mental Health First Aid: Nationwide Instructor Network

Mental Health First Aid Changes the Culture of North Carolina’s Colleges

Increasing Mental Health Literacy in the Faith Community

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March 15, 2013
Looking forward to seeing Bill McFarlane again next week. He’s asked me to talk about Mental Health First Aid on a panel to discuss his groundbreaking PIER project for early intervention for schizophrenia. So fitting. Mental Health First Aid is really all about support for families.

March 7, 2013
Was remembering our Alaska vacation because we talked to Sen. Begich’s staff today. He is another staunch Mental Health First Aid advocate. His state has trained Alaskan natives, Aleutian islanders, rural health workers, university staff and students, housing and homeless authorities, state employees, and behavioral health staff. Every course has been taught by at least one instructor who has experienced mental illness.

January 24, 2013
Mental Health First Aid bill introduced in the Senate. Bipartisan support is unprecedented. Thank you senators — Mark Begich (D-AK), Kelly Ayotte (R-NH), Richard Blumenthal (D-CT), Mike Bennett (D-CO), Jack Reed (D-RI), Debbie Stabenow (D-MI), Jeanne Shaheen (D-NH), Roy Blunt (R-MO), and Marco Rubio (R-FL)! We’ve come a long way but so much more to do.

January 16, 2013
What’s this Bronx girl doing as special invitee to the White House press conference?! Obama’s Now Is the Time gun proposal to protect children and communities by reducing gun violence calls for “Mental Health First Aid training to help teachers and staff recognize the signs of mental health disorders in young people and find them appropriate care.” Right there on page 11. http://wapo.st/15R4mLI. Only in my wildest dreams!
January 9, 2013
Good meeting with VP Biden’s gun control taskforce today. Chatted with Sec. Sebelius and Attorney General Eric Holder. Everyone onboard for widespread Mental Health First Aid in schools plus increased capacity for public mental health system.

January 1, 2013
Happy New Year. Nearly 100,000 Mental Health First Aiders trained in just 4 years! Will be as common as CPR and first aid, one day soon.

December 20, 2012
Met with Rep. Ron Barber today. Neal Cash joined us by phone from Tucson. Ron wants to introduce the Mental Health First Aid bill in the House, broaden scope to schools, colleges, first responders... What an advocate.

December 19, 2012
Sharing thoughts from my email to members today in response to Sandy Hook:
“We can no longer afford the luxury of inaction or ineffective solutions to the thief of community violence. On Friday, he stole 28 innocent lives, most of who hadn’t yet celebrated their eighth birthday. We know this thief. We saw him in a movie theater in Aurora, a high school at Columbine, a classroom at Virginia Tech. It is time to confront this thief, to draw in our wagging fingers of blame and fight for meaningful, lasting change.
It’s time for hard conversations and meaningful action. And we ask our member organizations to stand with us as we work on Capitol Hill and in communities across America.
We must all heed the call to equip our neighbors and communities to recognize mental illnesses and connect people to care. Mental Health First Aid can help.”

September 10, 2012
Thrilled to launch Youth Mental Health First Aid today with the first instructor training for youth and family members in SAMHSA Systems of Care. Thank you SAMHSA and Georgetown for all the support and hard work. So much more to be done. 13,809 school districts and 4,197 colleges in the U.S. – we have to reach them all!

August 17, 2012
I met with Zoraida and Pat today. Planned to talk about our accounting needs... But we just chatted about how mental illness touches all our lives and families. They finished Mental Health First Aid training here at the office yesterday and are excited. They get it now. It’s neat how Mental Health First Aid allows us to raise those taboo topics and have the important conversations.

October 10, 2011
Mental Health First Aid was on NPR Morning Edition today. So pleased that 4 million listeners were able to learn about this fabulous program. Another dream come true for our team -- thanks Meena for all the great PR.

May 27, 2011
Was so good to hear from Trisha Marsik today, after a long time. And proud to see the uptake on Mental Health First Aid in my home state. Trisha is now Assistant Commissioner for Mental Health in the NYC Department of Health and Mental Hygiene. She wants to see how we can bring Mental Health First Aid to city hall staff and other elected officials.
May 23, 2011

Meena, Susan, and I had a lovely visit with the Stavros Niarchos Foundation in NYC today. We went to thank them for their Youth Mental Health First Aid grant and learn more about their work. Andrea at SNF is a force! She reached out to us first after she read about Mental Health First Aid in the Chronicle of Philanthropy. Can’t wait for the youth rollout.

April 15, 2012

Did a Mental Health First Aid executive briefing today for division heads at HHS. Bryan shared excerpts from the training. Pam Hyde gave a great intro. We were all pleasantly surprised when Secretary Sebelius showed up — in person — and stayed for an hour and a half! Great to chat with her. Think she enjoyed the role-play and experiencing what it was like to “hear voices.”

March 28, 2012

Colorado Behavioral Health Council wins the 2012 Mental Health First Aid Best Community Impact award. Well-deserved. George delGrosso and his team have done a tremendous job with the statewide rollout. Approaching 10,000 Mental Health First Aiders and a great partnership with the CO Office of Behavioral Health, and all community mental health centers in the state.

February 25, 2011

Rep. Grace Napolitano’s office called today. The Congressional Mental Health Caucus wants to host a Mental Health First Aid training for members of Congress and their staff for Mental Health Month in May. Thrilled by the interest — everyone in public office needs this training.

January 18, 2011

So much press around Mental Health First Aid lately, but so sad that it comes on the heels of the national tragedy nation in Tucson. So relieved Gabby Giffords is doing better! Arthur Selzberger from the New York Times wanted to talk today about how the program can help on college campuses. Neal Cash and his troops at CPSA are working round the clock to offer Mental Health First Aid to the community.

May 12, 2011

Congratulations to Community Circles of Care in Dubuque, IA for winning the 2011 Mental Health First Aid USA Best Community Impact Award. They’ve trained more than 400 people in rural areas without easy access to trained mental health professionals. Iowa is a true champion — only state to have its mental health commissioner certified as a Mental Health First Aid instructor. They’ve done great statewide initiatives.

March 19, 2011

Larry Fricks called to say that the instructor training for peers in Decatur, GA this week exceeded all expectations. What a proud moment. 30 people who’ve experienced mental illness and addiction disorders are now ready to teach Mental Health First Aid to the public. Thanks Larry, couldn’t have done it without you. And thank you Georgia Mental Health Consumer Network and Sherry Jenkins Tucker for taking this on.

April 5, 2010

Great Executive Committee meeting today with our Mental Health First Aid USA partners in MO and MD. Reviewed certification standards. Was just thinking that we could not have come this far without our collaborative efforts. Benton, Daryl, Linda, Lea Ann — your dedication is inspiring!
October 1, 2009
Susan shared the latest reports on folks trained in Mental Health First Aid today. It’s mind-blowing to see how it’s spreading. Soccer moms, nurses, NAMI members, teachers, rabbis, cops, and even a couple of massage therapists... So encouraging, especially when I think back to my first job at the state hospital, to those helpless parents who had no clue how to handle psychosis in their grown children...This is for all of you. How I wish we’d known about Mental Health First Aid in those early days of struggle and heartbreak.

May 14, 2009
Rich Leclerc from Gateway, RI is the best champion Mental Health First Aid could have! He called today to say that the RI police academy decided to make Mental Health First Aid mandatory training for all new recruits. Incredible. Mental Health First Aid CAN make a difference.

September 5, 2008
Our six pilot sites from the first-ever Mental Health First Aid USA instructor training are doing an awesome job with the community rollout. A shout out to Bert Nash Center in Kansas, C4 in Chicago, Gateway in Rhode Island, North Central Behavioral Health Systems in Illinois, Iowa Division of Mental Health, and Seminole in Florida. Way to go!

February 8, 2008
Busy, busy time as we prepare to finalize the curriculum adaptation and prep for Mental Health First Aid rollout in the U.S. Betty Kitchener and Tony Jorm, the Australian founders, are amazing. Glad to be working with Missouri and Maryland, too — know our collaboration will make the program much stronger. Thank you to all for the support.

July 6, 2007
Bob says to go for it. He says Mental Health First Aid will be my legacy — and he doesn’t say that sort of thing easily (or just because he’s my husband and biggest fan). Haven’t been able to stop thinking about it ever since Fran mentioned it. Fran is doing well in New Zealand. Must call Betty Kitchener today. What time is it in Australia?
A Community Embraces Mental Health First Aid

Neal Cash, MS, President/CEO, Community Partnership of Southern Arizona and Special Editor, National Council Magazine, Mental Health First Aid Issue
All over the country, people are recognizing the importance of early identification and intervention for mental illness. Much of that recent awareness has come about because of terrible tragedies. In the past, such awareness would’ve generated concern, but little organized or effective action. That’s changing now – in part because of Mental Health First Aid.

Mental Health First Aid is a unique and powerful vehicle for community education, training participants to identify, understand, and respond to signs of mental illness on a “first aid” basis. It could be our best hope for identifying and intervening at the early signs of possible illness.

Family members, friends, and co-workers are the people most likely to notice when an individual’s behavior changes, but they usually don’t know what those changes mean or how to get help. Mental Health First Aid puts that information into their hands.

But it has more subtle and wide-ranging benefits. Mental Health First Aid provides a rallying point and focus to a community’s healing and desire to take positive action. It can help shape community discussion about mental illness, public safety, stigma, and how we care for the most vulnerable among us.

That became apparent in Tucson after the mass shooting of January 8, 2011, that killed six people and wounded 13 others, including then-Congresswoman Gabrielle Giffords.

As the state, contracted regional behavioral health authority for the Tucson area, Community Partnership of Southern Arizona assumed the role of meeting the community’s mental health needs related to the tragedy. Based in Tucson, CPSA has overseen public behavioral health services in Pima County since 1995.

In this close-knit community, many CPSA staff members knew someone who was killed or injured in the shooting. As we set up a special communitywide phone support line, organized crisis counselors for public events, and responded to other requests for assistance, we too felt an urgent need to do whatever we could to prevent another such tragedy.

It quickly became clear that the killer had an undiagnosed mental illness, which reignited old myths and negative stereotypes. CPSA mobilized with other community partners to challenge these harmful misconceptions and present Mental Health First Aid to all community members as an antidote to blame and feelings of helplessness.

Mental Health First Aid, which CPSA adopted two years before the shooting, helped frame Tucson’s discussion about mental illness and provided a venue for the community’s determination to take positive action. It helped shift the news narrative to one of empowerment and positive change.

With invaluable help from the National Council for Community Behavioral Health Care and the Arizona Department of Health Services’ Division of Behavioral Health Services, CPSA quickly organized and trained a new cadre of certified instructors, kicking off a statewide campaign to expand Mental Health First Aid.

The response in Tucson has been phenomenal. Our trainings filled within days of their announcement. One retired lawyer who knew one of those killed volunteered for and completed the five-day instructor training and has since helped certify almost 300 “Mental Health First Aiders.” An editorial writer for Southern Arizona’s It’s a sign of our community’s determination to bring light out of darkness.
major daily paper completed the 12-hour training and continues to write about its importance.

In the two years since the Tucson shootings, almost 1,500 people have become certified in Mental Health First Aid through more than 60 CPSA trainings.

It’s incredibly heartening that so many people would take time from their busy lives to participate in a 12-hour training, preparing and committing themselves to challenge negative myths and help people with mental health problems. It’s a sign of our community’s determination to bring light out of darkness.

Without **Mental Health First Aid**, the conversation about mental illness after Tucson’s tragedy could have been entirely negative, further entrenching fear and misunderstanding.

Without Mental Health First Aid, the conversation about mental illness after Tucson’s tragedy could have been entirely negative, further entrenching fear and misunderstanding. Instead, the training helped create a different story in our community one of renewed commitment to positive action and movement toward unity, civility, understanding, and hope.
Early Intervention for Child Trauma is Good First Aid...

And it’s our passion. That’s why Los Angeles Child Guidance Clinic pioneers innovative early intervention models for trauma-exposed children and young adults – earning national honors from both the American Psychiatric Association and the American Academy of Child & Adolescent Psychiatry.

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1 in 5 people suffers from mental illness; approximately 57.7 million Americans every year.

Among Medicaid beneficiaries with disabilities, 49% have a mental illness.

Mental illness affects everyone across age, sex, and race.

Prevalence of Serious Mental Illness Among U.S. Adults by Sex, Age, and Race in 2008

Mental illness drains our economy of more than $80 billion every year; 15% of the total economic burden of all disease.

A recent study estimates that serious mental illnesses cost society $255.4 billion annually in lost earnings in the U.S.

More than half of all prison and jail inmates have a mental health problem.

Up to 2/3 of homeless adults suffer from chronic alcoholism, drug addiction, mental illness, or some combination of all three.

1/4 of all Social Security disability payments are for individuals with mental illness.
More than 36,000 die by suicide every year. That’s like losing the population of Green Bay, Wisconsin, every three years.

Among Medicaid beneficiaries with disabilities, 49% have a mental illness.

Globally, 3 of the 6 leading disabilities are due to mental illness (depression, schizophrenia, and bipolar disorder).

In the public system, those with serious mental illness die 25 years sooner than the general population – men at about age 53 and women at age 59.

Our nation’s community behavioral health organizations employ more than 250,000 people who care for 8 million adults and children with mental and addiction disorders.

Mental health treatments work.

These success rates are comparable to those for physical healthcare.

More than half of all prison and jail inmates have a mental health problem.

Up to 80% of homeless adults suffer from chronic alcoholism, drug addiction, mental illness, or some combination of all three.

Up to 90% of people being treated recover.

Yet 2/3 go without treatment, mostly because of inability to access care and stigma.

What you can do

- Take a Mental Health First Aid course
  www.mentalhealthfirstaid.org
- Advocate for better resources for mental health
  www.thenationalcouncil.org/cs/advocate_now
- Talk to your doctor about your mental health

Success Rates

- 80% bipolar
- 60% schizophrenia
- 70% major depression, panic disorder, OCD

70-80% asthma and diabetes
60-70% cardiovascular disease
41-52% heart disease

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

Reading the Signs: Common Mental Illnesses

DEPRESSION

- Unusually sad mood
- Loss of enjoyment and interest in activities that used to be enjoyable
- Lack of energy and tiredness
- Guilt or feelings of worthlessness
- Thinking often about death or wishing to be dead
- Difficulty concentrating or making decisions
- Moving more slowly or sometimes becoming agitated and unable to settle
- Having sleeping difficulties or sleeping too much
- Loss of interest in food or eating too much
- Excessive self-criticism and/or self-worry
- Withdrawal from others

ANXIETY

- PHYSICAL: pounding heart, flushing, shortness of breath, dizziness, sweating, numbness, tingling, dry mouth, nausea, vomiting, restlessness, tremors and shaking, inability to relax
- PSYCHOLOGICAL: unrealistic and/or excessive fear and worry, mind racing or going blank, decreased concentration or memory, indecisiveness, irritability, anger, confusion, restlessness or feeling "on edge" or nervous, sleep disturbance, vivid dreams
- BEHAVIORAL: avoidance of situations, obsessive or compulsive behavior, distress in social situations, phobic behavior

DEVELOPING PSYCHOSIS

- CHANGES IN EMOTION & MOTIVATION: depression, anxiety, irritability, suspiciousness, blunted or inappropriate emotion, change in appetite, reduced energy and motivation
- CHANGES IN THINKING & PERCEPTION: difficulties with concentration or attention, sense of alteration such as the feeling that they or others have changed or are acting differently in some way, odd ideas, an unusual perceptual experience such as reduction or greater intensity of smell, sound, or color
- CHANGES IN BEHAVIOR: sleep disturbances, social isolation or withdrawal, reduced ability to carry out work or social roles

SCHIZOPHRENIA

- DELUSIONS: false beliefs of persecution, guilt, having a special mission, or being under outside control
- HALLUCINATIONS: commonly involve hearing voices, but can also involve seeing, feeling, tasting, or smelling things
- THINKING DIFFICULTIES: difficulties in concentration, memory, and ability to plan, making it difficult for the person to reason, communicate, and complete daily tasks
- LOSS OF DRIVE: lack of motivation even for self-care; it is NOT laziness
- BLUNTED EMOTIONS: unaware of things around them and often react inappropriately (e.g., speaking in a monotone, lack of facial expressions or gestures, lack of eye contact)
- SOCIAL WITHDRAWAL: withdraw from contact with others, even family and close friends; there may be a number of factors that lead to this such as loss of drive, delusions that cause fear of interacting, difficulty concentrating on conversations, and loss of social skills.

MANIA/MANIC EPISODE

- Increased energy and overactivity
- Elevated mood — feels high, happy, full of energy, on top of the world, and invincible
- Needs less sleep than usual — can go for days with very little sleep
- Irritability — often occurs if others disagree with unrealistic plans or ideas
- Rapid thinking and speech — talks a lot, very fast, and changes topics often
- Lack of inhibitions — disregards risk, spend money extravagantly, or is very sexually active
- Grandiose delusions — inflated self-esteem such as a belief that the person is superhuman, especially talented, or an important religious figure
- Lack of insight — convinced that manic delusions are real, not realizing that it's an illness

Excerpts from the Mental Health First Aid manual.
How much do you know about mental illnesses and addictions?

TAKE THE MENTAL HEALTH FIRST AID QUIZ

1. Which of the following is NOT a symptom of a panic attack?
   a. Chills or hot flashes
   b. Pounding heart, rapid heart rate
   c. Overeating or loss of appetite
   d. Fear of losing control or “going crazy”

2. What is the most commonly abused drug in the U.S.?
   a. Opioid
   b. Marijuana
   c. Cocaine
   d. Sedative and tranquilizer

3. _____________ — based treatment focuses on providing care and support to individuals so they can remain with family, in school, and in their everyday environment.
   a. Consumer
   b. Residential
   c. Community
   d. Support

4. What is the third leading cause of death for young people?
   a. Suicide
   b. Car crashes
   c. Eating disorders
   d. Homicide

5. In order to be classified as major depressive disorder, a depressive episode must last for at least how long?
   a. Ten days
   b. Two weeks
   c. Four weeks
   d. Two months

6. The term used to describe having more than one diagnosable mental disorder is:
   a. Comorbidity
   b. Dual diagnosis
   c. Co-occurrence
   d. All of the above

7. When enacting the Mental Health First Aid action plan — ALGEE — step ‘G’ suggests that a First Aider “give _______ and _______”.
   a. Help; Comfort
   b. Reassurance; Information
   c. Assistance; Support
   d. Thoughtfulness; Understanding

8. _____________ sometimes goes undiagnosed for a year or more, often because it begins in late adolescence or early adulthood and the early signs and symptoms involve behaviors and emotions that are common in this age group.
   a. Oppositional Defiant Disorder (ODD)
   b. Generalized Anxiety Disorder
   c. Psychosis
   d. Substance Use Disorder

9. Which of the following is considered a risk factor for almost every mental health disorder?
   a. Trauma
   b. Substance Use
   c. Lack of Motivation
   d. Biochemistry

10. What percentage of U.S. middle and high school students engage in nonsuicidal self-injury?
    a. 1-4%
    b. 5-9%
    c. 10-20%
    d. 21-25%
Mental Health First Aid — Facts at a Glance

The impact of mental health conditions on our nation is very real. Mental disorders are common in the United States. One in five Americans suffers from a diagnosable mental illness every year. In fact, mental illnesses are the leading cause of disability in the U.S. Even more shocking is the fact that 80% of Americans with treatable mental disorders do not receive proper diagnosis and effective treatment — largely because they don’t understand they have an illness and don’t know what to do or where to turn for help.

Mental Health First Aid is helping to change the dialogue — by demystifying mental illness; by helping us understand that mental illnesses are real, common, and treatable; and by showing people how to help people.

Program overview
Mental Health First Aid is an evidence-based public education program that is now being offered in 20 countries. Mental Health First Aid demystifies mental illness and gives participants the capacity to obtain, process, and understand the health information and services needed to make appropriate decisions and seek care.

The program teaches people how to assess a situation, select and implement appropriate interventions, and help a person in crisis or developing the signs and symptoms of mental illness. The groundbreaking training equips people to provide initial help until appropriate professional, peer, or family support can be engaged. Participants also learn about the risk factors and warning signs of specific illnesses such as anxiety, depression, psychosis, and addiction.

Whether it is a human resource professional learning how to manage a despondent, unproductive employee, or a law enforcement officer finding new ways to approach someone hearing voices in their head, Mental Health First Aid gives people from all walks of life the confidence and skills to help a person in crisis.

Changing Lives, Changing Communities
Mental Health First Aid was introduced in the U.S. in 2008, and to date more than 100,000 people from all walks of life have been trained and are using the program’s tools and resources every day.

Mental Health First Aid owes much of its success to the fact that it is capable of working and spreading effectively throughout society. It is a low-cost, high-impact program that generates tremendous community awareness and support. Healthcare organizations and local and state governments across the country are using Mental Health First Aid to open their doors; generate increased awareness and referrals; obtain media attention; and forge relationships with community leaders in primary care, businesses and workplaces, local government, law enforcement, criminal justice, schools and colleges, faith leaders, and many other groups. New York, Philadelphia, Washington, DC, and other major cities have recently adopted Mental Health First Aid as a novel strategy to engender healthier communities by training large groups of public health and public safety workers, government and social services staff, and caring citizens. Many mental health and addictions treatment organizations are also using Mental Health First Aid to orient and train their own support staff — in front office, billing, medical records, maintenance, and transcription.

In Your Community
Mental Health First Aid is offered through a live, in-person training by certified instructors in your community. To find a course or contact an instructor to learn about upcoming courses in your community, go to www.MentalHealthFirstAid.org. The website also helps you ensure that your instructors are credentialed and certified to teach the approved national course model.

The training to certify Mental Health First Aiders is 12 hours long and may be offered over two consecutive days or in 3-hour sessions spread over multiple days/weeks.

Anyone may train to be a Mental Health First Aider — the training is especially popular among key professions such as law enforcement and other first responders, primary care professionals, nursing home staff, and school administrators and educators. Other participating entities include faith community leaders, employers and chambers of commerce, state policymakers, mental health advocacy organizations, shelter volunteers, family members of persons with mental illness and addictions, and the general public.
**KEY PROGRAM ELEMENTS**

Mental Health First Aid teaches participants to implement a five-step action plan, ALGEE, to support someone developing signs and symptoms of mental illness or in an emotional crisis:

- **A**ssess for risk of suicide or harm
- **L**isten nonjudgmentally
- **G**ive reassurance and information
- **E**ncourage appropriate professional help
- **E**ncourage self-help and other support strategies

Mental Health First Aid enables recognition of the common signs and symptoms of psychosis and other mental illnesses to enable early detection and intervention. For instance, signs and symptoms of psychosis could include irritability; suspiciousness; blunted, flat, or inappropriate emotion; change in appetite; reduced energy and motivation; the feeling that self or others have changed or are acting differently; a reduction in or greater intensity of smell, sound, or color; sleep disturbances; and social isolation or withdrawal.

Mental Health First Aid instructors share information and conduct interactive exercises to help participants be prepared to act in the event of a psychiatric emergency. The course teaches participants how to interact with a person in crisis, how to protect themselves, and connect the person with professional help.

The program offers concrete tools and answers key questions like “What do I do?” and “Where can someone find help?” Instructors compile and provide a list of community healthcare providers and national resources, support groups, and online tools for mental health and addictions treatment and support.

**WHO’S BEHIND THE PROGRAM?**

The program is managed, operated, and disseminated by Mental Health First Aid USA, comprising three national authorities — the National Council for Community Behavioral Healthcare (National Council), the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health. These three entities hold exclusive U.S. rights to the full curriculum and all versions/modules, program development and licensing, and instructor training and certification.

**INSTRUCTOR TRAINING**

Anyone can train to become a Mental Health First Aid instructor. Individuals are required to complete a 5-day instructor training offered by the national authorities to obtain instructor certification. The interactive training program includes a written exam and evaluates each candidate's ability to present the Mental Health First Aid program to a variety of audiences.

Knowledge of or experience with mental health issues, prior experience in training adult learners, and commitment and capability to roll out Mental Health First Aid in the community if certified are key selection criteria for an instructor training course. No specific academic or professional credentials are required for instructor applicants.

Mental Health First Aid USA has trained and certified instructors from community mental health and addictions treatment organizations, state departments of health, universities, hospitals, federally qualified health centers, faith-based organizations, police and criminal justice, developmental disability centers, mental health authorities, other mental health advocacy organizations including MHA and NAMI affiliates, and independent trainers.

The 5-day instructor training introduces the interactive 12-hour program, overviews adult learning styles and teaching strategies, and provides in-depth instruction on implementing and managing the program in diverse communities. Instructors must demonstrate mastery of the program through a written test and an evaluated presentation.

Instructors are certified to teach the 12-hour Mental Health First Aid program to all audiences in their communities. Committed to spreading Mental Health First Aid to raise the profile of their organizations, instructors also champion the program's growth and development in the community.

The National Council offers 5-day instructor training and certification programs across the country and throughout the year. Instructors are required to teach at least three courses a year to maintain certification.

They receive lifetime technical assistance and marketing and PR support from the National Council.

A typical community course can include up to 30 participants. Instructors must provide manuals to those trained and may choose to charge participants a fee (recommended fee ceiling $180) for teaching the course and to seek grants and funding. They are required to report upcoming and completed courses to a national database at www.MentalHealthFirstAid.org.

**YOUTH MENTAL HEALTH FIRST AID**

The youth version of Mental Health First Aid is an evidence-based training program to help citizens identify mental health problems in young people, connect youth with care, and safely de-escalate crisis situations. The program, focusing on youth ages 12 to 25, provides an ideal forum to engage communities in discussing the signs and symptoms of mental illness, the prevalence of mental health disorders, the effectiveness of treatment and how to engage troubled young people in services. Youth Mental Health First Aid is primarily designed for adults — family members, caregivers, school staff, health and human services workers, etc. — who work with young people 12-25, but is also appropriate for older adolescents.

Additional churches, higher education programs, and community groups; mental health and illness affects us all. Let’s not wait for another tragedy to occur before we come together as a community to take care of one another.
About Mental Health First Aid

ALGEE
A Koala To Remember

Mental Health First Aid teaches a five-step action plan to prepare individuals to help someone who may be in crisis. ALGEE, the mnemonic on which the action plan is based, is also the name of the program’s mascot — a koala to mark the Australian origins of Mental Health First Aid.

Assess for risk of suicide or harm — When helping a person going through a mental health crisis, it is important look for signs of suicidal thoughts and behaviors and/or nonsuicidal self-injury.

Listen non judgmentally — It may seem simple, but the ability to listen and have a meaningful conversation with an individual requires skill and patience. It is important to make an individual feel respected, accepted, and understood. Mental Health First Aid teaches individuals to use a set of verbal and nonverbal skills to engage in appropriate conversation such as open body posture, comfortable eye contact, and other listening strategies.

Give reassurance and information — Individuals must recognize that mental illnesses are real, treatable illnesses from which people can and do recover. When having a conversation with someone who you believe may be experiencing symptoms of a mental illness, it is important to approach the conversation with respect and dignity for that individual and to not blame the individual for his or her symptoms. Mental Health First Aid teaches you helpful information and resources you can offer to someone to provide consistent emotional support and practical help.

Encourage appropriate professional help — A variety of health and behavioral health professionals and interventions can help when someone is in crisis or may be experiencing the signs or symptoms of a mental illness.

Encourage self-help and other support strategies — There are many ways individuals experiencing mental illness can contribute to their own recovery and wellness. These strategies may include: exercise, relaxation and meditation; participating in peer support groups; self-help books based on cognitive behavioral therapy; and engaging with family, friends, faith, and other social networks.
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Fairfax Co. employees get mental health first aid training

www.washingtonpost.com/local/fairfax-co-employees-learn-mental-health-first-aid/2013/02/06/6ce52238-6ca8-11e2-8740-9b58f43c191a_story.html

Last week, 15 Fairfax County employees took a course in mental health first aid. None of them has a job that would seem to call for such training, but as more mental healthcare is provided in settings other than hospitals, people who work in local government say they are more likely to encounter people in need of mental health services. So Fairfax, the region’s most populous jurisdiction, is moving to provide basic mental health training to more employees, particularly those who deal with the public every day.

First aid training for mental health


The mental health crisis in America is now on the minds of many in the aftermath of the tragedy at Sandy Hook. At Rushford, which offers a comprehensive behavioral health program, they have people, not experts in the field taking mental health first aid training. “There are treatments for the illness itself if someone can get there but if in the community, people aren’t talking to you and they are turning their heads and they cross the street, that is what can lead to worst outcomes,” said Dr. J. Craig Allen, Rushford Chief Medical Officer.

Okla. school security panel makes recommendations


The panel also recommended creation of a voluntary mental health first-aid training pilot program under the guidance of school superintendents and the Oklahoma Department of Mental Health and Substance Abuse Services. Lamb estimated its cost at $250,000. Among other things, the program would provide certified mental health training to help school personnel identify and cope with troubled students but the training would not be mandatory.

We have to do something to promote mental health, so here’s a start

www.azstarnet.com/news/opinion/sarah-garrecht-gassen-we-have-to-do-something-to-promote/article_d3aafcc5-f75a-5bb6-b974-c076de82f254.html

It’s a terrible feeling, being helpless in the face of something so overwhelming that it’s engulfing a friend, a relative or a stranger who reaches out. We want to have the answer and make things right. We want to help. We just don’t always know how…This is where Mental Health First Aid comes in.
Classes teach ‘first aid’ for mental health crises

www.yourlife.usatoday.com/health/story/2012-03-11/Classes-teach-first-aid-for-mental-health-crises/53489150/1

It’s called mental health first aid. And while the classes are not yet nearly as common as traditional first aid courses — the kind you take to learn how to help a choking victim or cardiac arrest victim — they are catching on.

Shooting in Tucson sparks interest in ‘mental health first aid’ courses

www.washingtonpost.com/wp-dyn/content/article/2011/01/17/AR2011011703281.html

Learning how to identify and help people with mental illnesses should be a first aid skill as common as CPR, according to the Washington-based National Council for Community Behavioral Healthcare.

After the Arizona Tragedy, Mental-Health Organizations Seize a Moment

http://philanthropy.com/article/Mental-Health-Charities-Seize/126190/

Regardless of the outlook for government support, some mental-health nonprofit groups are using the current interest in behavioral issues to educate the public and reach mentally ill people who are not getting adequate care. Ms. Rosenberg says her organization, the National Council for Community Behavioral Healthcare, is stepping up a campaign designed to teach ordinary people how to recognize and respond to signs of mental illness in others.

The Shooter Was Not Well

www.huffingtonpost.com/linda-rosenberg/ohio-school-shooting_b_1316640.html

I’ve heard countless stories about how the program has opened people’s eyes about the realities of mental illnesses, while helping them do their jobs... Now, I understand that no program is a panacea for these horrific acts. But perhaps if Mental Health First Aid ever becomes as popular as First Aid or CPR, more people may be able to be proactive, intervene early, and get help for someone who is “not well” and who often does not seek help for themselves.

Mental Health Class

www.huffingtonpost.com/kim-leisey-phd/mental-health-class_b_943455.html

At my college in suburban Baltimore, we are beefing up the number of people on campus capable of spotting someone who may need mental health services. Having people on campus trained in Mental Health First Aid is proving to play an increasingly larger role in helping to manage anxiety about mental health issues. Coming to the aid of someone who may be going through an emotional crisis on campus can be everyone’s responsibility.

Mental Health First Aid Course Removes Stigmas Associated With Mental Illness


We cover a range of mental health issues, everything from schizophrenia and bipolar disorder to alcoholism and drug abuse. But the program digs deeper by connecting people with resources and linking them to support groups. We let them know who to call for help and we teach people how they should respond or talk to someone who is experiencing any mental health issues.
Fifty years ago Tuesday, President John Kennedy shattered the national silence when he delivered a message to Congress in which he called for a bold new community-based approach to mental illness that emphasized prevention, treatment, education and recovery.

In the half century since, we’ve made tremendous progress as a country when it comes to attitudes about mental health. But recent events have reminded us that we still have a long way to go to bring mental health fully out of the shadows.

The vast majority of Americans with a mental health condition are not violent. In fact, just 3% to 5% of violent crimes are committed by individuals who suffer from a serious mental illness.

But we know that some instances of mental illness can develop into crisis situations if left untreated, and those crises can lead to violence. More often than not, those with mental health conditions direct these violent acts at themselves. Tragically, there are more than 38,000 suicides (http://www.sprc.org/basics/about-suicide) in America each year, more than twice the number of homicides.

This is just one of many ways untreated mental illness takes a toll on our society. Bipolar disorder and major depression are responsible for more than 300 million days per year in lost productivity. As many as three in 10 homeless Americans have a serious mental illness. In total, mental health conditions place a greater burden on our economy than cancer or heart disease; and yet more than 60% of people with mental illness do not receive help.

The Obama administration has already made great strides in improving access to mental health care. Because of the Affordable Care Act and previous legislation making care on a par with other illnesses, 30 million Americans will gain access to health coverage, including up to 10 million who have mental health issues. Mental healthcare must also be covered in the new Health Insurance Marketplaces, which will open in every state this fall to help citizens find coverage that fits their needs and budget.

The president has proposed additional actions that will make it easier for young people to get mental health care. This is critical since three quarters of adult mental health conditions appear by the age of 24. His plan would train more than 5,000 mental health professionals to serve young people and advance new strategies to make sure young people and their families continue to receive support after they leave home.

But we know that lack of coverage and access to services are not the only reasons people go without the care and treatment they need. The truth is that while America has come a long way, we are still a country that frequently confines conversations about mental health to the far edges of our discourse.

We often fail to recognize the signs of mental illness, especially in young people. And when we do see those signs, our first reaction is often not to reach out, but to turn away. This is a culture we all contribute to. And it’s one that all of us — community leaders, teachers, pastors, health providers, parents, neighbors and friends — need to help change if we want to reduce the tragic burden of untreated mental health conditions.

That’s why President Obama has called for a national dialogue on mental health that will be kicked off in the coming weeks. This dialogue will seek to address the culture of silence and negative perceptions of mental illness that keep so many of our nation’s young people from seeking care. It will challenge each of us to do our part to create communities where young people and their families understand how important mental health is to positive development and feel comfortable asking for help when they need it.

The good news is that when people do seek help, we have much more effective treatments and supportive services than we did 50 years ago. The proof is in the tens of millions of Americans with mental health conditions who are living healthy lives and contributing to their communities. But people will only take advantage of this progress if they are not afraid to seek help. Now is the time to work together to banish those fears and bring mental health out of the shadows once and for all.
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In the Beginning:
Mental Health First Aid Is Born in Australia

Betty Kitchener and Tony Jorm, Founders, Mental Health First Aid Australia

Mental Health First Aid began one evening in 1997 when we were walking our dog, King. At the time, Betty worked as a nurse and did first aid instruction for Red Cross after hours. Tony worked as a mental health researcher at the Australian National University in Canberra. The two of us discussed why traditional first aid courses did not cover how to help people with mental health problems such as someone who is suicidal, having a panic attack, or out of contact with reality. We knew these problems were much more common than many of the physical health emergencies addressed in traditional first aid courses. This seemed a major omission.

The need to provide first aid to people developing mental health problems also had a more personal meaning for us. Betty had had a serious episode of depression and a suicide attempt when she was 15. This was responded to with criticism rather than support, and she received no professional help. Perhaps because of this lack of early help, Betty developed recurrent major depression, experiencing episodes of depression throughout her life, including a period of hospitalization. She had also experienced discrimination in her work as a nurse after being hospitalized. Her supervisors felt that a nurse who had been a patient in the “psych ward” was not suitable for working with patients who were acutely physically ill.

That evening on our dog walk, we resolved to do something about this situation. We decided that we would start up a “mental health first aid” course as a community service activity in the city where we lived. We envisioned running one or two courses a year on weekends, and never saw it going any further than that.

During the next few years, we discussed what the course might cover on many occasions. However, the time pressures of work and family life meant that we did not get further than that. The big breakthrough for us was in 2000 when Betty decided to reduce her paid work at the hospital and to work as a volunteer on getting Mental Health First Aid started. After six months, she was able to get a small grant, which covered a part salary. We also employed volunteer family members to make up for our lack of financial resources. For example, our daughter and son developed a website, www.mhfa.com.au, while Tony’s brother provided free legal advice. We learned over and over that family members are a great source of support, skills, and voluntary help.

By 2001, Betty was the sole Mental Health First Aid instructor, running courses in Canberra for the public. At this point, Tony’s skill as a researcher became useful. Beginning with the first course, Betty had collected data on the effects of the trainings on participants. By 2002, we had an evaluation study published, showing benefits to participants’ knowledge, stigmatizing attitudes, and helping behaviors towards others.

In 2002, Betty trained a number of other instructors and the course began to spread across Australia. By 2003, the Scottish government had seen the published evaluation study and became the first country outside Australia to adopt the course.

From that point, expansion turned rapid and we began carrying out a number of other evaluations, including two randomized controlled trials that showed the program’s benefits.

An important milestone in the Mental Health First Aid’s evolution was the development of international guidelines. We realized we needed a better foundation for course information and providing Mental Health First Aid. In 2004, we won a small grant from Australian Rotary Health to develop best practice guidelines, using the expert consensus of mental health professionals, consumers, and caregivers. These guidelines formed the basis of Australia’s 2nd edition course and for what became the 1st edition course in the United States in 2010.

By 2013, more than 1,000 instructors and 200,000 Australian adults had been trained in Mental Health First Aid. That’s more than 1% of the population. And the course had spread to 20 other countries. On that dog walk in 1997, we never imagined any more than a couple of courses a year in one city. However, our vision grew. We now aim for 6% of the Australian population to be trained and for every teacher, nurse, police officer, and health student’s training to include Mental Health First Aid. We want a world where all people with mental health problems feel supported by those around them and where they receive the best professional help as early as possible.
International Developments in Mental Health First Aid

Reprinted from Mental Health First Aid Australia Blog, posted on January 23, 2013, by kathb@mhfa.com.au

On January 16th 2013, President Barack Obama announced his “Now Is the Time” plan, which put forward a new series of executive actions and legislative proposals to help curb gun violence. The plan includes several mental health proposals focused on recognising and treating mental health issues in children and youth.

As part of the plan, Obama recommends Mental Health First Aid (MHFA) training to help teachers, staff and other adults interacting with young people to recognise the signs and symptoms of mental illnesses and to assist them with finding appropriate professional treatment.

Obama’s plan includes four key recommendations:

1. Closing background check loopholes to keep guns out of dangerous hands;
2. Banning military-style assault weapons and high-capacity magazines, and taking other common-sense steps to reduce gun violence;
3. Making schools safer; and
4. Increasing access to mental health services.

Whilst acknowledging that the majority of people with a mental illness are not violent, point 4 — increasing access to mental health services — discusses the need for early identification of mental health issues, to help individuals get appropriate treatment before violent situations arise.

Specifically, it is recommended that teachers and other adults who interact with young people be trained in MHFA:

“Provide ‘Mental Health First Aid’ training for teachers: Project AWARE includes $15 million for training for teachers and other adults who interact with youth to detect and respond to mental illness in children and young adults, including how to encourage adolescents and families experiencing these problems to seek treatment.”

Previously, in June 2012, the Mental Health First Aid Higher Education Act 2012, was submitted to US Congress. According to the National Council for Behavioral Health (part of the coordinating body of Mental Health First Aid USA), several US Representatives sent a letter to Vice President Biden on January 9, 2013, urging the US task force on gun violence to support this Act.

This Act is part of the plan to improve access to and quality of mental health services provided across the United States. If passed, MHFA training would be provided to teachers, students, and campus staff (e.g., counselling personnel, dormitory resident advisors, and coaches and other athletic department staff) in communities nationwide through a 5-year demonstration program to fund MHFA training at 10 institutions of higher education. The ultimate aim is to improve student mental health. In a press release on January 16, 2013, Linda Rosenberg, President and CEO of the National Council for Behavioral Health, stated that Representatives Ron Barber and Senator Mark Begich will shortly reintroduce this Mental Health First Aid legislation in Congress to implement the President’s recommendations.

The Canadian Government is also championing MHFA across a broad range or sectors. In fact, the coordinating body of MHFA Canada is the Mental Health Commission of Canada (MHCC), a national non-profit organisation created by the Canadian Government in 2007 to govern issues relating to mental health and mental illness.

The first mental health strategy for Canada, “Changing Directions, Changing Lives: The Mental Health Strategy for Canada” was published in May 2012 to help address the gaps in Canada’s mental health system. This strategy called for an increase in the capacity of families, schools and workplaces to promote good mental health, reduce stigma and prevent mental illness and suicide wherever possible. MHFA training is mentioned under this priority, and is indirectly recommended for “front line service providers in health care, education and justice systems as well as for those providing emergency long-term care and social services.”

Over in England, in a Department of Health press release published in July 2012 the Deputy Prime Minister Nick Clegg and Care Services Minister Paul Burstow urged employers in England to take action by undertaking three steps needed to improve their staff members’ mental health, one being to provide them with MHFA training.

Closer to home, MHFA has been mentioned in policy documents such as the Queensland Plan for Mental Health 2007-2017. Part of this plan is to “support activities which will build mental health promotion, prevention and early intervention capacity,” whereby one of the strategies is to “improve mental health literacy and access to Mental Health First Aid training for non-clinical workers in key government and non-government services.” In a four-year report on the progress of this initiative, published in October 2011, it was reported that Mental Health First Aid had so far been funded for 653 non-government and Department of Communities staff.

More recently, in October 2012, the Victorian Parliament in Australia acknowledged the importance of youth mental health and MHFA training for teachers in the Family and Community Development Committees “Inquiry into workforce participation by people with mental illness.” This inquiry recommends that MHFA be incorporated as part of teacher training, and states:

“Staff within schools requires Mental Health First Aid training to identify students at risk of disengaging from education because of mental illness.”

Earlier in July 2010, during the election campaign, the Australian Prime Minister, the Hon. Julia Gillard MP, committed the Australian Government to redouble its efforts to prevent the tragedy of suicide, making clear that mental health is an important part of a second term agenda and announcing a $274 million Taking Action to Tackle Suicide (TATS) package of which $6.1M was allocated for Mental Health First Aid training for front line community workers (i.e., financial and legal sectors, relationship counsellors, and healthcare workers). People working in these sectors interact with those who may be in financial, legal or relationship crisis where the risk of suicide is increased.

As part of the implementation of the Government’s 2010 TATS package, in 2012 the Australian Government Funding invited 6 selected mental health training organisations to apply to provide MHFA training for front line community workers. MHFA Australia was one of 3 successful applicants. Read more about what we plan to do with this funding here.

It is really encouraging to see MHFA being supported by Governments, mentioned in policy documents in Australia and overseas and associated lobbying efforts by partner organisations. It means we are one step closer to MHFA Australia’s ultimate goal — that MHFA training become mandatory for certain professions, just as is physical first aid.
INTERVIEW WITH ARTHUR C. EVANS JR.
Why Philadelphia Loves Mental Health First Aid

Arthur C. Evans Jr., PhD, is the Commissioner of Philadelphia’s Department of Behavioral Health and Intellectual & Disability Services, a $1 billion healthcare agency. He is leading a major initiative to transform how behavioral healthcare and intellectual disability services are delivered in the city. Dr. Evans is a clinical and community psychologist. He holds a faculty appointment at the University of Pennsylvania School of Medicine. He held faculty appointments at the Yale University School of Medicine and Quinnipiac University. Dr. Evans has extensive experience in transforming systems of care while serving in several national leadership roles. He is highly committed to serving people who are underserved and ensuring that all people have access to effective, quality services. Dr. Evans shares his perspectives on people helping people to improve the mental health of communities with Meena Dayak for National Council Magazine.

MEENA: In a recent article you wrote for the Philadelphia Inquirer [see sidebar], you talked about “mental health’s great gray area.” Can you talk about this?

ARTHUR: In this piece, I talk about how our current mental health system is set up and describe some of the barriers to reaching people who need our help at the time that they need our help. Right now, our service system is set up such that people get help only when they meet a certain level of diagnostic criteria and that leaves out a lot of people who may not quite be at that point but who nevertheless need intervention. From a policy standpoint, that’s a big challenge for people like me who run mental health systems because sometimes there are literally hundreds of people who need our intervention, but because of the way we finance services we don’t have the resources to reach out to them. And so it creates this sort of gray zone of folks who need intervention but we can’t quite get to.

MEENA: Why can’t we get to them? And what do we need to reach out to the people in the gray area?

ARTHUR: We have a system where treatment is the “black box.” Our system is set up so that people have to get “fixed” and either they’re brought to the black box involuntarily or they come to the black box themselves. Then, we work with them and discharge them. That is a real problem because it’s a passive system that requires people to either be brought or voluntarily come to treatment. If a person is having difficulty and can’t identify that they have a problem — which often happens with mental illness — or they don’t reach our criteria of being a danger to themselves or others, there’s really no way to intervene with them.

MEENA: Speaking of being brought to treatment, tell us a little bit about involuntary commitment and the laws around that.

ARTHUR: The standard is a very high standard for involuntary commitment, as I believe it should be, because we’re talking about people’s civil and human rights. Serious mental illnesses, like schizophrenia or bipolar disorder, emerge over a long period of time, and people may have challenges before they reach that standard for involuntary commitment. If you think of a ramp up from zero, at some point people may reach a threshold where others can intervene.

So, the issue for us is how do we have a system that is not only focused on people who are at the back end of their illness, but also in the early part of their illness? And one of the reasons we really support Mental Health First Aid is because it’s one way people in need can be identified sooner by others in their lives who have the knowledge and skills to refer them to appropriate treatment.

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We want to be able to intervene with people further back on the ramp, before they reach that threshold. There are a couple of problems. One is how we finance services, and the other is the question of what kind of interventions we should have for people before they are at the point where they need to, say, be hospitalized. There is growing recognition that we need to have more types and varieties of interventions for people before they reach that point in their illness. Mental Health First Aid plays an important part in that process because it’s helping people who might be in a person’s life to identify the need for help before that person reaches the threshold.
MEENA: Do we have effective early interventions?

ARTHUR: Yes, there are interventions that have been developed for people who are in the early stages of, say, a psychotic disorder. We’re looking at how we can implement those interventions on a larger scale here in Philadelphia. There are programs that look at people who have their first episode of a psychotic disorder or are in a prodromal state where they’re starting to show some of the signs and symptoms. The research shows that if we can intervene with people in those early stages, they have a better course in how their disorder develops.

MEENA: Recent tragedies like Newtown have emphasized that people with serious mental illness and their families are often isolated. How can we reach out and end the isolation?

ARTHUR: Isolation can be part of the illness. People who have schizophrenia may become very isolated and inwardly focused. People who are beginning to show signs and symptoms of mental illness may also isolate because they understand they may be exhibiting behavior that could get them in trouble and that they don’t want to be identified in that way.

I keep going back to Mental Health First Aid. After tragedies like Newtown, you always hear people say, “Well, we knew something was wrong but we didn’t quite know what was wrong or we weren’t quite sure what we ought to do.” Even those who are isolated are coming into contact with people — whether it’s at school, work, or with family members. So when people recognize that there may be something going on here, what do they do? How can they intervene?

And I actually think that this is one of those areas where the solution isn’t necessarily going to come from the mental health community. You can refer people in need to mental health professionals. But the early identifiers or first responders are people from someone’s congregation or workplace or school. To get to folks who might be isolating, we need a public health approach to the issue.

MEENA: Can you explain the public health approach to behavioral health?

ARTHUR: Right now, we have a mental health system that waits for people to be really sick in order for us to help them, and once we begin to help people and they get well, we take those resources away. You’ll often hear people say, “I’m really concerned about my services being withdrawn as soon as I begin to do better.”

We have an acute care model that’s based on a broken leg rather than diabetes. You can splint a broken leg; the person starts to walk again, and can go on with their lives. With diabetes, you have to have a lifestyle change. With mental illness, we can’t just treat the acute symptoms but must really put into place a set of services and supports that help either prevent or ameliorate the impact of the illness.

I like to use the analogy of hand washing and the impact it’s had on our physical health. Our solution to the flu is not “We need to build more hospitals, so that when people get sick they’ll have a place to go,” which is exactly what we do for mental health issues. We hear arguments for increased funding for treatment after the fact, but a growing number of us in the mental health field recognize that we need to get further upstream and to see how we can intervene before people actually need treatment.

We must educate the public about what they can do to minimize or lessen the chances that people might develop a full-blown disorder. That’s what we mean by a public health approach. It’s not waiting to get to that point where people are really sick, trying to intervene earlier.

MEENA: Does the behavioral health field really focus on the “hand-washing”?

ARTHUR: We haven’t developed enough wellness-oriented interventions. I think that’s where the research ought to be right now. Very little of our research dollars are going into prevention.

We have more work to do in this area. There is research that shows that we can intervene early with people who have psychotic disorders and change the trajectory of those conditions. We know that if we intervene in the proper way with people who have gone through traumatic experiences, that that can also change the trajectory.

We know that if we intervene with people going through grief and loss, that can lessen the likelihood that people will develop a full-blown mental disorder.

As long as the way people get paid is based on you having an illness and the research is focused on that part of the continuum, we’re not going to have the resources that we need to pay attention to those things that can be done further upstream and upfront.

MEENA: What have you been doing with Mental Health First Aid in Philadelphia and where are you headed?

ARTHUR: Mental Health First Aid is probably one of the best things to happen to the mental health field in a very, very long time. I think it makes mental health issues accessible to the broader public, which is critical. It allows us to engage with people that we would not ordinarily engage with around these issues. And it helps us as a society and as a community address mental health issues in a much more public health way.

It’s a wonderful intervention and we’ve gotten a tremendous response from all kinds of groups here in this city as we’ve talked about it.

We started Mental Health First Aid in Philadelphia with a grant to train people from the criminal justice system — police, court personnel, the district attorney, the public defender, probation officers.

Mental Health First Aid is probably one of the best things to happen to the mental health field in a very, very long time.

We identified some one-time dollars to train a cohort of an additional 60 people across a variety of systems including city government, faith organizations, educational institutions, and so forth. Right now, we’re looking at how to sustain this work through ongoing grant dollars.

We’re taking a systemic approach. Our goal is ultimately to train 10% of the population — more than 100,000 people. We’re not going to do that overnight, but we want Mental Health First Aid to be as common as CPR and physical first aid. That is the kind of penetration communities will need in order to really move the dial on reducing stigma and improving people’s understanding of mental health issues.
We also have a very large evidence-based practice initiative that we have connected to this. As much as we’re putting the emphasis on educating the public, we want the public to receive state of the art treatment services when they actually connect with our system. So, we’re working both ends of this and making sure that this work is connected to the broader transformation of our system.

MEENA: What impact has Mental Health First Aid had on your community?

ARTHUR: Mental Health First Aid allows people to see people in a different light, and we think that alone is worth the training. People actually know how to intervene, and that is an added benefit.

Let’s take the example of the district attorney’s staff that were trained in Mental Health First Aid. They talked about how it really opened their eyes and they saw people who had experienced mental health problems differently. These are people who are running into people, are engaging those people who have mental health problems all the time, and now they really know how to deal with them.

We’ve had a number of nurses that have reached out to us and been trained in Mental Health First Aid and it helps them learn where they can access services and supports for individuals who need specialty behavioral healthcare. The emir, who is over the Sunni Muslims in Philadelphia, has mandated that all leaders within their group get trained in Mental Health First Aid. The school district is looking at how to train teachers and non-academic staff.

Mental Health First Aid is a fantastic tool that every commissioner ought to be using to educate the community about mental health issues.

The breadth of organizations that have partnered with us are really excited about doing this training. We are in the process of developing a relationship with American Red Cross here so that we’ll be doing the training jointly with them. And so in Philadelphia you’ll be able to take First Aid and get both Mental Health First Aid and physical first aid simultaneously or in a connected way.

MEENA: What would you say to other behavioral health commissioners across the country?

ARTHUR: Mental Health First Aid is a fantastic tool that every commissioner ought to be using to educate the community about mental health issues. There’s so much stigma associated with mental health that we have to use this as an opportunity to educate people.
aid, Medicare, or private insurance (the primary sources of funding for behavioral health care). Only services focused on ameliorating an active mental health condition are reimbursable.

This means funding agencies like mine typically devote less than 3 percent of their budgets to prevention and early intervention. That leaves families and communities to fend for themselves when it comes to identifying those who need help and navigating the system to get it.

Behavioral health systems across the country need more flexibility to fund “upstream” activities focusing on outreach, early identification, and engagement. We should probably be spending at least a third of our budgets on prevention and early-intervention services.

First aid

Despite current limitations, Philadelphia is undertaking several low-cost and potentially high-impact responses to gray-zone issues. One of the most promising is called Mental Health First Aid, a program to teach the public the basics of spotting behavioral health issues and addressing them earlier. The goal is to increase the community’s ability to recognize these issues and to give them the confidence to assist relatives, friends, coworkers, and others who may be experiencing psychological distress.

Philadelphia’s program is perhaps the most audacious in the country, with a target of training 10 percent of the city’s population, including teachers, first responders, parents, and others. So far, the enthusiastic public response has shown a thirst for this kind of information.

The city has also launched an online screening resource that can help detect mental health issues early and recommend ways to get help.

As we continue our painful national discussion of how to prevent the next Newtown — a discussion that must address gun control as well — we need to avoid stigmatizing mental illness, keeping in mind that violence is rarely associated with it. At the same time, we need to clearly identify policy changes that will allow us to improve our overall approach to mental health in this country. Yes, we need more consistent and sustainable funding. But we also sorely need more flexibility to spend our current funding in ways that allow us to intervene earlier and more effectively with those in the gray zone.
Mental Health First Aid Eliminates Fear of Mental Illness

Betsy Schwartz, Vice President, Public Education, National Council for Community Behavioral Healthcare

Did you know you are far more likely to talk with a person experiencing an emotional problem than you are to find yourself face-to-face with someone needing CPR? Not to diminish CPR’s importance — it’s a life-saving technique that can rescue someone in distress. So too is Mental Health First Aid.

Historically, our society has failed to become versed in the realities of mental health problems and strategies to help people in need. Perhaps you remember when we shrank from talking with someone struggling with cancer? We feared the unknown, the Capital-C-Cancer. Through scientific understanding, the hushed tones surrounding cancer gave way to a renaissance of public understanding. The scientific knowledge around mental illnesses and addictions are beginning to enjoy similar understanding, but accessibility of services continues to lag.

As our nation struggles to increase accessibility, while creating a national dialogue about mental health and addictions, we know the answer lies in public acceptance and knowledge. Mental Health First Aid is a public health answer to a public health problem. Just imagine if we eliminated the myths and fears of mental illnesses in the minds and actions of Americans. This program offers a simple, concrete action plan that does exactly that. President Obama knows this, too. He included Mental Health First Aid in his gun violence prevention recommendations, communicating to the American public that knowledge is the most powerful weapon.

Congress has introduced the Mental Health First Aid bill. President Obama is including Mental Health First Aid in his gun violence prevention recommendations. Some state legislatures have begun to include state funding for Mental Health First Aid. Corporations are considering Mental Health First Aid as a standard part of employee training. Some law enforcement organizations see potential in Mental Health First Aid as a complement to existing programs like crisis intervention teams. Clergy members look to Mental Health First Aid as a potential part of congregational outreach. And universities and schools are beginning to find ways to incorporate Mental Health First Aid into teacher trainings.

Now is the time to celebrate the growth of Mental Health First Aid and the nation’s efforts — small and large — to embrace knowledge of mental health problems.

Because Everyone’s Mental Health Matters to Us All.

Mental Health First Aid is a public health answer to a public health problem.

Whether Mental Health First Aid’s audience is teachers, clergy, law enforcement, human resource personnel, parents, or less traditional helpers such as hairdressers or cab drivers, we know that after participating in a training, people leave with new attitudes about mental health problems and are eager to help those who struggle with them. Help may take the simple form of sharing compassionate words, rather than making an unintended, harmful comment. It may take the form of recognizing symptoms in someone and knowing how and when to help. The National Council hears countless people say Mental Health First Aid gave them the knowledge and confidence to act, to make a difference.

For this reason, the time for Mental Health First Aid is now. It is time for it to become as common as CPR.

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KEYNOTE PRESENTERS
Geoffrey Canada, President & CEO of the Harlem Children’s Zone

Dr. James O. Prochaska, Director of the Cancer Prevention Research Center & Professor of Clinical and Health Psychology at the University of Rhode Island

David Granirer, counselor, comic, and founder of Stand Up for Mental Health

To learn more about conference speakers, visit www.mentalhealthamerica.net/go/annualconference/speakers.

To register and obtain more information about the conference, go to: www.mentalhealthamerica.net/go/annualconference. Additional questions can be directed to info@mentalhealthamerica.net or 703-684-7722
Leaders Speak

INTERVIEW WITH THOMAS INSEL
Prevention Is IN the Cure

Exclusive interview for National Council Magazine

Thomas Insel, MD, is Director of the National Institute of Mental Health, the component of the National Institutes of Health charged with generating the knowledge needed to understand, treat, and prevent mental disorders. His tenure at NIMH has been distinguished by groundbreaking findings in the areas of practical clinical trials, autism research, and the role of genetics in mental illnesses. Prior to his appointment as NIMH Director in fall 2002, Dr. Insel was Professor of Psychiatry at Emory University. There he was founding director of the Center for Behavioral Neuroscience, one of the largest science and technology centers funded by the National Science Foundation, and, concurrently, director of an NIH-funded Center for Autism Research. He has published more than 250 scientific articles and four books, including the Neurobiology of Parental Care (with Michael Numan) in 2003. Dr. Insel is a member of the Institute of Medicine, a fellow of the American College of Neuropsychopharmacology, and a recipient of several awards including the Outstanding Service Award from the U.S. Public Health Service.

Dr. Insel shares his perspectives on prevention and early intervention with Heather Cobb, Meena Dayak, and Susan Partain for National Council Magazine.

NATIONAL COUNCIL: What lessons can mental health learn from the rest of healthcare about prevention and early intervention?

DR. INSEL: Elsewhere in medicine — we’ve learned over time that the earlier we can intervene, the better the outcomes. It’s kind of astounding when you look at the reduction in mortality for heart disease, stroke, and AIDS, and certain forms of cancer. The sooner you intervene, the lower the death rate.

We’ve learned from AIDS that treatment is the best form of prevention. The way to prevent the spread of HIV is to treat people who are at high risk because they’ve already been infected, are at risk of spreading the infection, or they’re in a relationship or environment where they’re very likely to be exposed. There was a 96% reduction in transmission by treating people who are not yet infected but were at risk for being infected.

This approach can begin to inform the way we think about mental illnesses — recognizing who is at high risk and then intervening as early in the process as possible. If we have the right kinds of interventions, we’ll get much better outcomes.

What we’ve begun to realize is that defining these illnesses based on the onset of psychosis is a little bit like waiting until someone has a heart attack to say that they have heart disease.

What we think about at NIMH, increasingly, is how do you identify someone who is at high risk perhaps two or three years before the onset of full psychosis? What we’ve begun to define the phases of schizophrenia, and we’ve realized that psychosis is probably a fairly late phase, maybe phase three, with chronic disability being phase four. If you want to have the best outcomes, then you want to get there in phase one or two. Phase two, which is where we’re focused most of all, is this period of the prodrome.

We’ve learned from AIDS that treatment is the best form of prevention.

What we’ve begun to realize is that defining these illnesses based on the onset of psychosis is a little bit like waiting until someone has a heart attack to say that they have heart disease.

We can now define prodrome in adolescents through screening and looking at symptoms like thought problems and maybe even occasional, fleeting hallucinations. There may be adolescents who’ve had problems at school, whose grades have fallen, or who’ve become more socially withdrawn. The task has been to find interventions that would help any of these kids, whether they actu-
ally go on to psychosis or not; to define the high-risk groups; and then to provide the kinds of support — family education, cognitive behavior therapy, etc. — that will make a difference.

**NATIONAL COUNCIL:** Are any major early intervention initiatives under way at NIMH?

**DR. INSEL:** Yes, the North American Prodrome Longitudinal Study (NAPLS) that involved eight sites in North America. The study longitudinally follows about 960 people who are considered to be at high risk.

We know that, for brain disorders, behavior change is a very late event.

The task has been, in this last 5-year period, to identify the group at the highest risk, through cognitive testing or looking at biomarkers. So, they’ve been doing neuroimaging, looking at changes in brain development, and trying to understand which 15-year-olds may need intervention.

That is where this mantra of treatment as the best intervention comes into play, because what we think about now in terms of prevention is really more like pre-emption. It is sort of identifying the high-risk group and then being very focused on people in that group to provide them and their families the resilience that they’ll need, with the hope that you can actually preempt the psychosis.

**NATIONAL COUNCIL:** What is the state of the science on prevention and early intervention for more prevalent mental illnesses, like depression or anxiety disorders?

**DR. INSEL:** We’re trying to do for PTSD exactly what I’ve described for schizophrenia. We’d like to figure out in the emergency room — when someone shows up after a rape or car accident or being on the battlefield — who will go on to develop PTSD in three to six months versus those who are going to be just fine. We would use predictive biomarkers to identify who is at the highest risk and then come up with the appropriate intervention for someone who does not yet have the disorder but we know is at high risk for it. We’re working closely with the Army and the VA.

We have a whole series of universal prevention approaches that are available for a range of mental health problems. And, almost at every stage, there is some intervention that we’ve developed through the NIMH over the last 30 or 40 years.

**NATIONAL COUNCIL:** Do we have the equivalents of “eat healthy” and “exercise daily” in mental health? How can we build wellness and resilience?

**DR. INSEL:** Yes, building resilience means building brain pathways that allow people to buffer all of the things that they will go through. When we talk about schizophrenia, that means building formal cortical circuits, and we know how to do that. We know a lot about executive function and issues like judgment and working memory, and the kinds of things that you have to do to be resilient, that you can’t do when you fall into a psychotic state, or when you are at high risk for that.

So, what we think a lot about is how do you build that? Could you create an app? Could you create a video game that would be a way of actually helping people to build those circuits? We’ve done this for dyslexia in a really nice way, where you can help kids learn to read through this kind of an approach, and you can show the changes in brain pathways associated with that, and cognitive training in people with or at risk of schizophrenia. With imaging, we can see the brain changing and

When you can cure something, it is amazing how the stigma goes away.

the circuitry forming in just the way that you would want. So we’re pretty hopeful that this will work, again, in the domain of schizophrenia. Whether we would do the same thing for bipolar disorder is a little harder to know because we’re not exactly sure what the circuit is there that we have to go after.

Part of the reason we are so excited about the President’s mention in the State of the Union about brain mapping is because there is a vital need to understand mental disorders, since we think of these as brain disorders and distinctly as disorders of brain circuits. We know that, for brain disorders, behavior change is a very late event. But we don’t have all the tools that we want to get very precise measures of circuit function in the brains of people who are struggling with mood disregulation or hallucinations, or even severe depression.
Leaders Speak

Educating people about mental illness is, in some ways, even harder than educating them about hypertension and obesity.

In the case of Parkinson’s disease, you’ve lost 80 percent of your dopamine cells over a decade before you develop the very first symptoms — behavioral changes. With Alzheimer’s, there’s 10-20 years of cortical loss before you begin to show dementia. These are really important lessons for us because it may be that the very same thing is true for what we call “mental disorders,” but we frame them as behavioral problems. We’re probably missing that most important period, which could go on for years, of changes in the brain that say, “This is somebody who is on this trajectory, and let’s try to get there before they actually develop the behavioral manifestations.”

NATIONAL COUNCIL: Would thinking of these as brain disorders rather than behavioral health problems help people better understand the issues and overcome reluctance to seek care?

DR. INSEL: The treatments we have for mental health are just not good enough. And the best way to conquer stigma is to have more understanding and a much better range of interventions to offer. When you can cure something, it is amazing how the stigma goes away.

AIDS was incredibly stigmatized, but the really big change occurred when people realized that this could be conquered. It was a very different conversation when this became a chronic disease rather than a death sentence. So for serious mental illnesses, by framing these as real brain disorders that have real treatments, we can help people understand what they’re coping with.

NATIONAL COUNCIL: Are there treatments being tested with people in earlier stages of mental illness?

DR. INSEL: Yes, we are trying. There is a lot of interest in this, particularly in Australia and in the U.K., and other parts of Europe. We’re a little bit late to the party in the sense that some of the trials are just getting under way now. But we don’t yet have the right collection of interventions in the way we would for heart disease. I can’t tell you that we have an intervention that will drop the conversion to psychosis by 50 percent, but that is very much where we’re aiming.

I would say just about the highest priority right now at NIMH is trying to figure out — for schizophrenia, bipolar disorder, PTSD, and depression — how to build effective preemptive strategies, making sure that we identify risks through biomarkers and cognitive testing, and then building resilience probably not so much with medication but with other kinds of interventions.

NATIONAL COUNCIL: Are there things everyone can do to build resiliency against mental illness?

DR. INSEL: There are two strategies. The first strategy is universal prevention that you’d put in play for a whole population, like making sure that people walk instead of drive or get sugar out of sodas. We have some of those universal preventions. These are highly effective and just need to be implemented widely.

Another strategy is secondary prevention, or indicated prevention. That is to go after the group that is really at high risk, that you know is already on this trajectory, and trying to either slow or stop the progress toward illness. And that is a place we just haven’t been. It is a different approach. It is still very much experimental. We are not recommending that pediatricians start having every 15-year-old get a brain scan, but the emerging data are really kind of amazing, that suggest to us that there really is something here and that there are changes in the way that the brain is developing that you can pick up long before somebody develops the symptoms.

Probably the best example of this in the last year has been with autism. Even though the symptoms of autism are not apparent until about 18 months, it is very clear that, if you look at the kids at risk because they have an autistic sibling, you can pick out the kid who will progress onto autism before 12 months. And that comes about through brain scans and cognitive tests, through looking at eye gaze, the whole range of things that have not yet made it into a pediatrician’s office but probably will over the next year or so.

NATIONAL COUNCIL: What role does public education play in prevention and early intervention for mental illness?

DR. INSEL: It is tough. Educating people about mental illness is, in some ways, even harder than educating them about hypertension and obesity. But it is most effective in people who have had someone else in the family affected, and then they become unfortunate experts and realize what is at stake. But until you or someone in your family has gone through it, you just don’t realize the issues.

Our own community has got some work to do. We have such differences in our approaches to these issues, so I think that we have to figure that out as a community, “Are these real disorders or are they problems of living? Where do we really want to put our focus?” And, you know, we’ve got some internal work to do to understand how we contribute as a community to the stigma. I’m always struck by how much people will say, “It is not the disorder that I am concerned about, it is that I really don’t want to see a therapist. I really don’t want to see a counselor or a psychiatrist” because there is such stigma around the people in the profession. We have to think through our own responsibility here before we expect people to change their attitudes.
You could be the person who makes a difference in the life of someone with a mental illness.

Trust your intuition and make the right choice.

Linden Oaks at Edward is a behavioral health facility that offers Mental Health First Aid courses and specializes in the treatment of addictions, anxiety, depression, eating disorders, self-injury, and geriatric behavioral health conditions. We offer free assessments and an easy referral process.

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(630) 305-5500 to make a referral
MEENA: Since you took over as Administrator at SAMHSA, you’ve advocated for the public health approach to behavioral health. What does that approach look like for you?

PAM: First and foremost, I think of a public health approach that starts with prevention. The whole point of public health is to have healthy people, healthy communities, healthy lives, and to prevent disease, prevent illness, and prevent mental health and substance abuse conditions and abuse.

Second, I think of an approach that is very data driven. You monitor the public’s health — or in this case behavioral health — population data, community-based data, and other information that tells you how the community’s doing, how the population’s doing, how individuals are doing, and then you act accordingly. Behavioral health is a part of health. We don’t think you can have healthy communities without having good emotional health, mental health, and freedom from substance abuse.

Other aspects of a public health approach are the partnerships, the structures, the policies, and the environmental efforts in place to enable working together as a community, or as a group of people in a population, to make sure that people are healthy. We also want to be sure to screen people, identify those that have needs, get them into treatment early, monitor outcomes, and have the partnerships to do all that.

We have a tendency in our world to focus on getting people treatments, which is a good thing, but it’s only a part of what we do. Our goal must be to try to prevent disease first and try to get people into treatment sooner, and then we must try to have the structures, partnerships, and policies in place to prevent and treat.

MEENA: Is prevention really possible in behavioral health?

PAM: Absolutely. Prevention is possible, and I think that we know more about that than we did before. We know that adult issues often start in childhood — not always, but often. We have a fair amount of information that if we can keep young people from drinking under age then they are much less likely to have an adult drinking problem. We know that if we can keep them from drinking under age then they are much less likely to start taking other drugs. And we know that that we can prevent deaths caused by underage drinking if we can do that. So, we clearly have good information about those kinds of issues.

We also have some pretty good information that mental and behavioral disorders tend to start early — about half of them before age 14, and about three-quarters of them before the age of 25. So, if we can do effective work in those early years, we can not only help young people and their families, but we can also help address the adult issues as they grow. There’s lots of new research on young people experiencing first break psychosis, and we know that if we can intervene early we can prevent the disabling aspects of those psychotic illnesses, and in some cases restore the young person to a fairly common life trajectory. As opposed to what we used to think as being a pretty devastating and disabling condition long-term.

MEENA: What do we need to do to move prevention forward?

PAM: We are pretty clear that in order to implement prevention, you need to do skill building at the individual, family, and community levels. We need to help young people have skills to make the right decisions, help parents have the skills to work with their kids, help schools have the skills to work with their stu-
MADIES, and help faith community leaders have the skills to work with congregations. It's a community-wide effort, so you can't just attack it at one level. You can't just have one conversation in a health class in a high school and expect that to solve the problem. It's got to be a comprehensive approach.

MEENA: You talk about the importance of education as a means of prevention. You're talking about educating everyone and not just those we think are at risk for behavioral health issues, right?

PAM: That's right. I think we have for too long thought that mental health and substance use issues are somebody else's problem, not ours. We must educate people to recognize the signs and symptoms in self, or in a family member, or a neighbor or a friend, and to know what to do about it. Obviously, the work that the National Council has done to expand Mental Health First Aid is an example of the kind of work we need to do all around the country.

MEENA: Can you tell me about some public education initiatives that SAMHSA has, especially for young people?

PAM: We have lots of work going on both at the school and college levels. We have a grant program called Safe Schools, Healthy Students that provides grants to school systems to work with the school, the community, the parents and families, and the youth to develop awareness, activities, and prevention interventions, so that the community and the school together can promote a safer and healthier environment. And from that program we've got really good outcomes about the increased number of youth and school personnel who experience their school environment as safe. We see reductions in behaviors that are negative in the school and classroom and community setting, and we see increased referrals for treatment, which is exactly what we want. In other words, we want young people to be aware of what's going on and to be able to seek treatment earlier, when it's still a burgeoning issue rather than wait until it becomes a more complicated issue.

We have college campus-based programs focusing on suicide prevention and on underage drinking, as kids 18-21 are particularly vulnerable to binge drinking and other kinds of negative use of alcohol and other drugs. Our substance abuse prevention programs with the states are focused on underage drinking and on prescription drug abuse.

MEENA: What is our single biggest barrier to making the public health approach to behavioral health more widespread?

PAM: It would be easy to say that resources are our single biggest problem, but our single biggest barrier is lack of knowledge, and lack of understanding, and prejudices, and negative attitudes that are based on that misunderstanding. Our biggest challenge is to get people to really understand that behavioral health is essential to health, and it can be positively affected. We should be teaching our kids skills about emotional and mental health the same way we teach them math skills or soccer skills. But until we understand that completely, we're not going to be able to cross that barrier of inadequate resources or inadequate attention to the issues.

MEENA: SAMHSA has done tremendous work in using the voices of people in recovery to really show the world what's possible. Can you talk about how you've used peers to spread awareness and overcome negative attitudes?

PAM: We're very clear that the best people to talk about these issues are people who have lived the experience of addiction or mental illness. People with lived experience are some of the best advocates. They can tell their stories and change perception. They are much more likely to be able to tear down the barriers of misunderstanding and negativity. So we want to make it possible for them to tell their stories to help educate others.

We also know that a lot of times people will listen to peers before they will listen to somebody else. So a veteran, who is experiencing mental health or PTSD or substance use issues, is much more likely to be willing to confide in and talk to other veterans, at least at first. The same thing is true of youth. We know that youth are very often more willing to listen to other youth. Even in the adult world, recognizing that the person you're talking to has experienced what you have is very effective.

We've increasingly tried to support recovery coaches, peer-certified specialists in...
Leaders Speak

There is a need for a continued focus on mental health in our society. This can be achieved through various means, such as training community health workers and peers to be part of outreach and enrollment efforts.

**MEENA:** How can we keep the conversation around mental health alive and well in this nation?

**PAM:** President Obama has asked Secretary Sebelius and Secretary Duncan to launch a National Dialogue on mental health recognizing that we really need to talk about mental health differently in this country. We hope the initiative will launch in March 2013 and provide the opportunity to have positive conversations about mental health everywhere around the country in a number of ways, whether it’s electronically, or face-to-face, or through video.

We want to turn up the volume on a conversation that has been quiet. We want people who are not yet comfortable reaching out to get the help they need, or to talk to other people about what they’ve experienced. And we’d like to make that a lot more regular and more common so that mental health is not such a feared issue, and so that the negative attitudes decrease and therefore people are more willing to have their communities participate in planning and concerted efforts to improve mental health.
Sunovion Pharmaceuticals Inc. is dedicated to improving the lives of patients and their families who are living with mental illness.

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I’m Just a Bill: Mental Health First Aid on Capitol Hill

Charles Ingoglia, Senior Vice President for Policy and Practice Improvement, National Council

Many of us remember the fun and informative Schoolhouse Rock overview of the legislative process. Yet, even with this excellent overview, it is sometimes difficult to keep track of all the steps that go into making an idea into a bill and bill into a law that both houses of Congress have passed and the President of the United States has signed. So, let’s start at the beginning and review how the Mental Health First Aid Act will become a law.

What is the Mental Health First Aid Act?
The Mental Health First Aid Act of 2013 (S 153/HR 274) authorizes $20 million in grants to fund Mental Health First Aid training programs around the country. Participants would be trained in:

- Recognizing the symptoms of common mental illnesses and addiction disorders.
- De-escalating crisis situations safely.
- Initiating timely referral to community mental health and substance abuse resources.

The Substance Abuse and Mental Health Services Administration would administer the Mental Health First Aid grant program, making funding available so that Mental Health First Aid courses could be offered to emergency services personnel, police officers, teachers/school administrators, primary care professionals, and students. The ultimate goals would be to improve Americans’ mental health, reduce stigma around mental illness, and help people at risk of suicide or self-harm by connecting them to appropriate treatment.

The Mental Health First Aid Act was introduced in the House of Representatives by Congressman Ron Barber (D-AZ), with seven bipartisan cosponsors, and in the Senate by Senators Mark Begich (D-AR) and Kelly Ayotte (R-NH), with nine bipartisan cosponsors.

What Now?
Congress — not unlike many nonprofit boards — conducts most of its business through committees. Since the Mental Health First Aid Act creates a program administered by SAMHSA, the Senate Committee on Health, Education, Labor, and Pensions (HELP) has jurisdiction over the bill because it has jurisdiction over SAMHSA. In the House of Representatives, it was assigned to the Energy and Commerce Committee (E&C).

The first step toward making the Mental Health First Aid Act a law requires each Senate and House committee with jurisdiction to pass the bill. Then, the full chamber must pass it. But, that is the simple answer. Almost no legislation passes Congress on a stand-alone basis. What is much more common is that a committee of jurisdiction groups bills together to form a larger bill and then they are passed that way.

What Can You Do to Help?
The good news is that you do not have to worry about the details. The National Council monitors the legislative process and provides periodic updates through our weekly e-newsletter, Capitol Connector (formerly the Public Policy Update). If you don’t receive this weekly resource, sign up at www.TheNationalCouncil.org.

There will be times when this bill will need your support — especially when there are legislative milestones approaching such as when a committee, or the entire chamber, is preparing to vote on the bill. At these times, we will alert you to contact your legislator to ask them to support the bill. Responding to National Council action alerts is the most helpful way to support the bill and help expand Mental Health First Aid in our nation.

This year, with Congress focusing so acutely on mental health, we have a rare opportunity to win passage of the Mental Health First Aid Act and other legislative priorities. But, we can’t do it without a strong show of grassroots support! Together, we’ll help that little bill on Capitol Hill turn into a U.S. law!

State Legislative Toolkit

The National Council recognizes that state legislatures can play an important role in supporting the availability of Mental Health First Aid in communities. To support this proposition, the National Council developed a toolkit to support state level Mental Health First Aid advocacy. It includes research summaries, talking points, and model language for Mental Health First Aid grants and for making Mental Health First Aid certification available for certain professions.
Erasing Stigma, Guiding Action
A Powerhouse Partnership

Betsy Schwartz, Vice President, Public Education, National Council for Community Behavioral Healthcare

Mental Health First Aid USA is partnering with Bring Change 2 Mind to raise awareness and promote understanding that mental illnesses and addictions are real, treatable diseases that are more frequent than cancer, lung, and heart disease combined.

Bring Change 2 Mind and Mental Health First Aid believe that education, early recognition and treatment make a difference and that stigma is often the only thing that keeps people suffering in silence.

“When we talk about how common it is, we want to show that mental illness doesn’t separate one from the human race, it makes one part of it,” said Glenn Close, award-winning actress, who is the co-founder and chairperson of Bring Change 2 Mind.

Bring Change 2 Mind is a national messaging campaign aimed at ending stigma and discrimination. The idea was born out of a partnership between Glenn Close and Fountain House, where Glenn volunteered in order to learn more about mental illness, which both her sister, Jessie Close, and nephew, Calen Pick, live with. Once someone recognizes an illness and is ready to do something about it, Mental Health First Aid complements Bring Change 2 Mind by offering specific information and actions.

“For Mental Health First Aid’s partnership with Bring Change 2 Mind creates great opportunity to help people learn about mental health and take action by participating in Mental Health First Aid courses in their own communities. We look forward to launching our partnership later this year,” said Linda Rosenberg, President and CEO of the National Council for Community Behavioral Healthcare, one of the three entities that run Mental Health First Aid USA.

For more information

bringchange2mind.org
mentalhealthfirstaid.org
INTERVIEW WITH CONGRESSMAN RON BARBER
Mental Health First Aid’s Congressional Champion

Ron Barber grew up in a military family. While in high school, Barber met his wife, Nancy. They raised two daughters, Jenny and Crissi, in Tucson and now have five grandchildren who are also being raised in Tucson.

Before becoming a member of Congress, Barber had a 32-year career with the Division of Developmental Disabilities in the Arizona Department of Economic Security, eventually serving as its director. In 2007, Barber was appointed Congresswoman Gabrielle Giffords’ district director.

On January 8, 2011, Barber was standing beside then-Rep. Giffords as she held her Congress on Your Corner in northwest Tucson. An assassin shot the congresswoman, Barber, and 17 other people. Six of those people were killed. Giffords and Barber were both critically wounded.

In January 2012, Giffords resigned from office to focus on her recovery. Barber was sworn in to serve the people of southern Arizona in June 2012. He was sworn in to his first full term in Congress on January 3, 2013, and now serves his constituents on the House Armed Services Committee, Committee on Homeland Security, and Committee on Small Business.

He introduced HR 274, the Mental Health First Aid Act of 2013, which authorizes $20 million in FY 2014 for grants to train emergency services personnel, police officers, teachers and school administrators, primary care professionals, and students in Mental Health First Aid. This training will go a long way toward reducing the stigma around mental illness and addictions and getting people connected to the professional resources they need.

Rep. Ron Barber shares his thoughts on mental health with his constituent Neal Cash, President & CEO of the Community Partnership of Southern Arizona, and director on the board of the National Council for Community Behavioral Healthcare.

NEAL: Tell us about your career before politics.

RON: I started as the Head Start director in Tucson and helped to integrate kids with disabilities into the regular Head Start program. Then I went to work in the Division of Developmental Disabilities as the community outreach director and helped to get people with disabilities out into the community, into whatever setting made sense. That’s how I got interested in making sure that all people, whatever the label they’re given, have the opportunity for full inclusion in their community and are supported by their community.

As I became the regional director and then the state director I became aware of how many people had a dual diagnosis — a mental health disorder, as well as mental retardation or cerebral palsy or autism. That’s when I got much more involved with the behavioral health system, trying to make sure that we had a good bridge between the two systems for folks with dual diagnosis. We brought some people — like psychiatrists — on board that had not been basically allowed in the developmental disabilities system for a long time, and that was a big breakthrough.

NEAL: Let’s fast forward from that exceptional career to January 8, 2011, when you were with Gabby Giffords on that fateful day in Tucson. Tell us about it.

RON: Well, it was a beautiful January morning in Tucson and Gabby was doing her first, Congress on Your Corner since she won the election. We’d done many of these before — opportunities for members of Congress to meet one-on-one with constituents and hear what they had to say. So, we set up as we always did. I stood beside her to help. Arizona Chief U.S. District Judge John Roll then stepped inside our little enclosed area so he could say hello to Gabby when a constituent finished speaking, and at that moment, I saw the gunman come around, shooting directly at Gabby and then shooting me, John, and our staffer, Gabe Zimmerman (John and Gabe succumbed to the shooting).

What I experienced that day changed my life, no question about it. The real tragedy was that no one helped him get a proper diagnosis and from that a proper treatment. I really believe that if that had happened, that shooting might never have occurred.

I saw everything that happened that day. I was conscious pretty much the whole time and what I saw was just absolute mayhem, with 33 bullets being fired in 19.6 seconds. Loughner was about to load another magazine when he fumbled
it and it fell to the ground, and he was subdued and the magazine was grabbed.
The images from that day will always be with me. They certainly impacted my own
mental health significantly, at least early on, and I was very fortunate to get the
kind of support I needed both from my family, as well as professionally.

As I reflected on it and learned more about the shooter when I was in the ICU, it
became apparent that he’d displayed many symptoms of mental illness — many
pretty serious in terms of threatening classmates and teachers and a video where
he said his community college was his suicide school. I think even his parents
saw some things. But the real tragedy was that no one helped him get a proper
diagnosis and from that a proper treatment. I really believe that if that had hap-
pened, that shooting might never have occurred. So coming out of that realization,
my family and I set up the Fund for Civility, Respect and Understanding to try to pay
attention to the stigma around mental illness that prevents people from getting
treatment, and also to increase public awareness of the symptoms and treatment
options for mental illness. That fund is still active.

NEAL: How did you respond in the aftermath of this tragedy?

RON: We focused on bullying at first, as we know that many perpetrators of mass
shootings have been bullied or were bullies in school. Then as time went on, I be-
came a member of Congress and got to look at this issue in a different way. I heard
of Mental Health First Aid during the year of my recovery from the shooting and it
seemed to fit right in line with what I perceived as a major issue in our culture —
people are fearful of folks with mental illness, they don’t understand what they’re
seeing, they don’t know what to do when they do see it, and the stigma is huge
for both the person with mental health issues, as well as those around them. We
can talk about every other disease under the sun, but we just cannot talk about
mental illness in a public way. Mental Health First Aid is a program that helps to
change that.

We all know that 95 percent or more of people with mental illness never
commit a violent act. They’re more likely to be victims, so we must remind
people over and over again, that this is a population of people who are
typically untreated, undiagnosed, and need help. We must be sure we’re not
increasing the stigma by talking about mental illness and violence.

My career in developmental disabilities had a lot to do with getting people out of
institutions and into their community, where they could be surrounded by natural
and professional supports, and live real lives. That’s what we need to do and we
are doing, in large measure, for people with mental illness. The problems of course
pertain to funding and historically bad ideas about what a person with mental
illness is all about.

We know there’s a nexus of two things in most of the mass shootings over the last
two years — a serious mental illness that was undiagnosed or untreated and the
high firepower of the weaponry that the person used. Having said that, we all know
that 95 percent or more of people with mental illness never commit a violent act.
They’re more likely to be victims, so we must remind people over and over again,
that this is a population of people who are typically untreated, undiagnosed, and

NEAL: You’ve indeed been a great champion of Mental Health First Aid and recently
introduced the Mental Health First Aid Act [HR 274] in the U.S. House of Represen-
tatives — what do you hope to accomplish with that bill?

RON: Well, there’s several goals for the bill. First of all, the goal is to continue to
bring Congress’s attention to mental health. Governments have reduced funding
for mental health by billions of dollars over the last several years — we have to do
something to restore that. We need Congress to pay attention to the importance of
restoring funding, so the bill is one way of holding people’s attention. But I always
cautions that this is not a panacea. This is the first of many steps we need to take
to get mental illness the kind of funding and attention it requires. The bill will allow
states to experience the benefits of Mental Health First Aid training. If it passes,
the bill will allow $20 million to go out in grants to community organizations and
states, to set up Mental Health First Aid trainings.

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Another goal is one that I think is already being realized — we want to make sure
that state legislatures are paying attention. I know of two bills that are already
introduced, one in Virginia and the other in Arizona, both of which basically attempt
to replicate the Mental Health First Aid House bill. More states need to do that. If
we get the grants out to states where they can see what this program really can
do, more states will adopt it as a state-funded program. So the bill is part of what
I believe is a much larger array of supports and funding we need for mental health
services, but it really is an important first step.

These tragedies, horrific as they are, have opened a window of opportunity to get
mental health back on the front burner in terms of legislative and congressional
action. That’s what I’m hoping the Mental Health First Aid bill will do, as well.

NEAL: Are there things that we could do that reduce the probability of recurrence
of tragedies like Tucson and Newtown?

RON: I think there are absolutely things we can do. The first of three issues that I’m
focused on is funding for additional mental health services and for increased aware-
ness, which helps with early identification and connection to services. Treatment does
work and people with mental health issues can live full and successful lives.

The second issue is to pay attention to the use of weapons and who gets weap-
ons. Right now, we cannot enforce current law, because we have a huge hole in
the background check system. Forty percent of the weapons sold in this country
are sold without a background check. If you go to a gun show, you might have a
licensed dealer with a booth on one side of the room and an unlicensed dealer
on the other side. If the buyer does not want to go through a background check,
they just cross the room. It doesn’t make any sense. The law already has seven cat-
RON: Gabby is doing great. She works very hard, she’s very determined to continue to improve, and she’s come so far. When you look at the percentage of people who survive a shooting as she did, only 5 percent, I’m told, of people who are shot where she was shot even live. She’s done more than lived. She has blossomed, her cognition is a hundred percent, her speech is coming back better every day, and now she has a new cause that I think is motivating her in terms of her public service.

I’ve always been involved in public service, but when I saw that she was running for Congress, I quit my job and volunteered on her campaign. My wife said, “So, we’re unemployed now, are we?” That’s what I was, for a year, but I really believed in Gabby as a person who had not only the intelligence but also the vision to do something for our community, and a great heart. A lot of people who run for office are smart and have vision. The one piece that I always want them to have, and that Gabby has, is a heart so full of love and compassion for others. I think I learned a lot about that from her.

I remember one night we were coming back from a long day out of town. We’d been on the road for about 10 or 11 hours. We were talking philosophically about why we are on the planet and why we are here as humans. Gabby boiled it down to what I believe she’s about and what I hope I’m about: “We’re here to care for one another.”

That’s what motivates her and that’s what motivates me to be in public service. I told my wife a thousand times, “Don’t worry, I’ll never run for any office,” and here I am. I really felt it was important to continue the work that Gabby started, and she did ask me and it’s hard to turn her down. But beyond that, I wanted to also continue my own public service, and this is a way I can do that.

NEAL: What did a tragedy like that of January 8 do to shape the Tucson community?

RON: This community responded in a marvelous way, and I can’t think of anything that’s a downside because almost as soon as the shootings occurred, people flocked to the hospital to see those of us who were hospitalized. They spontaneously put up memorials at three different locations, led candlelight vigils, read poems, and sang songs outside the hospital. I literally got thousands of cards, letters, and emails from people, wishing me well, and I know the other survivors did, as well.

What happened in our community is a credit to who we are. We’re a very compassionate and caring community. Going out to a restaurant, I’ll have someone come up to me even now and say, with tears in their eyes, how are you doing?

It was very personal for our community, what happened. It wasn’t just ‘oh, it happened.’ It really shocked us to our core and made us wonder what was going on, but I think most people would say it never defined us. What defined us was what happened afterwards, the compassion and goodwill that came out of it, and that’s still going on. It’s happening all across the country in other communities rocked by tragedy, too. When the national news anchors came out to Tucson and reflected on what they had seen at other tragedies and other natural disasters, they commented that they’ve never seen a community respond the way ours did, and I think they were right. It just showed who we are.

NEAL: I know that you are close to Gabby and her husband, Mark Kelly. How is she doing? How did her experience shape your decision to assume the mantle?

RON: Gabby is doing great. She works very hard, she’s very determined to continue to improve, and she’s come so far. When you look at the percentage of people who survive a shooting as she did, only 5 percent, I’m told, of people who are shot where she was shot even live. She’s done more than lived. She has blossomed, her cognition is a hundred percent, her speech is coming back better every day, and now she has a new cause that I think is motivating her in terms of her public service.

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NEAL: In a recent letter to Vice President Biden you talked about the common sense approach in looking at Mental Health First Aid, and also at the public health approach. Can you elaborate?

RON: We can’t have a healthy community unless we address the full range of issues that people have regarding their bodies and their minds. We’ve all too often just treated them separately, and now we have to think of the whole person.

We have mechanisms that allow us to provide funding, and we need to use them. Expansion of Medicaid in the states is essential to bring more people into healthcare and into mental healthcare. We have the Affordable Care Act that’s going to open up more healthcare coverage to more people, and of course we have the parity bill that’s still not fully implemented, which requires insurance companies to cover mental health issues as they cover acute and other healthcare medical issues.

Public health — in this country, we’ve always thought of it as “You’ve got to vaccinate people, and if they’ve got a contagious illness you have to make sure they’re taken care of.” We’re giving people flu shots so the flu won’t spread. We need to think of mental health in the same way, not because it’s contagious but because of the ripple effects it has on family. The more help we can give families to support their loved one who has mental health issues, the better.

The public health issue is to have a healthy community, in body and in mind.
NEAL: We’ve seen incredible bipartisan support in Congress for moving the mental health dialogue forward. What do you attribute that to?

RON: People in Congress realize that mental health services are lacking. Finally, we see on both sides of the aisle in both the Senate and the House, an interest in dealing with one aspect of these mass shootings that have huge impact on our society. When 20 kids are killed, people pay attention. So I do think we need to make sure we keep this bipartisan support alive.

Lynn Jenkins (R-KS) is co-sponsor of my Mental Health First Aid bill. She has agreed to help recruit other Republicans to come on board. This has to be and will be a bipartisan issue. The caution is that we don’t just check the box — give mental health funding a boost, pass some of these bills — and we’ve dealt with the issue because we don’t want to deal with background checks or the size of magazines. We really have to have a comprehensive approach. I’m spending a lot of my time and energy on making sure that the mental health issue stays alive and that we actually get something done with it.

NEAL: As a father and as a grandfather, what is your vision for your children and your grandchildren in terms of safe schools, safe communities, and a culture that really supports recovery from mental illness?

RON: My grandchildren were foremost in my mind when I saw the photograph of one of the children that was killed in Newtown. I saw her in the paper and I saw my kids, my grandkids, looking back at me, and I really broke down. My wife and I hugged each other and sobbed for a long time, realizing that that could have been our grandkids’ school. The day after the shooting in Connecticut, my grandson, who is 11 years old, called me up and said, “Poppy, we really have to do something to make sure this never happens again.”

They get it, kids get it, and they want safe schools, but I’m not in favor of turning schools into fortresses or armed camps. I think that’s the wrong message and it doesn’t necessarily improve safety. I want my kids, my grandkids, to grow up in a community where they feel safe to go anywhere, to school, to the movies... I want it to be a community where if anyone or a friend has a mental health problem, they know where to turn for help.

I want it to be a community where we support families, because the best network to help a person with mental illness is the family, along with the right professional supports. Families need help because mental health challenges are difficult to face.

I think that’s the future I want for my grandkids. I think we have an opportunity to really turn the corner on mental health. We can’t miss this opportunity, even though it comes out of tragedy.
“Guns don’t kill people,” say guns rights advocates, “people kill people.” More specifically, we are warned, “Crazy people with guns kill people.”

Many well-meaning mental health advocates fail to disagree with this epithet against individuals with mental illness and jump on an adjacent bandwagon. Some speculate, “If only we had better access to mental healthcare, these kinds of things wouldn’t happen.” “Why should it be easier to get a gun than an appointment with a psychiatrist or other mental health professional?” they lament.

After a tragic event, it is a mistake to divert the conversation away from violence and gun laws in our society to lack of access to mental health treatment — as important as that conversation is. Here are three reasons why I think we should not focus on traditional mental health resource needs after mass shootings:

1. It reinforces the general public’s perception that there is an important relationship between mental illness and violence. In fact, there is not. People without mental illnesses perpetrated most violent acts. Most people with mental illness are not violent; they are often victims of violent crimes.

2. Since the amount of violence committed by people with a mental illness is relatively small, sitting in front of a client for whom we are expected to predict violence is akin to trying to find a needle in a haystack. A June 2012 meta-analysis in the British Journal of Psychiatry concluded, as clinicians, we sort of stink at predicting violent crimes. The odds of getting it right are better the less severe the future violence. We haven’t yet figured out how to pinpoint the next shopping mall shooter. There is still debate on whether it is best to use actuarial data such as standardized checklists or more of a “gut feel” from clinical interviews. It seems we do best, however we do it, by placing people in broad categories of low, average, and higher than average risk — not trying to predict the specific violence of a specific person.

I wish we were better at this, but much of the body of medical knowledge is a work in progress. One commencement speaker told a fresh group of MD’s clutching their diplomas, “Half of what you just learned is wrong, we just don’t know which half.” Let’s stop expecting traditional mental health resources to keep us safe.

3. When people turn their attention to needs after tragic events, we tend to invest in the parts of the mental health system that have a poor rate of return. Bad cases make bad laws — and often bad budgets. For example, you will hear cries that we emptied our state psychiatric hospitals and now people with mental illness turn up in our jails and prisons — not deinstitutionalized, but transinstitutionalized — and now we should put them back where they came from.
After the Virginia Tech shootings in 2007, much of Virginia’s focus was on trying to wordsmith commitment laws to get more people back in expensive psychiatric hospitals or more easily committed by courts to mandatory outpatient treatment. It didn’t work. The changed words in the code of Virginia after 2007 didn’t affect the numbers of people committed inside or outside the walls of state hospitals. That’s because there is not much return on investment when we focus on that small, often visible and emotionally charged part of the system. We can always wish for all kinds of more resources to help those with mental illness. It would be nice to think it is just a matter of more beds, office visits, medications, and evaluations by professionals.

Those resources may help, but the real positive effect on public safety, the best return on investment comes when we spread the resources available more widely across the community; when we educate more with programs such as Mental Health First Aid, focus on prevention, and work with other parts of the safety net system. This also includes improving access to medical healthcare, housing, education; teaching parental skills, job skills; and providing more alcohol and substance use treatment for all people, especially those with mental health needs. Communities will be better, safer places when we also realize people need to enhance the way members of a community look out for one another and connect dots to keep people from falling through the cracks, in addition to turning to laws or professionals for help.
Mental Health First Aid Connects Us to Each Other

By Oscar Wright  
Reprinted from The Sacramento Bee, Dec. 30, 2012

If it takes a community to raise a child, it may also take a community to save one. In the wake of the Connecticut elementary school shooting, I’m reminded of the saying, “Tears are the silent language of grief.” Despite our differences, we mourn in the same language. Now, we must act with common resolve not to be defined by indescribable tragedy but transformed by it.

Mass murder should not become the new political discourse for endless partisan debate but recognized as a confluence of public health issues: gun control, mental illness and needed resources.
Gun control is simply one facet of the problem. One facet of the solution is social capital; the connections we have to one another, our ability to seek and receive support from others. It's this social capital that could very well be the most important weapon we have against preventing rampaging violence in our schools.

**One facet of the solution is social capital; the connections we have to one another, our ability to seek and receive support from others.**

First, let’s dispel some myths about mental illness with facts:

- Most people who are violent do not have a mental disorder, and most people with a mental disorder are not violent.
- People with mental illness are more likely to be the victims of violent attacks than the general population.
- Mental illness is not the result of bad parenting. Most experts agree that a genetic susceptibility combined with other risk factors leads to a psychiatric disorder. In other words, mental illnesses have a physical cause.
- Inaccurate beliefs about mental illness lead to stigma, discrimination, and no treatment.

Next, is it possible to develop a profile of young school shooters?

A study commissioned by Congress in 2001 on school shootings in the 1990s compared traits of eight school shooters:

- All were boys.
- Five had a relatively recent drop in their grades at school.
- Five had engaged in previous serious delinquent acts, and the other three in minor delinquent behavior.
- Serious mental health problems surfaced after the shootings for six of the eight boys in these cases.
- All had easy access to guns.
- The rural and suburban boys had experience with guns, and one of the urban teens appears to have practiced with the gun he used.

What about protective factors that lessen risks in families, children and youth?

- Half of the shooters came from intact and stable two-parent families.
- Five of the eight were good students, at least until the eighth grade.
- Three of the shooters struggled with grades or experienced the early school failure that frequently precedes the development of serious delinquent behavior.
- One of the eight shooters was a loner.
- Two were gang members.
- Most had friends, although the quality of the friendships differed.
- Most of these shooters were not considered to be at high risk for this kind of behavior by the adults around them.

Obviously, there is no one-size-fits-all solution. We need a “one-size-fits-one” approach. Just when you think a descriptive profile of a shooter fits the mold, another assailant beneath the radar surfaces and confounds our presumptive theories. If a mental health emergency were to occur, would a teacher, parent, police or pastor’s congregation have the knowledge to provide support, the social capital required?

Many Americans are trained in first aid and CPR to respond to medical emergencies but few are prepared to help others experiencing a mental health crisis. A popular course that renders such training is “mental health first aid.”

A wise man once said, “Everyone hears what you say. Friends listen to what you say. Best friends listen to what you don’t say.” Mental Health First Aid is a great social capital tool.

The idea behind mental health first aid is no different than that of traditional first aid: to create an environment where people know how to help someone in emergency situations. But instead of learning how to give CPR or treat a broken bone, the course teaches people how to recognize the signs and symptoms of mental health problems and how to provide initial aid before guiding a person toward appropriate professional help.

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Notice how everything works lately?

> You don’t just watch the Oscars, you tweet your picks for best-dressed and bad hair.
> You don’t just remember the website for the cool red shoes in the airport display, you whip out your phone, scan the QR code, pull up the mobile website, and order right away.
> You don’t just wait for your stylist at the hair salon, you get their free wifi code, “check in” on Facebook and get $5 off.
> You don’t just watch Downton Abbey, you (spoiler alert) log onto your favorite online community about the preeclampsia that took Lady Sybil’s life.
> You don’t just read the newspaper online and email a letter to the editor, you instantly post comments on their blog.
> You don’t just go on vacation and lie by the pool, you buy an experience — skydiving, rhumba dancing, hands-on culinary adventures.
> You don’t just go to a museum and stare with eyes glazed over at objects, you play with interactive exhibits, like cracking a safe at the Crime Museum or tasting the Musée du Chocolat’s display.

The common theme is “interactive.” The most effective messages, activities, and experiences engage recipients and get them involved — get them to do something, say something, and share something. Engagement is the key to success in marketing — whether it’s for shoes, cars, smartphones, or behavioral healthcare.

Wait, did you just tune out and ask, “Behavioral healthcare marketing? Why do I need to market when I can’t even get those who’ve been waiting 6 months for an appointment in the door?” Wake up and smell the coffee — things are about to change fast! As parity and the Medicaid expansion make more people eligible for behavioral healthcare, consumers will also have more choices. They may choose to go to your competitor or their primary care doctor. They won’t come to the community’s only behavioral health center unless you compel them to. Those on your waitlist will eventually go elsewhere, too. And you’ll be the one waiting — for customers.
If you see the need to market your behavioral healthcare organization — at least as well as your local hospital, dentist, physical therapist, or even your barber — then you also need to understand that “let’s get a new brochure done,” “let’s mail our annual report to so-and-so,” or even “let’s send a press release” no longer cut it.

Today, the exact same factors that drive success in treating behavioral health disorders — access, engagement, and retention — also define marketing effectiveness.

**ACCESS:** Effective marketing tells people who you are and why they should come to you. It lets them find you wherever they look — Google, Yelp, Groupon, Facebook, their doctor’s office, or in chatting with their coworkers.

**ENGAGEMENT:** Effective marketing gives people a reason to visit you, talk to you, and stay in touch — so when they have a need for services, they’ll think of you first.

**RETENTION:** Live up to your promise. The quality of service you provide lets people know you’re looking out for them and makes them want to come back.

And in delivering access, engagement, and retention, there is no single marketing strategy that comes close to Mental Health First Aid. This powerful public education program and community outreach program gives people a reason to connect — and interact — with you. It offers concrete, memorable takeaways. And it strengthens your standing as a community leader and problem-solver.

The training positions your organization as the go-to place for mental health and addictions services. For example, “We’ve had a number of nurses that have reached out to us and been trained in Mental Health First Aid and it helps them learn where they can access services and supports for individuals who need specialty behavioral healthcare,” notes Arthur Evans, Commissioner of Philadelphia’s Department of Behavioral Health and Intellectual disAbility Services. And Greg Taylor, Chief Community and Public Relations Officer for Community Partnership of Southern Arizona explains how the Mental Health First Aid trainings delivered by his organization connect participants back to their crisis line.

**In delivering access, engagement, and retention, there is no single marketing strategy that comes close to Mental Health First Aid.**

At a time when safety net behavioral health organizations increasingly seek partnerships with others community institutions such as primary care centers, ACOs, health homes, law enforcement, schools, and colleges, Mental Health First Aid provides a concrete means of outreach. “It’s a tangible tool that helps us open doors. Mental Health First Aid has made a positive community impact because it helps neighbors help neighbors, and changes lives,” says Taylor.

Most important, Mental Health First Aid allows you to offer value-based marketing — satisfying the savvy and informed healthcare consumer’s desire for insights, experiences, skill building, and networking. The training helps participants feel informed and empowered. “Mental Health First Aid is a response to a community need. It truly helps us realize our mission to serve the community,” says Iliana Gilman, Chief Strategy Officer at Austin Travis County Integral Care, the organization that won the National Council’s 2013 Mental Health First Aid Community Best Impact Award.

“It’s a tangible tool that helps us open doors. Mental Health First Aid has made a positive community impact because it helps neighbors help neighbors, and changes lives.”

Mental Health First Aid has an international evidence-base, a national infrastructure and standards, and is low-cost, high-impact. Compare that to the thousands you could spend on other less effective marketing tactics like brochures, PSAs, newspaper ads, or direct mail.

Your hard costs for Mental Health First Aid could be limited to $1,750 tuition to train and certify one of your staff as an instructor, plus $15 for a manual for each person the instructor trains in the community. The costs of marketing your local courses are typically next to nothing as the impact is viral (those who take the course can’t help but tell their friends to go to the next one), media usually announce your course for free, and you partner with other community institutions like schools and law enforcement to offer courses. In addition, Mental Health First Aid USA’s national marketing and PR initiatives continuously drive people back to find a course in their local community.

“Mental Health First Aid is an easy sell to media,” says Heather English, Public Relations Manager at LifeWays Community Mental Health. English noted that the program has helped LifeWays build excellent community relations with the local hospital, community health plan, and others, as well as helped generate grant funding.

The numbers speak for themselves. In the four years since its introduction in the U.S., 2,500 instructors across the country have trained nearly 100,000 people. The demand continues to grow. Are you ready to ride the wave? Are you ready to access, engage, and retain your future customers? Start today at www.MentalHealthFirstAid.org.
Governments Discover the Importance of Mental Health First Aid

Caroline Cournoyer for Governing Magazine, June 2012


Summary

The June 2012 issue of Governing magazine featured the article “Governments Discover the Importance of Mental Health First Aid.” The article positions Mental Health First Aid as a “real-world solution for government managers.”

The article emphasizes that increasing the public’s mental health literacy can save money. Emergency calls to police and fire departments can be reduced; and if enough people are trained to detect mental health problems, not everything rises to the level of a professional intervention. Mental Health First Aid creates a better educated community where people can take care of themselves and take care of each other.

If your local, city, or state government has not yet heard of Mental Health First Aid, YOU can bring it to them and the National Council would be happy to partner with you. Bryan Gibb, our Director of Public Education, who has helped to launch citywide/regional population-based initiatives in Washington, DC, Philadelphia, PA, and Tucson, AZ, can tell you more — email him at BryanG@thenationalcouncil.org or call 202.340.4236.

One in four adults and 10 percent of children in the United States will suffer from a mental health illness this year. Mental disorders are more common than heart disease and cancer combined — the leading causes of death.

“You’re more likely to see someone having a panic attack than you are to see someone having a heart attack,” says Linda Rosenberg, CEO of the National Council for Community Behavioral Healthcare (National Council). Yet most people, she says, don’t know how to react to the former. That’s why in 2008, the National Council, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health joined forces to bring the Australian concept of Mental Health First Aid (MHFA) to the U.S.

Mental disorders are more common than heart disease and cancer combined — one reason states and localities are teaching their employees how to recognize the signs of mental health problems and how to help.

The idea behind MHFA is no different than that of traditional first aid: to create an environment where people know how to help someone in emergency situations. But instead of learning how to give CPR or how to treat a broken bone, the 12-hour course teaches people how to recognize the signs and symptoms of mental health problems and how to provide initial aid before guiding a person toward appropriate professional help.

Since its introduction in the U.S. four years ago, more than 50,000 people have been trained in 47 states and the District of Columbia. In at least 22 of those states, state or local governments supported the program, usually paying for employees to take the course, says Susan Partain of the National Council. Several states — including Arizona, Colorado, Georgia, Maryland, and Missouri — already have statewide programs, which require some public workers and citizens to complete training as part of their job. For example, in Rhode Island the course is part of police officer training. Austin, Texas, offers it to every public library employee. Maryland offers it at every community college — something several other states are looking to do. And Missouri partners with faith-based organizations since the clergy is often “the first place people go when they feel stressed,” says Edwin Benton Goon, the state’s program coordinator. Arizona toyed with the idea a few years ago, but really invested in the program after a mentally ill man shot U.S. Rep. Gabrielle Giffords in Tucson in January 2011.
Sometimes it takes a tragic event for governments to take notice of the program, says Rosenberg, but she believes it has the ability to prevent future incidents like the Giffords shooting. Chief Anthony Silva, the executive director of Rhode Island’s Municipal Police Training Academy, agrees. “The training helps our officers better understand people with mental illnesses so they can respond appropriately without compromising safety,” he said in a testimonial.

Not only does the course increase mental health literacy, according to studies of the Australian model, but it’s also shown to improve the mental health of those taking the training, making them more confident in dealing with people who have a mental health illness.

Some universities have started offering training to their staff and students. At least seven colleges in Missouri use MHFA, according to Goon, and at some of them, the course is integrated into the required curriculum for certain majors, like nursing.

Many high schools — faced with the fear of school shootings and everyday issues like bullying — have expressed interest in bringing the program into their classrooms. But most are waiting for a pilot program that tailors mental health training to young people. Plans are under way to roll out such a program sometime this year.

An MHFA course costs about $180, which pays for instructor time, materials, classroom location, and snacks. State and local agencies find several ways to finance this: Some pay for it using private donations; some use federal or state mental health funds; some partner with nonprofits; and some reduce costs by holding the training in public buildings for free. Maryland and Missouri pay for it out of the proceeds they receive for every MHFA training manual sold. As part of the national founding organization, they each get $1 for every sale.

The most cost-effective way to train people, according to Goon, is for agencies to have their employees become MHFA certified instructors. Anyone can become an instructor — regardless of their background or expertise in mental health — after successful completion of a five-day training program. Once an agency has its own instructors, it no longer has to pay for the instructors’ time — which makes up most of the course’s cost. “This is very cheap to do,” says Rosenberg. “You’re not talking about millions of dollars. You’re talking about hundreds.”

And though it’s difficult to quantify, increasing the public’s mental health literacy can save money. In most municipalities, people with untreated mental health illnesses cost the government money because they’re either unaware that they have a mental disorder or they lack healthcare. This segment of the population takes up a lot of police and fire department time by dialing 911 when they usually need a counselor or doctor.

Many public safety agencies are testing ways to stop this. For example, Baltimore tried connecting repeat 911 callers with a nurse and a case manager, and counties in Oregon and Washington began forwarding nonemergency calls to first responders who specialize in social service referral. But if enough people are trained to detect mental health problems, “not everything has to rise to the level of a professional intervention... [Mental Health First Aid] creates a better-educated community where people can take care of themselves and take care of each other,” says Rosenberg.

The course is typically administered over two or three days. The majority of the training is interactive and uses teaching techniques like role play. For example, one exercise simulates what it’s like for people who hear voices. According to Goon, participants tend to be quiet when the course starts, but once it gets rolling, they’re eager to learn and share their stories. “It’s like they’ve wanted to have these conversations for a long time,” he says.

Participants learn how to detect a number of mental illnesses — including schizophrenia, bipolar disorder, psychosis, substance use disorders, depression, anxiety and eating disorders — and how to respond to people who have them. Their response is guided by a five-step action plan, termed “ALGEE,” which stands for:

1. Assess for risk of suicide or harm.
2. Listen nonjudgmentally.
3. Give reassurance and information.
4. Encourage appropriate professional help.
5. Encourage self-help and other support strategies.

One of the program’s main goals is to erase the stigma associated with mental health illnesses. “It wasn’t long ago that cancer wasn’t openly spoken about,” Rosenberg says. “Mental illness is the last illness that people talk about in whispers.” But that will change, she says, once Mental Health First Aid becomes as common as CPR training — something she sees as inevitable.
Mental Health First Aid Gains Traction with Counties

Charles Taylor for NACO County News, Jan. 28, 2013


Aside to the Fairfax County, Va. Board of Supervisors will receive 12 hours of first aid training this month. That may sound fairly routine, but the training has nothing to do with splints, bandages or CPR.

The 10-member board’s support staff to will join the hundreds of county residents and employees who have taken Mental Health First Aid USA classes, taught by trainers from the county’s Community Services Board. Nationwide, counties as geographically diverse as Sedgwick County, Kan.; Fresno County, Calif.; Clackamas County, Ore. and Fulton County, Ga. also offer or have offered the program.

During the training, certified instructors teach the common warning signs and risk factors for mental health problems — such as depression, anxiety disorders, psychoses (delusions, hallucinations), eating disorders and conditions caused by substance abuse — and how to respond to or help someone experiencing them.

Bryan Gibb, a trainer of trainers with the National Council for Community Behavioral Healthcare, explains the similarities to “regular” first aid.

“We do not teach people how to diagnose or treat mental illness any more than first aid teaches you how to put in a breathing tube or diagnose hypertension in someone,” he said.

Rather, Mental Health First Aid teaches a five-step action plan for individuals to provide help to someone who may be in crisis. The steps are known by the acronym ALGEE, shorthand for:

- Assess for risk of suicide or harm
- Listen nonjudgmentally
- Give reassurance and information
- Encourage appropriate professional help, and
- Encourage self-help and other support strategies

The National Council for Community Behavioral Healthcare coordinates the program nationally along with the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health.

Fairfax County began offering the training in November 2011, according to Linda Buescher, a spokeswoman for the Fairfax Community Services Board (CSB), which provides services for people with mental illness, substance use disorders, and intellectual and developmental disabilities. Since then, about 500 people have been trained, some 350 county employees among them.

Board of Supervisors Chairman Sharon Bulova decided it was time for County Board office staff to do likewise. “This program is immensely helpful in preparing our staff to connect people with the services they need,” she said. In Fairfax, county employees can take the classes for free; the instruction is offered to the general public for $25. Gibb said many jurisdictions subsidize the cost of the training, which he valued at about $250. Sedgwick County charges $85; in Clackamas County it’s $200 for the general public, $100 for county employees.

Leslie Roberts is a trainer with Fairfax CSB, she said oftentimes, when people encounter someone exhibiting signs of mental illness, they respond fearfully.

“This takes the fear out of it and gives people just hands-on education about how they could intervene and help someone to get them to either an intervention or treatment or a therapist,” she said.

The classes are highly interactive, Gibb said — including a simulation of someone having a psychotic episode who is hearing voices (the person interacts with a group while another trainee whispers messages into the “psychotic” person’s ear).

“We take the action plan and apply it to various different scenarios, both crisis and non-crisis situations,” he said.

To become a certified trainer, a person must undergo five days of instruction, offered several times a year throughout the U.S., at a cost of $2,000 per student, according to Mental Health First Aid USA.

The concept originated in Australia and gained traction in the United States about five years ago, said Linda Rosenberg, CEO of the National Council. A colleague in New Zealand mentioned the program to her around the time Missouri and Maryland were also becoming interested in the concept. She believes the program is helping to de-stigmatize mental illness.

“If you remember back, 30 years ago, people didn’t talk about having cancer. And now we have pink ribbons and runs for breast cancer,” she said. “We talk about things like pancreatic and lung cancer, and the need for funding for research. Well, we have to do the same thing around mental illness.”

Sedgwick County was an early adopter — offering the program since 2008 — and will conduct its next training in February, said Jason Scheck coordinates the program there. Among those who have taken the classes in the past are hospital and school personnel, members of faith communities and state policymakers.

He said trainees leave the classes with increased mental health literacy and a greater sense of confidence that they can help a person deal with a mental health problem. “It just helps overcome that stigma or fear of saying the wrong thing and encourages people to do those basic things like listen, provide support.

“We’ve had people in the days and weeks following the training make very appropriate referrals to our mental health center for people who were really at risk of hospitalization or suicide,” he said. “So, I think we have seen referrals from our graduates that have been really on-target and possibly life-saving.”
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INTERVIEW WITH LLOYD SEDERER

From ADHD to Zoloft
A-Z Guide to Mental Illness for Families

Mental disorders left untreated can devastate our families and communities. Yet, the families and friends of the more than 50 million people a year diagnosed with a mental illness have nowhere to turn for authoritative, comprehensive advice about what to do. Lloyd Sederer’s The Family Guide to Mental Health Care is the first such resource for families struggling with a loved one’s mental illness. In this book, families can find answers to help them understand a variety of disorders, assess whether doctors are really helping them, identify the right treatments, and learn how to navigate the system and pay for treatment. From depression to schizophrenia, from Ativan to Zoloft, from the first signs of a problem to successful help, this book walks families through everything they need to know — and do — to help their loved ones.

“I respond personally to what Lloyd Sederer writes because he makes me feel like he is sitting at this very kitchen table, gently explaining to me, with great knowledge, insight, and patience, what is happening to my loved one and what my family and I can do about it,” said actress Glenn Close in the book’s foreword.

Dr. Sederer takes time to share some of the caring and practical insights from his book in an exclusive interview with Meena Dayak for National Council Magazine.

MEENA: Why did you write The Family Guide to Mental Health Care?

LLOYD: Over the past 10 or 15 years, the focus of my work has shifted from clinical care — the wonderful experience of taking care of patients — to a more public health approach to mental healthcare. And so it was about how I could help not just 20 or 50 people, or 100 or even 1,000 people, but tens of thousands or hundreds of thousands of people.

An important way to achieve that is by giving people with illness and their families the kind of information that not only informs but also empowers them with the knowledge and the confidence to better take care of themselves and to better manage a mental health system that is chaotic, unaccountable, and very hard to deal with.

Whether it's bipolar disorder, depression, schizophrenia, PTSD, or eating disorder — people must learn that these illnesses last and they need to find good services and stay in treatment. However, for most families that I learned from over the years, the biggest challenge was understanding and managing the mental health system, and the second challenge was helping their loved one get care when their loved one did not want care. That is such a heartbreaking problem — when you care for somebody and you see that help is possible, but they won’t get it.

MEENA: What keeps people from getting care?

LLOYD: Sometimes it’s the illness itself. With some of the more serious mental illnesses, including those involving psychosis, people don’t believe that they’re sick. Or they’ve had bad experiences with the mental health system. Or they don’t know enough about the illness to believe that anything can be done.

There’s a whole set of reasons. The statistics are profoundly disturbing. Only one in five people with mental illness actually gets care that meets what would be minimally adequate standards. That means 80 percent of people with mental illness don’t get the care they need. That’s mainly because the system of care — the system, not the people who work in it — is disjointed, lacking in continuity, unaccountable, and does not often deliver evidence-based care in a comprehensive way.
Most mental illness is persistent, ongoing. It’s not just about when you’re having a heart attack and somebody puts a monitor on you and shoots medicine into your veins to keep you alive. It’s about a person managing their own illness, and their life, over an extended period of time.

**MEENA:** In your book, you talk about how treatment has to be a shared decision between the patient, family member, and caregiver. As a family member, how can I get a loved one in denial about his or her mental illness to make a decision for care?

**LLOYD:** It starts with understanding what the person who is ill wants.

For an acute illness, people may step in and take over whether they’re healthcare professionals or law enforcement. But most mental illness is persistent, ongoing. It’s not just about when you’re having a heart attack and somebody puts a monitor on you and shoots medicine into your veins to keep you alive. It’s about a person managing their own illness, and their life, over an extended period of time.

You can tell somebody after they’ve had a heart attack and been released from the hospital, “Now look, I want you to be on a low salt diet and eat 1,800 calories a day, walk two or three miles a day, don’t drink, and don’t smoke.” All this is good advice, but it doesn’t get followed. Whether it’s heart disease, or diabetes, or depression, people have to come to believe that it’s in their interest to take care of themselves and to manage their illness. It starts with understanding what the person wants.

Somebody who had a heart attack might say, “I want to be around a year from now when my daughter gets married” or “I want to be able to have a job where I feel some dignity about myself.” Then you can say, “Let’s try to figure out how you can get what you want.” That’s where the negotiations begin. That’s where shared decision making kicks in. That’s where families have tremendous leverage because they can support what’s in a person’s interest and not support anything else that isn’t in that person’s interest.

Families are the biggest support that any of us can have. There’s no resource greater than that for a person who has a persistent illness.

It starts with a family understanding what a person wants. It starts with a doctor understanding what a person wants. Then, helping that person understand that the way they take care of their health and manage their illness will enable them to get what they want. Just exhorting people, telling them what to do, doesn’t work very well.

**MEENA:** You point out that it can be extremely difficult. You caution families not to get into fights, and to not ever give up.

**LLOYD:** Sometimes what looks like an impossible situation or one that’s going to go on forever, doesn’t. Sometimes if you wait, if you don’t burn bridges, if you help people continue to rebuild themselves in tiny ways, the moment comes along where things turn. They turn in the right direction and people begin to rebuild their lives.

Unfortunately, we don’t hear a whole lot about those examples because mostly when people do rebuild their lives, they’re not public about what their past was like or how sick they were.

**MEENA:** In your book, you encourage a family member to talk to the doctor in advance of a visit with the patient. Given HIPAA rules, can doctors have this type of conversation with a family member?

**LLOYD:** There’s a big difference between talking and listening. There’s no rule or law that prohibits a doctor or any other health professional from listening. Sure, without the patient’s consent, a health professional can’t give details to anybody.

As a family member, you can say to the doctor, “Look, I know you don’t have consent. I know you can’t tell me anything, but you can listen. There’s no law against your listening and I want to tell you some things that are really important and that you’re not going to hear from the patient.”

In a recent article in the Wall Street Journal, I talk about the issues of privacy and liberty and how these laws were created a long time ago with good intent, but under different circumstances. Today, lawmakers need to listen more carefully to families and to people who’ve recovered and rebuild the law to make it more effective.

**MEENA:** Can all this increased awareness about mental illness cause families to pathologize and to suspect mental illness when it might be grief, stress, or even just teen tantrums?

**LLOYD:** It’s a very fair question, but I hope that isn’t the result. The reality is that far more doesn’t happen than needs to happen, than might result from a few more people being overly diagnosed. This can be weeded out by a good clinician.

Families are the biggest support that any of us can have.

**MEENA:** You say the greatest challenge to care is the broken mental health system. If you could give the system a makeover, what would it look like?

**LLOYD:** It would be great to have a magic wand! An ideal mental healthcare system would start with children. The ACE (Adverse Childhood Experiences) study shows that when children grow up in homes where there is addiction, abuse, etc., they are likely to have serious physical and mental problems by the time they are in their teens. An ideal system would build in early detection and intervention at a family level because the long-term results would be profound.

Then there’s a whole layer of opportunity through the non-mental health system — pediatrics, primary care, and family medicine. Most people with a mental condition don’t go to a mental health professional. They appear in a doctor’s office not because they have PTSD or depression, but because they’ve got some other
problem — they’re unable to concentrate, they have sleep problems, they have headaches, backaches, or bowel problems.

We know that 50 percent of mental disorders come on by the time someone is 14, and 75 percent by the time someone is 24. The American Academy of Pediatrics says behavioral problems are the biggest reason kids and adolescents are brought to primary care. So, if you’re trying to detect and intervene early, you’ve got to do it in the teenage years and you’ve got to do it where the young people are most, which is in primary care. You have to build it in to the standard operations of practice. You have to screen just like you’re screening for diabetes. Otherwise, “there’s a culture of don’t ask, don’t tell,” as my former boss and New York State Commissioner of Mental Health Mike Hogan used to say.

You have to build in screening instruments. And then follow through so people who are detected in primary care settings have a chance for early intervention. Then you need a specialty mental health system because some people are going to have serious illness and are going to need to see specialists, just like some people who have arthritis need to see a rheumatologist or some people with heart disease need to see a cardiologist.

We’ve built a system that doesn’t focus on how to sustain a set of services for a person. So, it’s not one entity, one agency, one clinical team that says, “I’m your home.” We must move toward a single point of accountable care that builds in not just medical care, but the kind of help that you may need around wellness and links to social services. All of this needs to be in one place. It needs to be continuous. People should not have to wonder where to go for what. One-stop shopping, with the full set of accountable services delivered by one team that is going to help you no matter what, is what we need.

MEENA: Your book provides a powerful roadmap for families struggling with mental illness. Do you think families could also benefit from other forms of support and training?

LLOYD: Yes, there is a tremendous amount of illiteracy about mental health in this country. Programs like Mental Health First Aid, which can be taught to so many people, are effective in advancing mental health literacy. They help people understand that these problems are common. They tell people you can have certain basic skills that enable you to reach out to support somebody. You don’t have to have a degree in psychology to do that. But you can make a big difference.

An ideal system would build in early detection and intervention at a family level because the long-term results would be profound.

People with serious mental disorders are not faking it, complaining, or just wallowing in a bad mood: They have a disease. You would never blame a person with heart disease for his chest pain or shortness of breath, and you wouldn’t tell that person to “get over it.” Mental illnesses are no different.

— Lloyd Sederer in The Family Guide to Mental Health Care

Mental Illness: What Families Can Do

Excerpt from The Family Guide to Mental Health Care by Lloyd Sederer

Partners, mothers, fathers, siblings, children, and friends arrive at my office and those of countless mental health professionals, upset and bewildered. “What happened to the person I know? What’s wrong? Is it something I’ve done?” Above all, they want to know what to do. That is what this chapter is all about — concrete, practical, and positive steps that need to be taken toward getting correct diagnoses and effective treatments.

Many families also feel a tremendous sense of urgency. It’s an urgency fed not only by fear of the unknown but also by dread that this kind of injury, this kind of problem, won’t be fixed. It’s true that treating mental illness isn’t as straightforward as putting a broken leg in a cast or removing a diseased gall bladder. But I’m here to tell you, as I have told thousands of people over more than three decades of practice, that mental illness can be managed and treated effectively. Those afflicted can improve and go on to build satisfying and productive lives just like people who suffer other common, chronic illnesses such as diabetes or heart disease. But this is key: Patients and their families must be willing to take the steps needed to put them on the road to recovery.

Family and friends must learn how to set aside their confusion, sadness, and anger — suspending any feeling of despair — about what is happening in order to get on with what needs to be done. They must learn to overcome their reluctance to the idea that someone they love is mentally ill in order to fight for what their loved one needs to get well. All too often, that battle will be with their loved one, who may not recognize that anything is wrong in the first place. Families also must become toughminded, informed consumers and advocates for their loved one.

The following are the ideas and approaches — guideposts, if you will — that have, in my experience, helped patients and their families overcome
the significant challenges and burdens of mental illness. By themselves, none are easy; each demands perseverance as well as a belief that confronting mental illness, step by step, will have incalculable value over the long run. But taken together, they can help families find a way out of the malaise and hopelessness that mental illness can produce. Your journey begins with a single step — and then another, and another.

**Eight Guideposts to Navigating Mental Illness**

1. Analyze the behavior.
2. Remember it’s not your fault.
3. Trust yourself.
4. Don’t go it alone.
5. Seek help as soon as possible.
6. Don’t get into fights.
7. Learn how to bend the mental health system to your needs.
8. Settle in for the siege and never give up.

**Learn How to Bend the Mental Health System to Your Needs**

Excerpt from *The Family Guide to Mental Health Care* by Lloyd Sederer

You should expect to take up the cudgel on behalf of your loved one in order to secure proper diagnosis and treatment of mental illness — as well as to ensure the provision of recovery-oriented and hope-restoring services that need to follow. In other words, you will have to become something of a mini-expert on everything including what good treatment looks like, how to pay for care, the dizzying array (and quality) of private and public programs, and the laws governing mental health care, particularly patients’ rights.

Medications, therapies, clinics, insurance coverage, mental health and addiction laws, the role of school and work in recovery, and much more are about to become your subjects of study. You might have preferred learning about gardening, or sports, or film. It’s not fair. But it is necessary.
In wake of the tragedy at Sandy Hook Elementary School, mental health is being talked about a lot. But a real conversation about how to expose and erase the stigma associated with mental illness is missing.

We all acknowledge stigma. We see it in the media, our schools, our communities, and even in our homes. We must deal with the real issue that some children and youth have mental health challenges and their parents don’t have support or access to services for fear of losing their children to public scrutiny, bullying, discrimination, and even institutionalization.

Half of all lifetime cases of mental health disorders begin by age 14 and three-fourths by age 25. Yet, our society lacks knowledge of children’s mental health needs. These are not “bad” or “violent” kids and young adults. They need treatment and their parents need help getting help as early as possible for their children. Families need to know where to go for help, who to talk to, which treatment is best, and how to access community support. Instead, parents often feel isolated, keeping them from reaching out for help and knowing whom to trust.

There should be national outrage at the number of young people who die each year by suicide and drug abuse, the number of young people who go untreated, the lengths parents go to in order to keep their children safe and out of trouble. The stigma associated with mental health must change in our nation before we can adequately improve the children’s mental health care system.

Many people feel uncomfortable talking about their own or their child’s mental health problems in their workplace, community, or place of worship. Yet, they may breezily discuss a flu outbreak in their house, when all of their children get the chickenpox at once, or when a family member receives a cancer diagnosis. Even the media follows movie stars through their cancer journeys — through treatment and recovery — and we follow suit, praying for and then cheering their recovery. Yet, if a celebrity seeks help in a mental health facility, it becomes late night talk show comedic fodder, and many people just laugh along.

Greater mental health education is needed. This is accomplished by letting people know how they can get help free from discrimination and shame and by continuing to educate the public on recognizing and helping others. One way to meet this need is through Mental Health First Aid, a public education program that introduces risk factors and warning signs and teaches people to connect individuals with mental health needs to care, allowing for the early detection and intervention that our society needs.
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Our deep experience across our businesses—behavioral health, pharmacy, and radiology—uniquely positions us to deliver solutions that include positive, quality outcomes to our members in cost-effective ways. And with our rich, two-decade history of managing behavioral health Medicaid services, we understand the unique challenges of working in a public health care system. We have learned from the strengths of those individuals in recovery and their families who face challenges every day.

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One in five young people face mental health problems in their daily lives. One in 10 young people are affected by a mental disorder that seriously impairs their ability to function in school, at home, or in the community. Fifty percent of adult mental illness manifest by the age of 14, and 75% appear by the age of 24. These disorders affect a young person’s education, ability to work and form relationships, and can lead to alcohol and other drug use. This is why it is important to detect problems early and ensure that young people get the treatment and supports they need.

Mental Health First Aid has been adapted for use in many countries around the world. In the United States, nearly 100,000 people have trained in the adult version of Mental Health First Aid. However, there was no corresponding course for youth. The National Council for Community Behavioral Healthcare, along with the Maryland Department of Health and Mental Hygiene and the Missouri Department of Mental Health, worked with the Child, Adolescent and Family Branch at the Substance Abuse and Mental Health Services Administration and the Georgetown University National Technical Assistance Center for Children’s Mental Health to develop and pilot test a Youth Mental Health First Aid manual for use in the United States. That manual is now completed and serves as the basis for a curriculum to train Youth Mental Health First Aiders across the country.

This 8-hour interactive curriculum trains individuals who come in contact with young people—teachers, recreational staff, community workers, first responders, members of faith communities, and others—to be “Mental Health First Aiders” who can recognize when a young person needs help and help them get the help they need.

Brianne Masselli, a youth mental health advocate who provided input on the youth manual’s development, said, “Youth Mental Health First Aid USA is perfect because it gives community members, friends, and coaches an opportunity to better understand what mental health is, what some of the common diagnoses are, and how to respond to a youth who might be experiencing a crisis. Youth Mental Health First Aid USA is a great framework for providing immediate support to youth and getting them connected to other professionals and caring adults.”

In the aftermath of tragedies across the country, President Obama called for improved mental health services. As part of his “Now is the Time” plan to protect children and communities, he proposed $15 million to provide Mental Health First Aid training to teachers. SAMHSA is proud to have supported efforts to develop Youth Mental Health First Aid, and to continue supporting this program.

Learn more about Youth Mental Health First Aid at www.mentalhealthfirstaid.org/cs/youth-mental-health-first-aid
In the aftermath of tragedies across the country, 

PRESIDENT OBAMA called for improved mental health services. As part of his Now Is the Time plan to protect children and communities, he PROPOSED $15 MILLION to provide Mental Health First Aid training to teachers.
Big Man on Campus:
Grant Supports Mental Health First Aid at University of Iowa

A passionate group of University of Iowa faculty, staff, and students worked together to submit a grant application in February 2011 to fund a 3-year infrastructure development project to strengthen the university’s organization structures to support suicide prevention and mental health promotion. The grant proposal outlined several interventions, including Mental Health First Aid, to provide Mental Health First Aid certification to more than 800 faculty, staff, and students. In August 2012, the University of Iowa won a Campus Suicide Prevention grant through the Substance Abuse and Mental Health Service Administration to fund these efforts.

Dr. Sam Cochran, director of University Counseling Services, directs the CSP grant and supports Mental Health First Aid on campus. “In light of the increase in the numbers of students who are arriving on campus with significant mental health issues, Mental Health First Aid is an ideal training program for the large number of staff, faculty, and interested students who interact with students on a day-to-day basis. This training enables our staff and faculty to be able to refer students in need to available resources,” said Dr. Cochran.

Jill Kluesner, Mental Health First Aid instructor for the CSP grant added, “Providing Mental Health First Aid on the University of Iowa campus has been an incredible opportunity for faculty, staff, and students to learn about mental health together. It sends a powerful message of unity and support for mental health promotion when university program directors, administrators, professors, staff, and students are all involved.”

Mental Health First aid incites important conversations. Leah Wentworth, doctoral candidate in the Department of Occupational and Environmental Health, said, “I found two things from the training especially useful; first, the chance to practice effective communication strategies with someone in crisis, and second, the debunking of myths about mental illness. I thought the training did a great
job of covering a wide breadth of mental health emergencies, and I’m excited that this training is a major part of our Campus Suicide Prevention grant activities.”

Student health staff has also taken advantage of Mental Health First Aid trainings. One student health staff member, Katie Cavanaugh said, “I am assigned to the telephone triage desk. Soon after returning to the clinic from the inservice, I received a call from a student suffering from depression.”

Katie used the information learned in the training to ask someone if the student planned to take their life. “The patient not only answered the question in regards to his current state but embellished it with a historical perspective. The response from the patient was very informative in my assessment.”

Peg Johnson, RN, who also works at Student Health commented, “We have been praising the Mental Health First Aid training since we attended... offering support to the person, giving them choices for help, makes all the difference in the outcome.”

Jill Kluesner and Mike Hoenig, the two instructors for the CSP grant, continue to work with the grant advisory committee to sustain Mental Health First Aid on campus. “It has been an incredible journey to bring Mental Health First Aid to the University of Iowa, and with such great support on campus, we are confident it will continue to thrive.”

1,100 college students die by suicide each year making it the 2nd leading cause of death on college campuses.

44% of college students report being so depressed it was difficult to function in the past year.
Mental Health First Aid Changes the Culture of North Carolina’s Colleges

Robert L. Wilson Jr. Project Coordinator NC Evidence Based Practices Center
Southern Regional AHEC, Fayetteville, NC

From my experience as a Mental Health First Aid instructor, I have seen the stigma associated with society’s treatment of the people with mental illness, especially the negative association of mental health treatment in general. It is a prominent problem today on college campuses. Mental illness and the stigma associated with it not only have a profound effect on students, but also on the school’s faculty and staff.

The North Carolina Evidence Based Practices Center offers Mental Health First Aid training to universities and community college campuses working to build mental health literacy by raising awareness and disseminating accurate information regarding mental illness. The NC EBP Center has been an agent of change with students, faculty, staff, and administrators at campuses across North Carolina. Mental Health First Aid has facilitated greater mental health literacy on college communities by empowering and encouraging members of the academic community to identify signs, symptoms, and resources for those with mental illness.

The NC EBP Center provides trainings, technical assistance, and consulting to college campuses statewide. The goal is to promote mental health literacy, awareness, education, and wellness in North Carolina college communities. Through the Mental Health First Aid training, university and community college staff that attended trainings are changing the way they disseminate information to students, faculty, and staff on mental health and resources.

The university’s director of nursing, who was trained in Mental Health First Aid, was so impressed with the program that she has chosen to make it part of the curriculum for a group of her nursing students. She believes it will help them care for patients who may suffer from mental illness.

The director of counseling services reviewed and changed internal policies within the counseling center, altering the way information on mental illness was disseminated on campus. At another college, the counseling services team decided, after attending Mental Health First Aid USA training, to re-educate staff and faculty on the process for referring students to mental health services offered on campus, and on available community mental health resources. The trainings have highlighted the importance of identifying the signs and symptoms of mental illness and how they can affect academic performance and social interaction among students as well as work performance and relationships among staff and faculty.

The NC EBP Center appreciates that the state’s universities and community colleges have taken this unique opportunity to change the culture of mental health on their campuses. It is a model approach for working with other statewide organizations that would benefit from Mental Health First Aid USA training.
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USC School of Social Work
Mental Health First Aid is an education program that helps professionals to identify, understand, and respond to signs of mental illnesses and substance-use disorders. Mental Health First Aid USA is managed, operated, and disseminated by three national authorities: the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health.

Recently, police in Rhode Island turned to the Mental Health First Aid training initiative after several highly publicized incidents ended tragically when officers used deadly force on suspects with mental illnesses. Mental Health First Aid training gives officers more response options to de-escalate incidents and avoid tragic outcomes.

“The new training helps our officers better understand people with mental illnesses so they [the police] can respond appropriately without compromising safety,” said Chief Anthony Silva, executive director of the Municipal Police Training Academy in Rhode Island. Chief Silva said the training — a 12-hour certification course offered to help average citizens respond to psychiatric emergencies until professional help arrives — had to be tailored to include the police perspective along with the mental health perspective.

“Police have to learn more than the signs and symptoms of mental illness,” said Lieutenant Joseph Coffey, who initiated the training at the police department in Warwick, Rhode Island. “Police officers need to look at the total situation while considering how to avoid injury to themselves and to the person in crisis.”

The training was introduced to Rhode Island police officers in 2008 when Lieutenant Coffey teamed up with Carole Bernardo, a certified Mental Health First Aid instructor, at Gateway Healthcare—one of seven pilot locations in the United States for the program. More than 200 officers in Rhode Island have now received the tailored mental health training.

“Part of the training involves the officers listening to tapes of voices, similar to voices a person with mental illness may hear in his head,” said Bernardo. “That’s often a turning point for officers, when they realize what a person with serious mental illness may be experiencing when trying to respond to questions [from police].”

The training became applicable recently when Warwick police responded to a man with schizophrenia who had barricaded himself in his apartment after breaking into a neighbor’s house. In the past, the police response may have been a dynamic entry to effect the arrest, however in gathering information from the man’s family members and a neighbor...
familiar with the man’s condition, the responding officers utilized their mental health training and defused the situation within an hour. Instead of taking the man to the cell block and potentially triggering another incident, police instead sent the man to a hospital for evaluation.

“We’re finding that Mental Health First Aid is not only helping police officers better identify the signs of mental illness, but also improves their knowledge and understanding of mental illnesses,” said Linda Rosenberg, president and chief executive officer of the National Council for Community Behavioral Healthcare.

She added that the training has the potential to become as common as first aid and CPR. “We hope the training will reduce the stigma of mental illness and addiction and help people understand that the illness is real, common, and treatable.”

Rosenberg said community mental health organizations across the nation are replicating Rhode Island’s success by offering the Mental Health First Aid program to local law enforcement and corrections officers.

The effectiveness of Mental Health First Aid has been proven in randomized trials. One trial of 301 randomized participants found that those certified in Mental Health First Aid had greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved concordance with health professionals about treatments, and decreased stigmatizing attitudes. Unexpectedly, the study also found that the program improved the mental health of the participants.

Information about Mental Health First Aid is at www.MentalHealthFirstAid.org.

Mental Health First Aid training gives officers more response options to de-escalate incidents and avoid tragic outcomes.

Launched on March 1, 2011, SAFELine is a toll-free 24/7/365 telephone crisis intervention hotline with on-site, clinical counseling services, community education, and outreach programs for pre-teens and teens in Erie, Pa.

Behavioral health professionals from Safe Harbor assist callers with issues such as bullying, teen pregnancy, suicide, dating abuse, rape, peer pressure, and other concerns.

Safe Harbor Behavioral Health, UPMC Health Plan, and Community Care Behavioral Health are proud to collaborate on SAFELine – helping local youth stay healthy, happy, and safe.
Missouri Increases Mental Health Literacy in the Faith Community

When people need support for mental health problems, they often turn to clergy and their faith-based community, regardless of other mental health services and supports available. Faith-based groups often stand at the heart of the community — particularly in rural areas. Armed with mental health knowledge and understanding, these faith communities can support people living with mental illness.

As part of a health literacy initiative, the Missouri Department of Mental Health received a grant from the Missouri Foundation for Health in 2009 to implement Mental Health First Aid among faith-based leaders and lay congregants. The initiative aimed to increase mental health literacy among people in the state’s rural areas where mental health resources are scarce and the need for supports is great. The initiative involved several other partners. The Missouri Institute of Mental Health evaluated the program and Pathways Mental Health Center and the Missouri National Alliance for the Mentally Ill provided Mental Health First Aid training and support to communities.

Prior to implementation, a faith-based curriculum module was developed to ensure material’s relevancy for the faith community. MDMH held a focus group with Mental Health First Aid instructors who were also clergy members. The consensus was that the Mental Health First Aid required few adaptations and that instructor orientation was of primary importance. Materials were developed for instructors to increase their understanding and sensitivity to issues that may be of importance to different faiths, but the focus was not placed on religion. We highlighted the importance of listening nonjudgmentally and encouraged discussion about Mental Health First Aid’s relevance to faith communities. We added scenarios that explored situations that could occur in faith-based settings to aid discussion and application of ALGEE.

Twelve-hour Mental Health First Aid trainings were conducted in 84 counties between September 2010 and April 2012. During this time, nearly 1,500 people were trained and certified as Mental Health First Aiders.

Surveys were conducted before and after training. The findings, along with personal accounts, showed that at least in the short-term, Mental Health First Aid affects the participants’ view of individuals with mental illnesses by reducing stigma and increasing willingness to interact with individuals with a mental illness. One participant shared that, as a preacher’s son, he had been taught that people with mental illnesses were lazy and needed to pull themselves up by their bootstraps. He said, “Now I know that this is a disease that needs professional treatment.”

Participants were also more willing to have neighbors, friends, colleagues, and in-laws that have a mental illness. And were significantly more confident helping someone with a mental illness. Many representatives from faith-based organizations left the training saying they planned to build a ministry at their church that included people with mental illnesses more fully in the faith community.

These survey results suggest that Mental Health First Aid improves mental health literacy and better equips those trained to help a friend or family member experiencing a mental health problem.

The Missouri Department of Mental Health is one of the national partners, along with the National Council for Community Behavioral Healthcare and the Maryland Department of Health and Mental Hygiene, that administers Mental Health First Aid in the U.S.
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**NATIONAL COUNCIL MAGAZINE**
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The Ministry of Mental Health First Aid

INTerview With Nathan L. Krause

Nathan Krause’s search for “the good life” led him through substance abuse, yoga, martial arts, Buddhism, Hinduism, Humanism, and a New Age cult. After staring death in the face, and then being miraculously spared from it, he found peace — and the answers to his questions — in the Bible. Nathan has traveled, studied, and served in nearly 30 countries. For nearly three decades, he has enjoyed preaching and teaching the truths he discovered in various capacities such as Bible teacher, evangelist, university professor, and pastor. Since 2002, Nathan has served as the pastor of the Olney Seventh-day Adventist Church in Maryland, where in addition to ministering to the congregation, he enjoys being part of the greater Olney community.

MEENA: What interested you about Mental Health First Aid? Why did you want to get involved?

PASTOR KRAUSE: I heard about Mental Health First Aid from a church member and immediately saw the need. I could see how it would be practical and beneficial for me and my ministry. I come in contact with various individuals who are having a mental health crisis, either themselves or in their family. Even now, I could name four or five individuals in our congregation who are dealing with a mental health need — depression or substance abuse or other challenges.

MEENA: Do members of your congregation reach out to you about their mental health challenges?

PASTOR KRAUSE: Yes. Before, those who struggled with mental illness or their family members might have come to me as a pastor, and said, “This is what the problem is and we’re looking to you as a pastor to help.” But I didn’t have the tools and training. Mental Health First Aid gave me hands-on training in how to have a dialog with somebody who might be experiencing a crisis. The ALGEE acronym is very effective and something I could use immediately in my ministry.

MEENA: Would you share an example of how you’ve used your Mental Health First Aid training in ministry?

PASTOR KRAUSE: I’m currently in a counseling relationship with someone who is recovering from substance abuse. So it’s been helpful for me to draw on what I’ve learned from Mental Health First Aid to help that individual overcome problems.

I’m also currently dealing with a family where depression has struck close to home and it’s creating challenges for the individual and also for the family. I’ve been able to help them understand what to say and what not to say thanks to the key concepts I learned in Mental Health First Aid.

Another time, a woman from whom I trained at a national church health conference wrote to say that a few days after she took the Mental Health First Aid course, a man who had been visiting her church asked to speak with her husband. The man was visibly agitated and experiencing extreme anxiety. Thanks to what she learned in the course, the woman I trained was confident in knowing what to say (and what not to say) and was better equipped to assess the seriousness of the situation. She was able to arrange for professional help for the man and to continue to support him.
MEENA: Do you think your congregants can benefit from Mental Health First Aid training themselves?

NATHAN: I think it would be an immense help because they would be able to understand that if they’re struggling with a mental health challenge, they’re not completely abandoned and without resources. They would have reassurance that they’re not alone—for example, through some of the statistics that are shared during training—that others have dealt with similar challenges and been successful in managing and even recovering. They can get practical tools and instructions that they can put to use immediately.

I’ve taken regular first aid, and I’ve used both, but certainly the opportunities to use Mental Health First Aid are much more abundant.

Also, I may not be the first one as a pastor who becomes aware of a need among church members. You know, there are others in the congregation who may have a close relationship with someone and Mental Health First Aid training would help in at least two ways. First, it would help them to be more observant of the possible signs of a problem; and second, it would help them know what they can do to help a friend in need.

MEENA: Do the concepts taught in Mental Health First Aid align with your church’s beliefs?

PASTOR KRAUSE: Yes. In the Seventh-day Adventist Church, there’s a real focus and emphasis on treating an individual completely. We believe that God came to restore into his image and that certainly includes our health—mental, physical, and spiritual. But many times, we in ministry will just put our energies toward the spiritual health of our congregants.

Our church does have a strong health message and many lay people are involved in a health ministry of some sort. But we’ve traditionally relegated mental health to the professionals because we feel like we’re not trained and have nothing to offer. But Mental Health First Aid helps us feel like “I do have something to offer. I can understand this at my level.” Mental Health First Aid is a real powerful tool in the hands of church members to enhance their skills and ability to offer a health ministry.

MEENA: Studies have shown that Mental Health First Aid has a positive impact on the mental health of those trained. Would you agree?

PASTOR KRAUSE: Absolutely. I don’t think I’m unique in that, as a member of the clergy. We have great stress placed upon us. There are great expectations, and sometimes the expectations we place upon ourselves are greater than they should be. All of these things can add up to a very stressful experience which, if not managed well, can kind of usher us into an experience of depression and that has been my experience several times over the course of my ministry; there have been some low times when I’ve struggled and I’ve felt depressed.

Mental Health First Aid training has taught me some methods that I can use to deal with that, and also helped me to realize that it’s not something that lasts forever. There is hope, and it can be managed and we can come out of it, as well.

MEENA: What are your plans for Mental Health First Aid moving forward?

PASTOR KRAUSE: I’d like to offer the training to our church members, to fellow clergy, and more broadly to the community. It’s the kind of thing we can continue to offer and expand the opportunities for people to learn so that they can be frontline ministers for those who have mental health needs.

I just believe it’s a Godsend. I am thankful that such an important program has been developed and is available. One of the best things about Mental Health First Aid is that it’s so simple and easily learned and put into practice, that anyone can benefit from it.
Every month I send employees in my credit union a quiz about different wellness topics. The quizzes serve to both educate them about timely health matters and to gauge their interest levels in conditions ranging from heat stroke to frostbite. When the topic one month focused on depression, I was surprised to receive twice as many responses as usual.

It wasn’t until I took a Mental Health First Aid course last year that I fully understood the reason for the high level of interest in mental health. More than one in five Americans ages 18 and older suffer from a diagnosable mental health problem in any given year, according to the National Institute of Mental Health. In fact, mental disorders are the leading cause of disability in the U.S., costing businesses more than $79 billion a year, $63 billion of it in lost productivity.

I am one of more than 10,000 people certified in Mental Health First Aid since the training was introduced in the United States from Australia two years ago. The highly interactive 12-hour curriculum is managed, operated, and disseminated by the National Council for Community Behavioral Healthcare (National Council).

I found the training to be one of the most valuable courses in employee wellness that I have participated in during my human resources career. The training
helps HR professionals identify employees who may be suffering a mental health problem and teaches them how to provide help and refer people to self-help and professional resources.

It teaches a five-step process to assess a situation for risk of suicide or harm, listen non-judgmentally, select and implement appropriate interventions, and help an employee in crisis or who is developing signs and symptoms of mental illness receive appropriate care. I also heard about the risk factors and warning signs of specific illnesses such as anxiety, depression, psychosis, eating disorders and addiction.

A point that was driven home during the course was to be more aware of the terminology we use to describe someone who may be experiencing an emotional disorder. Describing a co-worker as “crazy” or a “nut case” may be hurtful to people going through an emotionally trying time.

Lately, it seems more and more employees need to call EAP either for themselves or for a family member dealing with a mental health crisis. I found the course to be particularly useful in helping HR clients of an EAP better understand the services available to their employees and know when to assist in a referral.

One major difference between an EAP issue involving a physical ailment or a financial crisis is the stigma associated with mental health conditions. Mental illness may be common, but it is one of the least discussed problems.

“Mental illnesses may not be the most popular water-cooler topic because of the stigma around it, but there’s a real hunger out there for reliable information,” said Linda Rosenberg, the National Council’s president and CEO. “People are interested in the topic because mental illness touches so many lives.”

Of nearly 1,000 participants in a webcast on “Understanding Depression,” offered by the National Council in May 2010, more than 60 percent said they were concerned about a friend, colleague, family member, or themselves being depressed.

Evaluations of the course show that the evidence-based Mental Health First Aid program saves lives, expands people’s knowledge of mental illnesses and their treatments, and reduces the stigma associated with mental illness by helping people understand and accept mental illness as a medical condition.

One trial in Australia of 301 randomized participants found that those who took the training had greater confidence in providing help to others, greater likelihood of advising people to seek professional help, and decreased stigmatizing attitudes.

Unexpectedly, the study also found that Mental Health First Aid improved the mental health of the participants themselves.

“By understanding the signs and symptoms of depression, I learned to recognize this in myself,” said Kellie-Ann Heenan, director of human resources at Lighthouse Computer Services, Inc. in Lincoln, RI.

Heenan, who was in my training class last year, has an adopted son from Russia who suffers from a number of emotional issues.

“The tools I learned made it easier to connect with him and better understand where he’s coming from,” she said. “In the end, the training improved my own mental health.”

Heenan thought the training also helped in her professional life.

“The training left me with a greater sense of confidence about how to deal with a variety of people issues that come up in every office,” she added. “There’s such a stigma around mental health and people don’t want to talk about it, so having the information gives me confidence that I’ll be able to handle these types of situations when they arise.”

The training proved to be particularly helpful to Lynn Conwin, who also took the course with me. Some months after the training, two employees of the United Way of Rhode Island walked into her office in a panic. They told Conwin, director of human resources at the organization, that a co-worker was extremely upset about the recent earthquake in Haiti.

“The training left me with a greater sense of confidence about how to deal with a variety of people issues that come up in every office.”

The distressed young woman had a close friend in Haiti and had been unable to contact the person for five days. Fearing the worst, the woman was having difficulty managing her emotions, let alone being able to work.

While the two workers had no idea how to deal with the situation, Conwin sprung into action.

“I used what I learned in the course to calm the woman down and talk with her about how she’s feeling,” says Conwin. “I explained to her that it was OK to be upset, and to not be embarrassed about it.”

Mental Health First Aid will not only help HR professionals learn how to respond to various psychiatric crises, but it teaches them that mental illnesses are real, common and treatable.
Latinos don’t easily seek help for mental health problems. They are much more likely to seek medical attention for mental health symptoms that appear as physical complaints. In fact, Latinos are twice as likely to seek mental health treatment in other settings such as primary care or churches as they are to seek it from behavioral health specialty settings. Only one in 11 Latinos with a mental illness contacts a mental health specialist, while one in five contacts a general health provider. Stigma is high.

Chicago, like many communities nationwide, has a large Latino and Spanish-speaking population. The Community Counseling Centers of Chicago (C4), which has delivered Mental Health First Aid trainings in the Chicago area since the program was introduced in the U.S. in 2008, faces ongoing requests for Mental Health First Aid trainings in Spanish. Approximately 28% of the city’s residents are Latino. We deliver services to Latino families that speak little to no English and support partner organizations comprised mostly of Spanish-speaking workers who prefer intervening with people in their native language.

So, I jumped at the opportunity to be part of the Mental Health First Aid Spanish adaptation team. This group included six Latinos: Luisa Lumbano, Elisa Alford, Iliana Gilman, Dalimarie Perez, Betsey Yañez, and me. The diversity represented was great. The group included first and second generation Latinas of different ages, hailing from different countries and states; some licensed mental health professionals and some not.

The group’s goal was to create a quality, culturally competent product that reflected Latino culture. It was a complex task given the different idioms per our great diversity. We wanted to ensure that Latino communities could understand the wording as many speak “Spanglish” with a mix of words in both languages.

Translating the Mental Health First Aid action plan, ALGEE, proved challenging. The group sought a word that would work as an acronym to reflect the content of ALGEE, had a meaning, and would be easily remembered. We selected REDES, the action plan for primeros auxilios para la salud mental (PASM). REDES means nets or network, a perfect cultural word to convey the ALGEE action plan of support, respect, and reassurance.

As a part of the adaptation team, I piloted the Spanish adaptation in Chicago for 23 community health clinic workers where Latinos are identified as a high-risk group for depression, anxiety, and substance abuse. The training resonated with this group, and speaking in the workers’ native language brought a sense of intimacy, confidence, and competency to participants.

As part of a member of the Chicago community and as an employee of a behavioral health organization, I believe in the recovery paradigm, in early intervention and promotion of wellness, and in educating consumers. The Mental Health First Aid curriculum helps explain and destigmatize mental health issues and increase mental health literacy. Helping individuals learn how to identify problems early and to appropriately refer and intervene is a concept that strengthens all communities.
The Affordable Care Act, parity, Medicaid expansion, and new market and customer forces are ushering in an era of powerful change. Behavioral health coverage will expand to 62 million Americans in 2014. Mental health and addictions treatment organizations have to gear up NOW to meet increased demand, competition, and performance standards.

David Lloyd and his MTM Services team — of SPQM fame — have led 700+ behavioral health organizations across the country in adapting to changing healthcare delivery and payment systems. Today, MTM Services — in partnership with the National Council for Community Behavioral Healthcare — offers a full suite of consulting services to prepare community behavioral health organizations, large health systems, managed care entities, and state and county behavioral health systems for the new healthcare marketplace.
Community collaboration is essential to achieving integrated primary and behavioral healthcare. Given the limited resources funneled to states’ behavioral health safety nets, community providers in particular must strengthen ties with the array of social support agencies to ensure a standard continuum of care. For optimum collaboration, behavioral health organizations must first find a common ground to engage community partners.

Many communities across the country already teach a common language — Mental Health First Aid. Mental Health First Aid trainings use role-playing and simulations to demonstrate how to recognize and respond to the risk factors and warning signs of specific illnesses like anxiety, depression, schizophrenia, bipolar disorder, and substance use disorders, and how to help a person in crisis.

“We can no longer have a system where [providers] treat people and then send them back into communities that aren’t receptive to them,” says Arthur Evans, Commissioner of the Philadelphia Department of Behavioral Health and Disability Services. Evans and the City of Philadelphia are taking a population-based approach to Mental Health First Aid rollout, and aim to train up to 10% of the city’s population in Mental Health First Aid over the next few years.

To implement the trainings, Evans first built an advisory committee comprising organizational leaders from each community they wished to train. The advisory board was presented with a preview of the training so that each partner could see firsthand what Mental Health First Aid trainings entail and decide who from their respective agencies should be trained as instructors.

We can no longer have a system where [providers] treat people and then send them back into communities that aren’t receptive to them.
“The response we have gotten to Mental Health First Aid has been tremendous,” continued Evans. “We are very excited about this initiative and the impact that we believe it will have on community health. We see this initiative as an important component of our public health approach to behavioral health issues...It’s been one of the best things to happen to the field.”

Mental Health First Aid training is appropriate for a variety of community stakeholders, including primary care professionals, non-clinical behavioral health staff, public safety professionals, social services, faith leaders, and more. Since its inception, the program has undergone several studies that show that participants gain better recognition of mental health concerns, more confidence in providing help to others, improved mental health for themselves, and decreased social distance from individuals with a mental illness. Since its introduction in the U.S. in 2008, nearly 100,000 people have been trained through a network of 2,400+ certified instructors. These citizens in towns and cities nationwide are prepared to intervene and get help for people showing symptoms of a mental illness/substance abuse or in a mental health crisis.

Beyond simply engaging community partners, educating in Mental Health First Aid creates a healthy perspective that is responsive to the needs of consumers and supportive of their recovery. By creating community-wide collaboration, we create a building block of a recovery and resiliency-oriented approach.

“Regardless of how much we tried to move toward recovery-based services, we recognized there was still a need to reduce the negative perceptions [around mental illness] in our communities,” said Neal Cash, CEO of the Community Partnership of Southern Arizona in Tucson.

In the past, mental health organizations have spent millions of dollars on awareness campaigns and TV ads. But to hold a Mental Health First Aid course, all you need is a space, manuals, and instructors. In these budget conscious times, the program can educate a lot of people in a community for a small price (usually under $100 per person) — and emphasizes the important neighbor helping neighbor concept.

We see this initiative as an important component of our public health approach to behavioral health issues... It’s been one of the best things to happen to the field.

As Mental Health First Aid continues to grow, it enables more Americans to take charge of their own behavioral health and become more literate in helping themselves and their neighbors. It is a critical social support that plays an increasingly pivotal role in bringing about healthier communities, particularly for some of our most vulnerable citizens.
In Our Communities

Mental Health First Aid Creates Community Connections

Linda Ligenza, LCSW, Clinical Services Director, National Council for Community Behavioral Healthcare

We all have memories of the candlelight vigils that followed the Tucson, Aurora, and Newtown shootings, large impromptu gatherings of tearful mourners near the event sites, public displays of flowers, and the cards and letters that followed. These are signs of a community in the midst of healing itself and those most directly affected by tragedy. Most communities have the health and strength to rally around those who hurt and to help each other through the difficult reactions of shock, grief, and sadness. Are there ways communities can bolster against disaster or stressful events beforehand? In other words, can they promote resilience?

In simple terms, resilience is the ability to positively adapt and cope with adversity. Community resilience has been defined as “a process linking a set of networked adaptive capacities to a positive trajectory of functioning and adaptation in constituent populations after a disturbance.” Therefore, to build resiliency, communities must prepare to help people heal and recover, increase adaptive capacities, and build resilience. This can be achieved in part by assessing and addressing the following dimensions: leadership capacity; cultural identity; connections/partnerships; commitment; collective resources; communication mechanisms; skills, knowledge, strengths of community members; and prevention, preparedness, and response planning for adverse events. Mental Health First Aid promotes resilience prior to a stressful event, and it can and has been used as a strategy to address community healing and to promote resilience after adverse events because it helps the public identify, understand, and respond to signs of mental illnesses, trauma, and substance use disorders.
Through Mental Health First Aid, they can build a knowledge base that prepares individuals and communities to better recognize stress after tragic or adverse events.

Behavioral health organizations are well suited to lead community outreach to constituents such as faith-based groups, local business, community groups, and schools. Through outreach and Mental Health First Aid education, these organizations can build partnerships and connections, demonstrate commitment to improving community wellness, and increase their community’s knowledge and skills around mental health, trauma, and substance use issues. Through Mental Health First Aid, they can build a knowledge base that prepares individuals and communities to better recognize stress after tragic or adverse events. Behavioral health organizations can also promote better understanding in situations where tragic community events involve persons who may have experienced past trauma or who have a mental illness and/or substance use disorder.

Following the Tucson tragedy, Arizona state officials designated the regional behavioral health authority, Community Partnership of Southern Arizona (CPSA), to coordinate response to community mental health needs following the tragedy. They decided that they could contribute to the community’s healing by encouraging dialogue and providing education on mental illnesses. Their approach was two pronged: they dramatically expanded delivery of Mental Health First Aid and worked with local advocates and news media to combat myths and misunderstandings. CPSA’s response is an excellent example of how behavioral health entities can connect with local groups and organizations to create a community conversation about mental illness, leading to the promotion of resilience and wellness.

We shouldn’t wait for tragedy, however. Behavioral health organizations can bolster their community’s ability to adapt by reaching out and partnering with local schools, business, and faith-based groups to educate them through Mental Health First Aid.

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Can you imagine being 24 years old, hundreds of miles from home, and responsible for a thousand or more people displaced by one of the nation’s most destructive and costliest hurricanes? That’s where more than 20 AmeriCorps team leaders found themselves in October 2012 as they responded to the needs of residents caught in the path of Hurricane Sandy.

“Our team members were understandably scared and intimidated,” said Laura Tuck, LCSW-C, campus counselor for AmeriCorps and trained Mental Health First Aid Instructor. “But, each team leader had been trained in Mental Health First Aid months earlier and was able to draw on that training to help people who were really counting on them.”

AmeriCorps members provided assistance in setup, staffing, and shelter operation, in many cases serving as shelter managers and volunteer coordinators. At relief sites across multiple states, Corps members addressed food distribution, personal care assistance, health management, children’s activities, and key service coordination.

AmeriCorps NCCC (National Civilian Community Corps) is a full-time, national service program in which 1,100 young adults serve each year, it is administered by the Corporation for National and Community Service. During their 10-month term, Corps Members, 18-24 years old, work on projects that address critical needs related to natural and other disasters, infrastructure improvement, environmental stewardship and conservation, energy conservation, and urban and rural development.

Corps teams from the Atlantic region campus in Perry Point, Maryland, were among the first on the scene after Sandy made landfall. “It was really chaotic,” says Tuck. “Group homes had been flooded, elderly residents had been evacuated from homes they had lived in for decades, and initially many were separated from their families and support networks.”

Yet, Tuck and other AmeriCorps leaders saw a tremendous accomplishment as the Mental Health First Aid-trained members connected with individuals traumatized by loss, people who were emotionally distraught, and those who were angry and irritable. “It was really interesting to talk with our Corps members,” said Tuck. “Some of the folks we supported had gone days without their medication and were actively experiencing hallucinations and delusions. Because of their Mental Health First Aid training, our Corps members knew not to argue with the delusions, which many of our members said they would have done had they not learned the ALGEE action plan.”

Of course, while the Super tent Center and shelters have disappeared, Sandy’s impact is still felt across the Northeast and AmeriCorps members are still sup-

Disaster Relief through Mental Health First Aid

Lea Ann Browning-McNee, Deputy Director, Mental Health Association of Maryland
porting the recovery and relief efforts. Nearly six months later, members are still using their Mental Health First Aid skills, not just helping residents continue to cope with the long-term impact, but also supporting one another.

AmeriCorps members provided assistance in setup, staffing, and shelter operation, in many cases serving as shelter managers and volunteer coordinators.

“It’s one of our lessons learned about Mental Health First Aid,” explains Tuck. “Our leaders report the impact of the training on their team dynamics, their ability to provide peer support, and on their individual confidence.”

Tuck points to the program evaluations completed long before Corps members were called on to use their new skills. Trainees commented that everyone should take this class. It simply helps them be better human beings. Tuck also notes that Mental Health First Aid was one of the two top-rated trainings provided to the Corps last year. Since the initial team leader training in Maryland, groups from other campuses have been trained in Mental Health First Aid, which is now a standard training for team leaders.

The Mental Health First Aid’s indoctrination plays a big part in future AmeriCorps plans. CEO Wendy Spencer has endorsed the program and has made it a critical component of the newest AmeriCorps undertaking by creating FEMA Corps, a program that will double AmeriCorps’ population on campuses nationwide. FEMA Corps leaders will specialize in many of the same public service areas as traditional Corps teams, but will have more concentrated responsibilities in mass care, disaster response, and emergency assistance.

“No matter where our teams are deployed, they take care of one another, as well as the communities they’re assigned to,” said Tuck, who believes that may be one of the most critical aspects of the program for Corps members. “When they go into a new community, Mental Health First Aid helps them know what questions to ask and where to look for help when they need it.”

One of the most promising outcomes of Mental Health First Aid and the Hurricane Sandy experience is that it helps to draw young, public service focused leaders to the behavioral health field, and they earn money toward their college education in doing so. “A lot of these young people who have been certified in Mental Health First Aid and who have seen the impact on their teams are now looking to further their education in mental health,” according to Tuck.

To learn more about AmeriCorps’ effect on communities, visit www.americorps.gov/nccc.

The Maryland Department of Health and Mental Hygiene is one of the national partners, along with the National Council for Community Behavioral Healthcare and the Missouri Department of Mental Health, that administers Mental Health First Aid in the U.S.
Embracing a Community Torn by Tragedy

Neal Cash, MS, President and CEO
Vanessa Seaney, MSW, LCSW, CPHQ, Chief Operating Officer
Steve Nagle, MA, Training Specialist – Community Partnership of Southern Arizona

Community Partnership of Southern Arizona was an early adopter of Mental Health First Aid, sending two staff members to the very first U.S. instructor training in 2008. Soon after, we offered Arizona’s first Mental Health First Aid training. Based in Tucson, CPSA has served as the state contracted regional behavioral health authority for Pima County since 1995. Throughout that time, we’ve grounded our prevention initiatives in community mobilization, making the Mental Health First Aid model a perfect fit for CPSA.

We already knew that preparing community members to be partners in early identification and intervention would exponentially expand our reach and impact. CPSA’s successful suicide prevention initiative, based on Applied Suicide Intervention Skills Training (ASIST), had already laid the groundwork for our staff and service providers to work together as trainers, in various combinations and with various populations.

As it happened, CPSA was in the midst of a Mental Health First Aid training on January 8, 2011 — the day everything changed.

On that sunny Saturday morning, a young man shot and killed six people outside a local grocery store and wounded 13 others, including then-Congresswoman Gabrielle Giffords. It quickly became clear that the killer had an undiagnosed mental illness, igniting a community discussion that dredged up old myths and stereotypes.

While working with the media to challenge these misconceptions, we recognized that Mental Health First Aid could provide a focus for the community’s determination to bring something positive and lasting out of its grief, combating the myths and dramatically expanding the capacity for early identification and intervention.

CPSA CEO Neal Cash spoke with the National Council for Community Behavioral Healthcare and the Arizona Department of Health Services’ Division of Behavioral Health Services immediately after the shooting. Thanks to their support and swift response, CPSA hosted a Mental Health First Aid instructor training in late February that certified 23 new instructors from across the state, marking the start of a statewide initiative to expand offerings of the 12-hour training. We held the first community training in March 2011, with 20 participants.
We decided to provide Mental Health First Aid training at no cost to as many community members as possible, as long as demand remained high. And so far, it has. We’ve filled almost every training within days of posting online. With grant help from the National Council’s Community Implementation Challenge and the Christina-Taylor Green Memorial Foundation (founded in memory of the youngest shooting victim), CPSA has offered, and will continue to offer, all its Mental Health First Aid training at no cost to participants.

The news media has recognized Mental Health First Aid’s significance and been a great help in getting the word out about trainings. Every area media outlet has featured at least one story on CPSA’s trainings, and all have devoted significant time and resources to reporting on various aspects of mental health. An editorial writer for the Arizona Daily Star, Southern Arizona’s major newspaper, completed Mental Health First Aid training in July 2011 and continues to write about its importance.

CPSA continues to be in the vanguard of Mental Health First Aid innovations. CPSA staff was involved in the pilot version of the youth adaptation, providing Arizona’s first youth training in May 2012. CPSA piloted Mental Health First Aid’s module for military and veterans in January 2013 and plans to offer the new first-responder and Spanish-language trainings by late spring or early summer 2013. In addition, we have provided two trainings for the Tohono O’odham tribal government and members.

The Tucson community enthusiastically embraces Mental Health First Aid and continues to make an effort to learn simple and effective ways to offer friends, family, neighbors, and co-workers hope, support, and resources during times of mental distress.

Arizona Daily Star, Southern Arizona’s major newspaper, completed Mental Health First Aid training in July 2011 and continues to write about its importance.

CPSA was in the midst of a Mental Health First Aid training on January 8, 2011 – the day everything changed.

Since the tragedy, CPSA has provided 66 Mental Health First Aid trainings, four of them focused on youth and some for specific groups and organizations such as:

- Federally qualified health centers
- United Way
- A community college
- Boys and Girls Club
- Military and faith-based organizations
- The county department of institutional health
- The criminal justice system
- The state rehabilitation services administration
- Agencies serving people who are homeless

The 1,458 individuals who completed CPSA’s Mental Health First Aid training in the same period ranged in age from high school seniors to retirees and included:

- 311 non-clinical staff from behavioral health agencies
- 259 educators (K-12 and higher)
- 184 medical personnel
- 55 tribal members and tribal government personnel
- 48 from the criminal justice system
- 46 clergy and others from the faith community
- 44 peer support workers
- 37 high school, college or university students
- 21 military members or veterans
- 17 first responders
In Maryland, the approach to implementing Mental Health First Aid focuses on building community capacity. The state trains instructors in key communities that can make Mental Health First Aid a standard part of community life or organizational operation. To date, instructors are embedded in Mental Health Associations and provider groups, at colleges and universities, in health facilities, and in social service agencies throughout the state. Recently, the state completed an effort to train nearly 100 instructors from law enforcement and corrections, a move that led to the Maryland Police and Correctional Training Commissions’ goal of training more than 10,000 correctional staff across 27 state institutions and 45 community supervision offices.

It’s a vision that Harford County Sheriff Jesse Bane fully supports and thinks has been necessary for a long time. “Years ago, as a deputy on the street, I didn’t have enough options to help someone struggling with a mental health problem. Too many times I was forced to lock people up who needed more from us.”

That experience, and the partnership of Harford County Department of Community Services, led to the Harford County Sheriff’s Department, with jurisdiction over both the county’s law enforcement and correctional facilities, becoming one of the first public safety agencies in the nation to operationalize Mental Health First Aid. “We made the program mandatory orientation training for all new employees, sworn and civilian, back in 2010,” reports Bane. Since then, the agency has also made Mental Health First Aid a prerequisite for officers applying to other special teams such as the Crisis Intervention Team, Critical Incident Stress Management Team, and the Crisis (Hostage) Negotiations Team. Bane says, “Mental health is a priority for us, so we’re making Mental Health First Aid a standard part of how we function.” His department has increased its jail diversion rate to 46 percent. The department’s latest strategy is to extend Mental Health First Aid to the families of its employees, and courses will roll out later this year. “Our spouses, our families are our rocks — where we turn for refuge and support, and where we find consolation.”

Lea Ann Browning-McNee, Deputy Director, Mental Health Association of Maryland

Maryland’s Approach to Implement Mental Health First Aid

As a deputy on the street, I didn’t have enough options to help someone struggling with a mental health problem. Too many times I was forced to lock people up who needed more from us.

Harford County Sheriff Jesse Bane
Bane believes, “My job is to take care of my people, my jail, and my community.”

It’s a sentiment that resonates with Sharon Lipford, deputy director of the Harford County Department of Community Services. “Everyone on our team needs to be trained in Mental Health First Aid. It’s a tool that should be available at every level of the community so that we make Harford County a place where it is safe to have a mental illness.”

Lipford and her team have initiated a communitywide effort to train Mental Health First Aiders in key areas of the community such as social services, aging, emergency response, military, and schools. And, to make the core training accessible to the people who need it. Lipford partnered with the Sheriff’s Department to sponsor an instructor training in fall 2011. She says, “Our goal is to add Mental Health First Aid to the training menu for all the people who influence our community health. We see the program as a way for residents to find help and support when and where they need it.”

The “where” includes some pretty influential places. One of the newer Mental Health First Aid partners in the county is the U.S. Army’s Aberdeen Proving Ground, the county’s largest employer with approximately 10,000 civilian employees and thousands more military and government contractors on base. Lipford is also targeting the county’s transit services for Mental Health First Aid training, hoping to train drivers to recognize when someone is struggling and know how to offer assistance.

“Mental health is a priority for us, so we’re making Mental Health First Aid a standard part of how we function.”

The Mental Health Association of Maryland and the state’s Department of Health and Mental Hygiene are sharing the Harford County experience as a model for other communities, whether led by county government operations or on college campuses.

Lipford believes that ultimately Mental Health First Aid will help keep people out of the criminal justice system, help reduce unnecessary hospitalizations, and create a community environment that fosters an individual’s ability to recover from mental illness. “No one should ever be embarrassed to ask for help. As a county, we are working to make sure that help is easy to find.”

The Maryland Department of Health and Mental Hygiene is one of the national partners, along with the National Council for Community Behavioral Healthcare and the Missouri Department of Mental Health, that administers Mental Health First Aid in the U.S.
No Better Time, No Better Message

Brian Turner, Special Projects Director, Colorado Behavioral Healthcare Council

Mental Health First Aid came to Colorado in 2009, starting with just a handful of instructors trained in the original U.S. pilot program. Since then, the Colorado Behavioral Healthcare Council, the Colorado Office of Behavioral Health, and the statewide network of community mental health centers spearheaded an effort to roll out the program statewide. In 2013, the state’s network will exceed 200 instructors, delivering both the adult and youth programs, as we rapidly approach 10,000 certified Mental Health First Aiders. This means 10,000 people now understand symptoms and prevalence, can heed warning signs, and have the skills to help others.

It also means the state has 10,000 potential new advocates for behavioral health issues.
Aurora Mental Health Center introduced Mental Health First Aid to the city’s fire department, paving the way for increased partnership. Across the state, we see examples like this of increased collaboration across systems and with key community partners, initiated thanks to Mental Health First Aid. At the local level, Mental Health First Aid opens doors to working with criminal justice, education, first responders, faith-based communities, and many more community partners. At the state level, the program strengthens the voice of behavioral health issues for the governor’s cabinet, state legislature, and Departments of Safety, Public Health and Environment, Corrections, Education, and Health Care Policy and Financing.

Mental Health First Aid is outstanding standalone prevention program and means for linking people to care. However, it’s Mental Health First Aid’s immense potential to bust stigma and enhance behavioral health literacy at all societal levels that has anchored the program’s proliferation in Colorado. When we began to consider these latter benefits, we realized the opportunity Mental Health First Aid provides for public and community stakeholder outreach and marketing. The more people understand our issues, the more willing they are to receive our messages.

With more than 30 million people entering the U.S. insurance market and being eligible for behavioral healthcare in the coming years, there has been no more critical time for the messages contained in Mental Health First Aid.

Our goal in Colorado is not to grow Mental Health First Aid for the sake of having a successful program. The goal is to enhance behavioral health literacy statewide, which will in turn encourage more people to seek and offer help, receive treatment, and feel empowered to recover. With so much opportunity on the horizon for behavioral health in this country, we must embrace powerful tools like Mental Health First Aid to play a key role in advocacy and marketing.

“I believe Mental Health First Aid is essential training for anyone who comes in contact with the public on a regular basis.”

Mike Garcia, Fire Chief for the City of Aurora

With more than 30 million people entering the U.S. insurance market and being eligible for behavioral healthcare in the coming years, there has been no more critical time for the messages contained in Mental Health First Aid.
Where Isolation Breeds Collaboration

Heather Cobb, Senior Director, Strategy and Creative, National Council for Community Behavioral Healthcare

Isolation breeds collaboration? For one small, isolated town in the archipelago forming the Alaskan panhandle, it does. In this rural setting, Alaska Island Community Services (AICS), the community health center, has a long history of working collaboratively with other community organizations.

Given its isolated geographic location, this mountainous, forested island community is conducive to the adoption of a collaborative healthcare approach. Limited resources on the island bring community organizations closer together, and grant funds from SAMHSA’s Primary and Behavioral Care Integration program enabled AICS to bring Mental Health First Aid to the island to increase mental health awareness and understanding. AICS partners with other key community players to maximize outreach. The community reports notable benefits such as:

- Local school system staff trained in Mental Health First Aid use their new skills to better work with troubled students and parents, as well as to de-escalate issues in general.
- Respite providers within senior and disability services report improved staff sensitivity.
- EMT first responders de-escalate situations more effectively.
- Support and entry-level medical staff in integrated primary and behavioral healthcare clinics have increased sensitivity in their work with patients, smoother flow of integration, and better recognition of symptoms.

AICS staff reports that Mental Health First Aid positively affects their healthcare integration efforts. They find that it underscores the role of behavioral health in the healthcare system, reduces discrimination, makes healthcare more user-friendly, and therefore more accessible, and increases referrals. As a community health center with imbedded behavioral health services, this increased awareness has increased the likelihood of clients following up for behavioral health problems after a referral.

AICS makes a difference in its community. Working collaboratively is nothing new to this innovative community health center. However, bringing Mental Health First Aid to this community not only increased the knowledge and understanding of behavioral health and its impact on the island as a whole, but it has also built on the community’s natural collaborative strengths. Seeing opportunities where others see barriers, AICS and its community partners have made broad strides to destigmatize mental illness in Wrangell, Alaska.

Visit www.integration.samhsa for more information on the Primary and Behavioral Health Care Integration grantees and the SAMHSA-HRSA Center for Integrated Health Solutions that supports them with training and technical assistance.

Thanks to support and guidance from the SAMHSA-HRSA Center for Integrated Health Solutions (CHS), a Rural Mental Health First Aid initiative began in 2011 to tailor the core curriculum for rural settings, identify and support instructors teaching in these areas, and build alliances with rural organizations to raise awareness. Instructors teaching in rural areas can now access the packet of tailored curriculum materials and obtain a special rural designation on the Mental Health First Aid USA website. Individuals in rural communities wishing to learn how they can bring the program to their community can easily locate instructors with the rural designation on the national website; access a Quick Start guide on implementation; and have a central point of contact to help with any questions. For more information, visit http://www.mentalhealthfirstaid.org/cs/rural.
When We Empathize, We Don’t Stigmatize

Joseph S. Munson, PhD, LMHC, NCC, Vice President of Residential Services, Meridian Behavioral Healthcare, Inc.

Our community faces many challenges each day. However, some are preventable. More than 500,000 people live in our area and about 125,000 are affected by mental illness at a given time. Yet, two-thirds of these people go without treatment. With the average cost of mental health services for each person somewhere between $2,500 and $13,000 per year, there are many barriers to timely and adequate care. So, many times, I am asked, “What can be done about this?”

As with most problems of this magnitude, there is no easy solution. We need the capacity to provide a public health campaign that incorporates education, prevention, early identification and intervention, and direct mental health service. The program that best addresses this need is Mental Health First Aid.

During trainings I ask participants, “What is the goal of Mental Health First Aid?” The largest response is “to save lives.” Since this training is framed around recovery, we begin by improving understanding. I tell my classes, “What we can understand, we can empathize with, and when we empathize, we tend not to stigmatize.”

Stigma delays people from getting the help they need and perpetuates the belief that treatment is scary and shameful, and generates discrimination for those who seek it. Mental Health First Aid interventions can change these misconceptions, reduce the length of time it takes people getting help on their own, and allow someone to get their life back. Mental Health First Aid training makes believers out of the public. After completing training, community participants have said:

- “I was very impressed with the course and feel I learned quite a bit of information that will be helpful both in my line of work and with certain family members.”
- “WOW! I have a better understanding of what a mental illness is and how to offer assistance.”
- “Very enlightening. I am glad to have been educated about a seemingly straightforward approach to helping others.”
- “I’d love to see more folks in the community and in the social service field take this course to learn more about working with people who have mental illness.”
- “The concept is great and the simple 5-step approach is easy to remember and use.”
- “It was important knowing how to assist a person with a mental health issue until they can receive the professional or supportive help they need.”
- “Learning about the different kinds of mental illness, I think there should be more of the courses in offices everywhere. Maybe we could avoid having problems like in Colorado.”

Currently, Meridian Behavioral Healthcare has conducted Mental Health First Aid trainings with a variety of community partners such as the Department of Children and Family, Alachua County Court Services, Alachua County Community Services, Meridian’s support staff, Society for Human Resource Management, Elder Options, Gateway College, United Church of Gainesville, and Trinity United Methodist Church. It is important to have this training throughout our community at every level. We also work to bring this training to law enforcement agencies, city government, school boards and teachers, as well as additional churches, higher education programs, and community groups. Mental health and illness affects us all. Let’s not wait for another tragedy to occur before we come together as a community to take care of one another.
The Y Fits to a T: 
Mental Health First Aid at the YMCA

Susan Visser, Healthy Outcomes Partnership Coordinator, and
Sue Diebold, Senior Director of Healthy Living, Somerset Hills YMCA

With a focus on healthy living, youth development, and social responsibility the Y is a natural fit for Mental Health First Aid training. At the Somerset Hills YMCA in Basking Ridge, New Jersey, we see firsthand the importance of offering Mental Health First Aid in our community.

Like so many other communities, Somerset Hills has dealt with several mental health crises in recent years. During these tragedies, community members have turned to the YMCA for help — forming informal support groups, talking to a trusted staff member, or finding professional help. Our YMCA is seen as a safe and reassuring environment for people seeking support and information.

Recognizing this new “hat” our YMCA was wearing, we formed a coalition known as the Healthy Outcomes Partnership or “HOP” in 2009. HOP’s primary goals are to offer ongoing community education to reduce stigma, build greater awareness and knowledge of mental health, and to connect people to mental health providers. We quickly recognized that Mental Health First Aid was the perfect resource to help HOP achieve its goals.

Our staff is on the frontline every day, interacting with our members and co-workers, who at any given time can exhibit signs of emotional distress, eating disorders, or problems with alcohol and drugs. So, we began offering Mental Health First Aid to our employees. The response was overwhelming. “I was able to not overreact and truly listen when a 12-year-old girl in the dance program told me that she was cutting herself”, said one staff member, Jessica. “Without my Mental Health First Aid training I would have panicked and not known what to say.”

Another staff member, Kate, told us about a conversation she had with a member: “Having the ability to listen differently when he told me his daughter suffered from depressive episodes was the insight I gained from Mental Health First Aid.” What could have been a difficult conversation with a member regarding our concerns that she may be suffering from an eating disorder went smoothly because of the Mental Health First Aid-trained staff member’s ability to be non-judgmental and empathetic.

The examples of Mental Health First Aid in action at our Y are endless, but most importantly the training gives staff the knowledge and resources to assist. We see that early intervention not only helps the individual but all involved — directly or indirectly — in the crisis.

Mental Health First Aid has been so impactful and made such a difference that we have started a new pilot program that hopefully will bring Mental Health First Aid to all New Jersey Y’s. At our last community training, more than half of the participants were Y professionals who were overwhelmingly excited to bring Mental Health First Aid back to their communities. We hope the momentum will continue and that by using the success of our Y as an example of how Mental Health First Aid can work, YMCAs nationwide will join the Mental Health First Aid movement.
Rosalynn Carter opens her 2010 book, Within Our Reach: Ending the Mental Health Crisis, proclaiming that stigma is our biggest challenge. She says, “Stigma is the most damaging factor in the life of anyone who has a mental illness. It humiliates and embarrasses; it is painful; it generates stereotypes, fear, and rejection; it leads to terrible discrimination.”

With stigma’s devastating impact in mind, the National Council partnered with OptumHealth and Georgia’s Department of Behavioral Health and Developmental Disabilities (DBHDD) in 2010 to host two pilot Mental Health First Aid trainings led by individuals in recovery from mental illness.

The impact of engaging people in recovery to deliver Mental Health First Aid was so positive that Georgia has since trained 15 certified peer specialists as instructors and funded 23 trainings through the Georgia Mental Health Consumer Network — with more on the way.

Georgia DBHDD Commissioner Frank Berry, who has formally directed a large provider agency in the state, says he has first-hand knowledge of how damaging stigma can be to an individual’s sense of self-worth and recovery. When he took over as commissioner last year, one of his first acts was to start every DBHDD board meeting with a Georgia consumer or family member’s story of recovery/meaningful life.

“To build a culture of recovery you have to call forth and support the unlimited potential of consumers, families, and their communities and be proactive about changing beliefs about the stigma of mental illness.” Berry added, “That’s why we invest in peer specialists to be Mental Health First Aid instructors in our communities, sending a clear message that recovery works for even the most serious of mental illnesses and should be the community expectation, with ways to support it.”

The University of Maryland Center for Mental Health Services designed and analyzed a special evaluation of the two Georgia pilots. Results showed that the trainings delivered by instructors who share their lived experience of recovery during appropriate sessions received the highest approval rating possible by 96% of attendees with comments such as: “It greatly diminished stigma about mental illness and demonstrated that people who have experienced mental illness, including psychosis, can recover.”
“It made all the difference in the world. Someone else could have presented the material in an eloquent matter, but it would not have been as effective as sharing personal experiences.”

“People who are recovering and/or have personal experience make the issues real. They are not just ‘textbook cases.’

“The voice is far more empowering than hearing anything secondhand. I would rather see a sermon than hear one. These folks have lived it. Their stories give me hope and a new optimism about recovery and the many resources available.”

“Not only was hearing about the disorders from the “horse’s mouth” more interesting/informative, but they were powerful testimonies to the potential for recovery for people with severe mental illness.”

The pilots had such a positive effect on promoting recovery among community participants that OptumHealth — like Georgia — now invests primarily in Mental Health First Aid trainers who have recovery experience. That concept has expanded to other states, including Tennessee, where the Department of Mental Health and Substance Abuse recently began funding peer-delivered Mental Health First Aid through the Tennessee Mental Health Consumers’ Association.

“OptumHealth uses peers with lived experience almost exclusively to offer Mental Health First Aid in the communities we serve,” says Sue Bergeron, Vice President of Consumer Affairs for OptumHealth. “Having a person with the lived experience as an instructor helps participants better understand that recovery is possible and it further de-stigmatizes mental illness by allowing participants to get to know a consumer in recovery.”
Mental Health First Aid Enables Difficult Conversations

Cheryl S. Sharp, MSW, ALWF, CPSST, Senior Advisor for Trauma-Informed Services, National Council for Community Behavioral Healthcare

When I first heard about Mental Health First Aid, I was skeptical. I was cynical about yet another program that put me and others like me in a clinical box. When I took the initial training, I told my instructor that I was interested in learning about the program, but would watch with a critical eye for stigmatization of people who have mental and emotional struggles. I was hypervigilant regarding labels and diagnoses. I was prepared to naysay Mental Health First Aid.

As a person considered an “expert by experience,” I’ve been labeled many things over my lifetime. As a past consumer of services, labels bother me. John Briere said, “If we could somehow end child abuse and neglect, the 800 pages of the DSM would shrink to a pamphlet in two generations.” Indeed, many of the labels we have been given are rooted in adverse childhood experiences (ACEs). What the DSM frequently refers to as symptoms are often adaptation or coping mechanisms developed by people to find relief from the pain of trauma. As a person who also has a clinical background, I know the language of diagnosis, but I also learned to look through a trauma-informed lens at the world of struggles and challenges.

My mother also struggled with severe episodes of depression. Her life ended very early because of inadequate supports. I watched my father try to hold our family together and support my mother, and later both of my parents were bereft watching my struggles. They didn’t know how to help me. They didn’t know how to have a conversation about my challenges. They didn’t know what was available in the community. They had no words of comfort to offer.

Sometimes we just need someone around us to initiate a conversation that could change our lives.

My family loved me and wanted the best for me. They experienced anger, frustration, and disappointment, and at one point my father told me not to call anymore. He had done all he could. I now know that my family and friends could have benefited from being able to talk with me about my challenges in a way that would have moved me towards appropriate supports.

Mental Health First Aid offers family members, friends, coworkers, and the community a way to become comfortable having hard conversations. Being afraid to engage in difficult dialogues has stood in the way of many of us getting the help we need whether through groups, counseling, self-help, or peer support.

My experience of the training and attempts to look through the eyes of people without my experiences in the consumer-survivor movement or in the clinical world helped me understand that we have to speak a language that makes people feel comfortable and familiar. Once we have the initial conversation, we can begin a new dialogue. I learned that Mental Health First Aid is not about diagnosis, it is about giving people confidence to have conversations that they feared in the past.

Regardless of whether you become a Mental Health First Aider or not, you must have the hard conversations. Most of us with mental or emotional problems want, need, and crave talking, but often don’t have the words to do so. Sometimes we just need someone around us to initiate a conversation that could change our lives.

“Being afraid to engage in difficult dialogues has stood in the way of many of us getting the help we need.”
In December of 2012, I participated in my first Mental Health First Aid training in Montgomery County, PA. I quickly had nearly half of the staff at the homeless shelter where I work trained and am now working on adding the rest as well.

Two weeks after completing the training, I received a call from a shelter resident calling to say goodbye. He told me where he was going and why: he was walking towards a bridge to jump. I immediately went into “ALGEE mode.” I assessed the risk of suicide or harm was extremely high and contacted a co-worker to send police and rescue to the bridge. I listened non-judgmentally and gave reassurance and information on what I was doing in response to what he presented. I encouraged him to accept the professional help that was coming and encouraged him to utilize the knowledge and strategies he had developed for himself. Finally he said, “I can’t hold on.” The phone went dead. I sat at my desk waiting for the phone to ring again. In the meantime, I sent his caseworker and an outreach worker to the bridge.

The phone rang 10 minutes later and I learned that he was okay. The police got to him in time — though he had already committed to jumping, he changed his mind and was hanging onto the rafter. It took seven officers to get him safely back onto solid ground. I was thankful for their quick and professional response to his situation, and now, several months later, this man is preparing to move into his own apartment.

Though well experienced in crisis situations and response, I don’t know how this would have turned out had I not had Mental Health First Aid training. I do know, however, that running those five letters, A-L-G-E-E, and what they represent, through my head during the crisis allowed me to quickly and competently respond to what I was handed that day, and this man and I were handed precious gifts.

I am certain Mental Health First Aid will help everyone handle emergencies in the same competent and decisive way. Using the skills taught in Mental Health First Aid allows a person to assist another in a manner that is deeply personal, fully engages the person in crisis, and encourages dialogue that is truly human and life affirming. For people that care about people, which is hopefully all of us, Mental Health First Aid offers practical skills and information that develops indispensable knowledge in serving others.

Genny O’Donnell, Director, Coordinated Homeless Outreach Center, Resources for Human Development gennyo@rhd-choc.org

Mental Health First Aid Helped Me Save a Life!

He was walking towards a bridge to jump.

I immediately went into ‘ALGEE mode.’
Mr. Gibb: The Spokesperson in Us All
Bryan Gibb, Director of Public Education, National Council for Community Behavioral Healthcare

"Mr. Gibb, thank you for being on the show. My first question for you is how can Mental Health First Aid protect us from all the violent people out there with mental illness?" I was in an interview with drive time AM radio on a small rural station. I expected the question.

As a national trainer and spokesperson for Mental Health First Aid USA, it was not the first time I had been presented with that challenge. How do we address people’s fear and confusion, and still use the opportunity to educate, reduce stigma, and share the good news about Mental Health First Aid?

The tragic shooting in Newtown, Connecticut, and the subsequent endorsement of Mental Health First Aid by President Obama produced a deluge of media interest in mental health challenges, and we cautiously embraced the opportunity to share the myths and facts about mental illness and how Mental Health First Aid can help.

Individuals with mental illness are no more violent than the general population. I often discuss this fact in my teaching and in conversations with media. I’m also clear that during Mental Health First Aid trainings, we emphasize that we want people to be comfortable offering help and to take care of themselves. I share facts about early intervention — research shows that the sooner someone gets help for a mental health problem, the more likely they are to have a positive outcome and less likely to experience a crisis.

Media interviews on Mental Health First Aid have been great sharing opportunities. Once, I had a 2-hour conversation with a writer for a national bodywork publication who was doing a story on how massage therapists could incorporate the teachings of our program into their holistic practice. On NPR, I answered questions from listeners who wanted to know how to sensitively approach a co-worker who appeared to be depressed and whose symptoms were affecting staff morale. One of my favorite interviews involved a long conversation with a pastor one Sunday morning on an Atlanta R&B station. We discussed how urban churches could learn to better serve vulnerable members of their communities — in body, spirit, and mind.

Whichever the Mental Health First Aid team talks to, our messages are the same: mental illness is common and can be debilitating. However, mental illness is just like a physical illness. People can and do recover and live full lives if they get the treatment and supports they need. And with basic awareness and resources, every one of us can support our family, friends, neighbors, and coworkers.

My experience is not unique. Every one of the nation’s 2,500 instructors, as well as the 100,000 individuals trained in Mental Health First Aid, can be an ambassador for the program. The idea is so simple, and the public is so hungry for information and helpful strategies. The more we talk and the more we share, the more we dispel myths, help people, and change lives.

A First Aid Kit for Mental Health Emergencies
Excerpts From NPR’s Talk of the Nation

Guest: Bryan Gibb, Director of Public Education, National Council for Community Behavioral Healthcare

Many people know how to respond when colleagues hurt themselves, or are killed by heart attack or stroke. But few know what to do in a psychiatric crisis. The Mental Health First Aid program aims to teach people to respond to psychiatric emergencies, from anxiety to eating disorders to psychosis.

NEAL CONAN, host: This is Talk of the Nation. I’m Neal Conan in Washington. Many of us have been trained how to respond if a colleague suffers a heart attack or choking on food, but few know how to recognize a mental health crisis, much less what to do about it.

A program called Mental Health First Aid aims to teach people how to respond to emotional emergencies like anxiety, depression or psychosis. The courses take aim at a major problem. Colleagues might think somebody’s a klutz if they break their arm, but can respond very differently to a mental health crisis.

We want to hear from supervisors and administrators. How does this play out in your workplace? Give us a call...

CONAN: And Bryan Gibb’s at our bureau in New York. And you remember — may remember hearing him in a story on Morning Edition on Mental Health First Aid, and Bryan Gibb, I was startled to hear you say in that piece last week that we’re more likely to encounter a mental health crisis at work than a heart attack or somebody choking.

GIBB: Yes, it’s true. I mean, in the course we teach people how to look for signs and symptoms that show that maybe something has changed in the person, and maybe how to be aware of those and how to respond — ideally, as early as possible.

CONAN: And that would be of help, but people are also reluctant to intervene.

GIBB: Well, certainly, and most of those are low-intensity issues, not crises, but in the course we do prepare people how to respond to a crisis or just someone who’s starting to feel unwell.

CONAN: And it’s difficult because, as we say, if you see blood, you know there’s a crisis. It’s a little more difficult in terms of mental health.

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GIBB: Well, it’s true because I think there’s a stigma around mental illness that is not as much around physical illness. You know, when someone has cancer, you know, we bake a casserole, and we go down...
and we — you know, we knock on the door, and we provide our support. But if someone got a diagnosis for, you know, severe depression or schizophrenia, we may be less comfortable in approaching them and offering help.

CONAN: And I hate to say it, but in a workplace environment, people can be cruel.

GIBB: Well, certainly they can, but you know, I think HR professionals recognize that the most valuable resource for any organization is their people. And you want to protect that resource. If someone developed diabetes or something at the workplace, you would help that person get the services they needed so that they could be productive. We're just suggesting that someone with depression or anxiety or even a substance use disorder, you know, deserves the same kind of outreach.

CONAN: Take us through the training course. How similar or different is this from traditional first aid?

GIBB: Well, it's similar to first aid in that we don't teach people how to diagnose or treat. We teach people how to recognize, provide comfort, and refer someone to services. You know, in the course we teach, we have an action plan, ALGEE, A-L-G-E-E, much like the ABC of CPR, you know, the mnemonic device to help us remember the steps.

And those steps are A for assess for risk of suicide or harm; L, listen non-judgmentally; G, give reassurance and information; E, encourage appropriate professional help; and the second E is encourage self-help and other support strategies.

CONAN: So as you're going through this process, do you ask for help from a supervisor? Do you go to HR and say, what should I do? But often you're confronted with the situation right in front of you.

GIBB: Sure, and I mean, it certainly depends on the relationship that you have with a co-worker or a person that you're supervising. You know, certainly, HR professionals oftentimes are a little skittish about this issue, rightly so because they have very specific professional requirements about privacy and things like that.

And we often say, you know, treat someone in that case just like you would supervising them. You know, look for observable changes in their behavior, observable signs and symptoms, and ask them, you know, if they're OK and if you can help.

CONAN: If they're OK — that seems pretty basic.

GIBB: It does, you know, and Mental Health First Aid is very basic. And, you know, that's the first step, of course, you know, open-ended questions, encouraging someone to talk about what they're feeling or what, you know, they're aware of as far as they're experiencing their symptoms.

And it could be as simple as suggesting someone do some reading on the subject or even call the EAP, you know, the Employee Assistance Plan, which many workplaces have. And oftentimes, people aren’t aware of the services that they have available.

So they’ve recognized that this is something valuable for their members to learn and understand...

CONAN: We’re talking with Bryan Gibb, director of public education for the National Council for Community Behavioral Healthcare. And he leads mental health first-aid training courses around the country. If you’re in the workplace, if you’re a supervisor or a manager in particular, how does this play out at your workplace? Give us a call, 800-989-8255. Email us, talk@npr.org. And we’ll start with Tracy from O’Fallon in Illinois.

TRACY: Hey, good morning, Neal… But I have to tell you, it struck me, and then it struck me in my gut because I’ve been in the military for nearly 25 years; I cannot tell you how much education we’ve had, especially about suicide prevention, and yet in spite of the fact that training has occurred, I am being — I’ve been diagnosed with a mental health issue, and it’s not a physical issue that’s obvious to everybody.

But when you — when it’s been brought up, I’ve been turned into a bad airman as opposed to being a sick airman and — because you can’t deal with this. You know, why aren’t you able to deal with this? These are questions that my peers, my subordinates, my superiors in my chain of command have asked me over the past two years of my trying to deal with this.

I’m now seeking a medical retirement, and it’s just amazing to me that in spite of all the training, like how much ignorance there is still out there regarding mental health issues.

CONAN: And Bryan Gibb, we hear about that problem in particular with veterans returning from combat, but it is much broader than that.

GIBB: It is, and thanks for your question and your comments, Tracy. You know, I think what you’ve described is that there still is stigma around mental illness in our society, especially in the military. And unfortunately, one in three returning veterans from Afghanistan and Iraq will experience a mental illness in any given year. So the prevalence rates are even higher.

You know, and so part of what we’re trying to do with our program, you know, reaching out to everyone so that that stigma around mental illness is less, and it’s a — you know, it’s a slow process, but the lower that that stigma is, we hope that the more accepting society will be that mental illness is just like a physical illness; it just impacts us in a different way.

CONAN: Here’s an email from Wade in Kalamazoo: I had to deal with a mental crisis with a colleague. Of more significance than not knowing exactly how to respond was the fact that as a result of HIPAA, it was virtually impossible for me or my co-workers to get help for our colleague — and HIPAA, of course, the federal law that covers the privacy aspect of this.

GIBB: Yeah, and HIPAA, of course, is very important, and HR professionals, you know, understand what the requirements are. And you know, when we work with HR professionals, we say that Mental Health First Aid is just another tool in your toolkit. It doesn’t supplant any of your other, legal responsibilities or professional responsibilities.

But you’re right that, you know, the privacy of an individual is protected, and that can make it tricky in general, but especially in a workplace. You know, but we really encourage people to, you know, keep trying to, you know, ask — offer help if they can. And, you know, certainly if someone’s behavior extends to the point of being unsafe, or the person’s performance drops to a level where they, you know, they can’t do the job, then that becomes another issue.

But we’re really looking at generally, low-intensity conflicts with Mental Health First Aid. So the vast majority of those are going to be people who are just starting to feel unwell, and we want to teach people how to offer help.

Read more at www.npr.org/2011/10/18/141473382/a-first-aid-kit-for-mental-health-emergencies
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Lilly salutes the Reintegration Award winners and the National Council’s Awards of Excellence winners.
Awards of Excellence: 2013

Each year, the National Council for Community Behavioral Healthcare honors those who inspire us to fight against mental illness and addiction. Through its Awards of Excellence, the National Council spotlights the innovative and inspirational efforts of those individuals and organizations — staff, board leaders, volunteers, consumers, families, and community partners — who are changing the lives of children, adults, and families living with mental illnesses and addiction disorders.

In 2013, the National Council is proud to partner with Eli Lilly and Company to include the Reintegration Awards and Welcome Back Awards in the Awards of Excellence celebration. Since 1997, the Reintegration Awards have celebrated the achievements of those in the community who dedicate themselves to improving the lives of individuals with serious mental illnesses, and the achievements of those living with schizophrenia or bipolar disorder who battle tremendous odds to improve their own lives and the lives of their peers. The Welcome Back Awards were established in 1998 to fight the stigma associated with depression and to promote the understanding that depression is both common and treatable.

Honorees of the Impact Awards, Reintegration Awards, and Welcome Back Awards receive cash prizes of $5,000 to $10,000, to be donated to non-profit organizations of their choice.

2013 Honorees, National Council Awards of Excellence

Welcome Back Awards: Community Service
First Prize: Lois and Sam Bloom, Rancho Palos Verdes, CA
Second Prize: Candace Crawford, President/CEO, The Outlook Clinic, Mental Health Association of Central Florida, Inc., Orlando, FL

Welcome Back Awards: Destigmatization
First Prize: Alison Malmon, Founder and Executive Director, Active Minds, Washington, DC
Second Prize: David Granirer, Stand up for Mental Health, Active Minds, Washington, DC

Welcome Back Awards: Lifetime Achievement
First Prize: Major General (ARMY Ret.) Mark Graham and Carol Graham, Colorado Springs, CO
Second Prize: Michael Kuhl, President, Depression and Bipolar Support Alliance Louisville, Louisville, KY

Welcome Back Awards: Primary Care
First Prize: Dr. Georgy Thomas, Medical Director, Dayspring Family Health Center, Jellico, TN
Second Prize: Teen Health Connection, Charlotte, NC

Welcome Back Awards: Psychiatry
First Prize: Timothy Florence, MD, Medical Director, Washoe Community Support and Treatment Services, Ypsilanti, MI
Second Prize: Kelly Atkins, MD, Behavioral Health Medical Director, Volunteer State Health Plan of Tennessee, Chattanooga, TN

Reintegration Awards: Achievement
First Prize: Elliott Steele, Executive Director, Vincent House, Pinellas Park, FL
Second Prize: Carol Jean Garner, Director of Nonclinical Services, Midwestern Colorado Mental Health Center, Montrose, CO

Reintegration Awards: Advocacy
First Prize: Dylan Henry, Morgan Henry, Travis Henry, and Mari Arsch, Hope and Advocacy, Helena, MT
Second Prize: Fred Frese, MD, Hudson, OH

Reintegration Awards: Artistic Contribution
First Prize: Works of Heart Art Event and Auction Family Service & Guidance Center, Topeka, KS
Second Prize: Rebecca Atkins, Artistic Director, Second Step Players, Norwich, CT

Reintegration Awards: Clinical Medicine
First Prize: Child and Adolescent Bipolar Services (CABS), Western Psychiatric Institute and Clinic of UPMC Presbyterian-Shadyside, Pittsburgh, PA

Reintegration Awards: Education
First Prize: Fountain House, New York, NY
Second Prize: The Jed Foundation, New York, NY

Reintegration Awards: Employment
First Prize: Thresholds, Chicago, IL
Second Prize: Mental Health Center of Denver, Denver, CO

Reintegration Awards: Housing
First Prize: Main Street Housing, Inc., Baltimore, MD
Second Prize: Jewish Board of Family and Children’s Services, New York, NY

Reintegration Awards: Mentorship
First Prize: Bipolar Babe, Andrea Paquette, Executive Director, Victoria, British Columbia
Second Prize: Greg Dycharry, Magellan Health Services, Phoenix, AZ

Impact Awards: Excellence in Behavioral Healthcare Management
Winner: Grafton Integrated Health Network, Winchester, VA
Program of Significance: Vinnie National Center, Loretto, MN

Impact Awards: Excellence in Health Information Technology
Winner: Rhode Island Quality Institute, Providence, RI
Program of Significance: Riverbend Community Mental Health Center, Concord, NH

Impact Awards: Excellence in Service Innovation
Winner: Burke Center Mental Health Emergency Center, Lufkin, TX
Program of Significance: Southeast Mental Health Services, La Junta, CO

Mental Health First Aid Community Impact
Winner: Austin Travis County Integral Care, Austin, TX
Program of Significance: Fairlax Falls Church CSB MHFA Initiative, Fairfax, VA

Visionary Leadership
Joe Dziobek, President/CEO, Fellowship Health Resources, Inc., Lincoln, RI
Jose Friez, CEO, Families and Youth, Inc., Las Cruces, NM
Heather Gates, President and CEO, Community Health Resources, Windsor, CT
David Johnson, CEO, Naxos, Seattle, WA
George Kimes, Executive Director, Pennsylvania Community Providers Association
Dan Ranieri, CEO and President, La Frontera, Tucson, AZ
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Founded in 1957, Creative Health Services, Inc is a not for profit provider of community based behavioral health services to children, families and adults throughout Southeastern Pennsylvania. For more information, or to inquire about how we may assist you in your design and development projects, please contact Dr. Andrew Trentacoste at 484-941-0500 or visit us on the web at www.creativehs.org.